New approaches to integrated rural training for medical practitioners

Final report

Findings and outcomes of the consultation process and research component

A project funded by the Department of Health
31 January 2014

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Disclaimer

The five consultation summaries at Section 3, 3.1 (3.1.1-3.1.5) reflect the views of consultation participants engaged by the RACGP for the purpose of assessing the Review of Australian Government Health Workforce Programs (Mason Review). These views were captured across several recorded sessions. They are provided solely for Commonwealth consideration, and not for publishing. All participants are believed to be reputable and reliable. Their views reflect their then knowledge and understanding of the Mason Report (without RACGP input), however should not be regarded as a comprehensive consideration. Additionally, the summaries do not necessarily represent the RACGP’s endorsed position. A summary of the RACGP endorsed position appears in the Executive Summary. The RACGP accepts no liability for the views or content of any of the summaries, including in relation to any inaccuracy or misrepresentation, or any subsequent reliance on the content.

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# Contents

**Section 1: Project management**  
1. Project context  
2. Project reporting  
3. Project approach  

**Section 2: Findings and outcomes**  
1. Policy context  
2. Executive summary  

**Section 3: Policy input component**  
3. National consultations  
4. Case studies  
5. Policy surveys  
6. Stakeholder consultation  
7. RACGP State Faculty consultation  

**Section 4: Research component**  
4. Introduction  
5. Defining advanced skills in rural general practice  
6. Research – advanced skills in rural general practice  
7. Skills in focus  
8. Appendices  

**Section 5: Project activity materials**  
5. Project management activity materials  
6. Consultation activity materials  
7. Research activity materials
Section 1: Project management

1.1. Project context

1.1.1. Background

On 5 August 2013, the Department of Health, formerly the Department of Health and Ageing, ("the Department") and the Royal Australian College of General Practitioners (RACGP) signed a funding agreement for the project. The project, ‘New approaches to integrated rural training for medical practitioners’, included a broad project aim to provide policy advice to inform future rural training and workforce reform implementation. As outlined in the Contract for Services and Project Plan, the project was approached in two parts, with the specific aim of each project component detailed below.

1.1.2. Policy aim

To undertake consultations with the RACGP rural general practice membership to identify the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter general practice in regional and rural communities. This includes identifying the structural requirements and advanced skills training for new entrants and the existing general practice workforce. The input obtained will be guided by the key recommendations in the Mason Review relating to the coordination of training and the proposed National Rural Training Pathway (N RTP).

1.1.3. Research aim

To conduct research to develop quality data and intelligence around the training and support needs of rural GPs in order to acquire and maintain advanced skills and encourage their retention. A further aim is to identify the barriers for rural GPs to undertake training for an advanced skill to meet a need in their community. Broader retention issues including those around competing specialties and the need to ensure that communities can retain the desired rural medical workforce through a critical mass of GPs with advanced rural skills.

1.1.4. Policy advisory group

A project advisory group was formed to help guide the policy development, lead consultations and conduct research. The membership and their advisory function is provided below:

Dr Kathryn Kirkpatrick, Chair;
Dr Cameron Loy, GP Academic and Research Lead;
Dr Karin Jodlowski-Tan, Education Advisor;
Dr Rodney Omond, Advanced Skills Advisor;
Dr Morton Rawlin, RACGP Council Representative.

1.1.5. Project team

The project team comprised four members of the RACGP National Rural Faculty. The team membership and role is provided below:

Lauren Cordwell, Project Executive;
Bronwyn Darmanin, Project Manager and Policy Lead;
Kelly Dargan, Research Lead;
Hildegard Mostmans, Event Coordinator.
1.2. Project reporting

1.2.1. Final report

This report contains information about the steps taken by the RACGP to deliver the consultations and research in accordance with the terms and conditions set out in the Grant Agreement and outlined in the Detailed Project Plan. This includes a summary of the policy input from each consultation, policy analysis against these and the overall outcomes and recommendations. The report also provides the full findings from the research component.

1.2.2. Activities statement

In accordance with Item B of the Schedule and the Detailed Project Plan, the RACGP convened a series of national consultations between October 2013 and January 2014. The aim and approach for the consultation component of the project is outlined in 1.3 (1.3.1) and for the research (1.3.2). The policy analysis from the consultation input is provided in the Executive Summary at Section 2 (2.2.2) and for the research (2.2.2.3). The full summary of the national consultations is provided at Section 3 (3.1). The full research report is provided at Section 4 (4.3).

1.2.3. Challenges and opportunities

In accordance with Section E: Reporting (final report requirements, point 2), an opportunity to expand the national consultation series to include the Northern Territory was identified early in the project, after the post project brief (15 August 2013). Two additional consultations were added to the GP13 program in Darwin, on 16–17 October, with one session being added to the National Rural Faculty Member Forum (16 October) and the other to the Board Meeting (17 October).

In terms of challenges, due to capacity constraints during December within the College statistician team, the data analysis of the survey results was outsourced. The University of Queensland Centre for Military and Veterans’ Health was engaged to undertake the initial research analysis component against a robust service agreement. The key strategic writing task remained in-house and was undertaken by the Research Lead and members of the Project Advisory Group and Project Team.

1.2.4. Activity material

The activity material used in undertaking this project is provided at Section 5 in accordance with Section E: Reporting (final report requirements, point 3).

1.2.5. Findings and outcomes

In accordance with Section E: Reporting (final report requirements, point 4), the findings and outcomes of the consultation process are provided in the Executive Summary (Section 2) and Policy Input Component (Section 3) of the report.

1.2.6. Financial acquittal

In accordance with Section E: Reporting (final report requirements, point 5), an independently audited financial acquittal as per G4 of the Schedule will be provided to the Department by the end of March 2014.
1.3. Project approach

1.3.1. Project components

The Department funded the RACGP National Rural Faculty to facilitate policy discussion with the general practice profession and undertake advanced skills training research in the 6 months from August 2013 to January 2014. The shaping and implementation of a national rural training pathway and the coordination of training across the full training continuum were two key areas examined. Both were comparable policy areas with a shared policy outcome. The first was the coordination of training to find improved ways to address capacity concerns at several training points to meet recent growth in medical graduates. The other was the rural pathway to increase rural exposure and quality experience across the full training continuum, supporting retention and workforce maldistribution aims.

As well as these important training requirements for new entrants, the training and support needs of the existing general practice workforce required a related and parallel project focus. Specifically, the project explored some of the policy uncertainties around retention factors relating to the use of advanced skills by GPs in rural settings.

1.3.2. The consultations

The ‘investing in rural skills series’ involved four consultations across four states and were held from October to December 2013. The policy consultation process began in Queensland on 2 October, Northern Territory (16 October), South Australia (29 November) and New South Wales (10 December). Strong national representation was assured at each through state faculty nomination, with diversity in both career stage and rural and medical training experience. This diversity ensured comparative analysis in addressing the varying jurisdictional training arrangements.

The consultations were structured against six key themes:

- Access to quality care for rural and remote communities;
- Integrated rural training pathway;
- The use of advanced skills in rural areas;
- GP-rural generalist – defining the role and pathway;
- Embedding more primary care in the training; and
- Training capacity.

The policy analysis throughout this report has been developed from the input provided during the national consultation series. The input obtained was guided by the key recommendations in the Review of the Australian Government Health Workforce Programs (the Mason Review)\(^1\) relating to the coordination of training and the proposed National Rural Training Pathway. Other consultation methods were used to filter and further test advice including through electronic membership polling and reviews through RACGP boards and committees.

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1.3.3. Formal research

The aim of the research was to explore the advanced skills (both procedural and non-procedural) used in rural general practice, and to identify the barriers and enablers impacting the acquisition, use and retention of these skills. Advanced skills form an important component of healthcare in rural and remote areas. However, there is currently a perceived bias towards procedural skills (namely anaesthetics, obstetrics, surgery and emergency) in terms of funding and training support. This research defines what advanced rural skills are and clarifies the skillset required in order for GPs to provide safe, high quality holistic health care in a rural and remote context.

The research collected comprehensive qualitative and quantitative data through various research methods including literature review, survey and analysis of various datasets. The research addressed three key objectives:

i. Explore how advanced rural skills are defined by the general practice profession.

A literature review (Section 4.2) was undertaken to explore definitions of advanced rural skills and draw conclusions about how advanced rural skills should be defined. Comparative analyses of rural GP narratives were collected through a small sample survey to test this proposed definition.

ii. Clarify and identify the full range of advanced rural skills practiced in rural communities; explore retention and supportive factors in skill acquisition and maintenance.

Research (Section 4.3) conducted through a cross-sectional online survey targeted to rural GPs to determine the scope of need for advanced rural skills currently used and needed by rural GPs; and the barriers and facilitators to the acquisition, use and retention of these skills.

iii. Analysis and recommendations.

Research outcomes where analysed and recommendations developed for future training and planning to support the needs of rural GPs in acquiring and maintaining advanced rural skills.
Section 2: Findings and outcomes

2.1. Policy context

A number of recent health workforce reviews have highlighted the issue of workforce maldistribution in rural and remote Australia. The role of primary care and generalist medicine in addressing health disparities, particularly in rural areas, is an important part of the health reform discussion. The focus is part of the wider task required to address increasing health needs by devolving skills out of larger institutions and reversing the trend of recent decades towards increasing specialisation. The Mason Review identifies the development of an integrated rural training pathway with a focus on generalist training designed to increase patient access to primary care in rural communities.

The Mason Review’s National Rural Training Pathway (NRTP) proposal identifies a number of requirements to build a broader ‘specialist generalist approach’ to training that encompasses the full range of advanced skills. Adopting the NRTP proposal involves significant changes to both the coordination of medical training and structural arrangements that are presently complicated by variations in arrangements between jurisdictions. The positive yet significant shifts identified in the improved, more integrated medical training pathway include embedding more primary care, early linkage of intern positions with specialist training positions, and allocating placements according to specific learning needs. Prioritising more acute settings for senior students, while improving interconnectedness along the full medical training continuum, is an approach to both address capacity concerns and provide for more structured learning for the trainee.

In the interest of achieving vocational training objectives, specifically in meeting increased general practice placements and associated rural workforce gains, the proposed, targeted NRTP aims to provide a comprehensive rural training experience and seamless transition from undergraduate training into rural practice. The RACGP National Rural Faculty-led project sought to test some of these ideas and provide further strategies to advance a more integrated rural training approach for general practice.

2.2. Executive summary

2.2.1. Introduction

For the policy component of the project, the ‘investing in rural skills series’ national member consultations have enabled an important and timely policy dialogue to be undertaken with the general practice profession. These consultations have identified many innovative and practical solutions to address the current training capacity constraints and broader barriers to training. Efficient management of the undifferentiated patient presentation sets general practice apart from other specialities; the broad skillset required to provide timely, appropriate patient care depends very much on the health needs and context of the community. GPs tailor their practice to the community they serve, which highlights the need for training to be flexible and broad. Learning by GPs is lifelong and contextual to their stage of career. Training opportunities therefore ought to be adapted to the career stage and community need, including both upskilling and skills maintenance, delivered in a supportive framework which enables service continuity and practice viability, particularly in rural Australia.

The research component was designed to help define ‘advanced skills’ and clarify and prioritise those skills in greatest demand by GPs and the communities in which they work. The study shows that the view of ‘advanced skills’ extends well beyond the current procedural emphasis, which reinforces the position of the RACGP National Rural Faculty that there is a need for broad generalist training experiences, balancing the workforce imperative with training. There is a clear disconnect between the skills the profession values (e.g. mental health, emergency medicine, chronic disease management, paediatrics, small-town rural general practice, Aboriginal and Torres Strait Islander Health, aged care and palliative care) against those currently prioritised in embedded workforce policy (e.g. obstetrics, anaesthetics and surgery). Significant numbers of GPs are intending to remain working in rural Australia for 5 or more years, as identified by this study, and this provides strong evidence of the requirement for focused support strategies to sustain the long term rural commitment of both current and future rural doctors. 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.

“Policies and criteria for remuneration and recognition of advanced skills are ad hoc, characterised by jurisdictional complications and competing interests. Some advanced skills carry a remunerative imperative, as well as agreed requirements for ongoing maintenance of professional standards. These operational requirements impose a responsive definition of advanced skills within the sector that is not consistent with that understood by the general practice profession.” [Research Section 4.2, Structural Constraints]

2.2.2. Policy summary

There is a lack of flexibility in policy application, in the current training arrangements for general practice, to support the existing workforce to meet the shifting skill requirements to address patient and community need. Training solutions must be flexible enough to accommodate the fluxes that occur over the duration of a doctor’s career as the doctor responds to changes in their community, or changes in the doctor’s circumstances. Post Fellowship, there is a need for a flexible system that allows GPs to gain the additional skills they need, at a time that is appropriate for them. GPs working in rural and remote Australia need to be able to respond to shifts in government priorities such as hospital closures, as well as changing community need such as a specific rising chronic disease burden associated with an ageing population. The ageing population and increasing disease burden further emphasises the need for a patient-centred approach led by general practice and supported by primary healthcare teams.

For those in their early medical career and particularly those in prevocational general practice training, flexibility and choice are essential. As decisions or orientation toward rural practice may not occur early (medical student or prevocational doctor), restrictive early entry into rural training programs can be counter-productive to achieving rural recruitment. Early in medical education, emphasis is needed on primary care and generalism, accompanied by targeted rural exposure strategies. Recruitment strategies for students must allow for flexibility to provide a broad and varied training experience, which meets the needs of the learner and the learner’s future community. Workforce-driven policy which imposes negative conditions, including time constraints on acquiring skills and an overemphasis on securing positions early in training, are inherently overly restrictive. The key issue undermining policy success is the lack of support for the trainee to navigate the system from medical school through to rural practice. Support structures that empower and flexibility that enables choice are needed along with targeted, yet accommodating, incentives in support of rural intention.

The integration of general practice training has been impeded by jurisdictional barriers where state and national policies intersect. This results in silos around key policy and training decisions, which contribute to an underutilisation of existing training networks. Overwhelmingly, rural GPs are willing to support a new and more integrated approach across the full training continuum, as well as local commitment to find ways in their own community to build the networks and training culture required for success. A more seamless transition from undergraduate training to rural general practice, linking the different stages of training in a rural setting, can be achieved through investing in the development of Training Hubs in strategic locations led by the RACGP. Building community connectedness by establishing training communities across health disciplines will help to attract the critical mass of students needed for sustained success. This approach will enable trainees (at all career stages) to maintain a link to a specific rural community and provide for a more supported and positive rural training experience with tailored options appropriate to the learning stage and in line with community health needs.

2.2.3. Policy component: key learnings and recommendations

The key learnings and recommendations from the ‘investing in rural skills series’ are provided below and are structured against the six policy themes explored during each consultation. These have been further tested through a survey with the broader RACGP rural membership.

Theme 1: Access to quality primary care for rural and remote communities

Strategies to increase access to quality primary care are predominantly GP-led and achieved through innovations in technology, through building sustainable networks and skill-specific solutions that address service gaps. Needs analysis in rural areas would help to target and address unmet need. Some of the skill-specific solutions identified through the member consultations, such as local service solutions for the treatment of chronic diseases, will provide significant costs savings for government (by local management and treatment and avoidable hospital admissions) and enhance patient care. Establishing realistic expectations around minimum service obligation is an area identified for further research. Clarifying this area of policy (service obligation) will help to build a service standard and support equitable policy treatment in terms of prioritising interventions or incentives against need. The ASGC-RA classification system is not explored here, though informs this discussion.

Recommendations

1.1. A flexible funding solution is needed to meet the additional cost burden for private rural practices where they are meeting a broader public health service. This fund would support the general practice to sustain the local solutions that either work to fill a service gap or address a health need in their community. These solutions may address the distance and cost barriers for patients to access care, help reduce costly patient transfers as well as reducing the demand placed on the regional tertiary services.

1.2. There is support for a broad general practice experience during training, with the opportunity to gain advanced skills anytime during the GP’s career, to meet the needs of their community.

   1.2.1. Ensure better planning to align training investment to service need with priority for primary care and generalist training for rural and remote practice, supported by appropriate infrastructure.

   1.2.2. Facilitate upskilling opportunities in the local setting by linking visiting specialists with GP registrars while retaining flexibility of choice for those wishing to acquire such skills at a later stage.

1.3. Create an ‘access innovation fund’ that empowers GPs in rural and remote areas to access training and supervision to address a skill or service gap and meet a community need.
1.4. Flexibility in training to include both generalist and advanced skills, acquired in hospital and community that build resilience and confidence. Primary care generalist skills are essential for safe, quality care in rural and remote communities and should not be overshadowed by acquisition of advanced skills.

1.5. Provide incentives to support the development of outreach clinics (in areas of identified need) to enable patient access, enhanced teaching capacity and spread of multidisciplinary teams to sites in rural areas. Focus effort on areas that provide both a training benefit and meet a community health need. Provide the incentives both financial and professional to link training with the outreach services and build these opportunities in to the rural training pathway.

Theme 2: Integrated rural training pathway

The need for more targeted investments to support the creation of training hubs in rural towns across all medical disciplines is supported by the participants at the consultations. There is a need to develop hubs at strategically placed rural locations to support a critical mass of students who make community connections that continue in intern, prevocational and vocational training years. Linking the different stages of training in a rural setting requires system reform to remove the current barriers and provide for more flexibility and choice in training. Supportive structures inherent to the hubs will encourage a broader team-teaching and learning approach and help to draw out the untapped teaching workforce across disciplines. Creating partnerships between the key local education, training and health providers – the local GPs, local hospital, Rural Clinical School, universities and Regional Training Provider – will be essential for a sustained and integrated training effort.

For the integrated rural training pathway model to work effectively there must be investment in a coordinator position to address the major barriers, including navigation of the system for the learner and the administrative burden placed on the teacher/supervisor. A relatively small investment would lift these current and significant impediments and facilitate a varied training experience, which fully utilises the local health and education networks. The recommended approach is a policy shift from the current relatively individualistic model. The current model imposes significant administrative constraints on the teaching workforce and fosters confusion for the learner. Experience shows that a move to partnerships that permit regional autonomy and better local support structures have positive impacts on numbers training in the area and translate to workforce retention.

Learners’ perceived key enablers for rural training (tested by survey) include flexibility and choice (the what, where and when of learning). A critical mass of students is deemed less important to the learner than the quality aspects of the placement, including mentoring and coordination supports. However, it is clear that a critical mass of students matters in terms of viability for the teaching network. Learners consider strategies of early exposure to rural and remote communities, voluntary long-term rural placements together with medical schools in rural areas and rural GP university teachers, to be more effective than bonded or compulsory placements for recruitment and retention. There is a strong learner preference for rurally based internships that combine acute hospital-based training and community-based primary care training or blended placements that are offered in a range of rural settings. Rurally based internships would help develop the broad range of skills required by rural GPs and facilitate a seamless transition from undergraduate training to a rural medical career.
Recommendations

2.1. Provide a national system to coordinate an integrated and consistent strategy, which enables support across the full training continuum, allowing for flexibility and choice of placements for the learner. This approach would provide the assistance to navigate the system with incentivised support for community (trainee) internships and include a mentoring component.

2.2. The national system should be underpinned by a supporting policy that sets minimum durations for rural placements, enabling shorter periods during the early years, moving to more extensive periods as skills develop with the option of returning to the same community. Ensure training can remain rurally based with rotations to urban centres as required.

2.3. Prioritise rural training with better utilisation of locations that already have capacity across the training continuum, including regional locations around catchment areas of the Rural Clinical Schools. There needs to be balance in the training time spent in hospital and community, with the flexibility for the learner to change focus and enable movement and choice.

2.4. Ensure the training pathways are flexible, with the option to change, and without compulsion. This will help ensure there is sufficient exposure to rural practice, but also secure resources for those with a genuine commitment to rural training.

2.5. Explore the concept of an integrated rural training pathway across the specialty colleges, with foundation generalist training to all prevocational doctors.

2.6. Invest in interdisciplinary rural learning hubs in locations that ensure the learner/trainee can be placed in a rural community for a substantial period, allowing for community-led models and solutions that develop and sustain the training pathway. Funding for a 1.0 FTE training coordinator is required to provide integrated support for coordination of training within the local training hubs, in order to facilitate and sustain the networks.

2.7. Encourage a shift to extended placements in the same community, particularly those providing a high quality education. Clear induction and information regarding the curriculum and learning outcomes from universities to supervisors is required and expected. Adapt placements to meet local community circumstances and health needs.

2.8. Provide learning and training opportunities for the supervisors, including critical reflection activities.

2.9. Ensure more effort targeting suitable GP trainees for rural practice, with due consideration of the known influences (rural background, rural intent, rural-role models, rural curriculum, ruralised assessment, high quality rural placement), and retain them by enabling more flexibility and skill choice throughout training.

2.10. Support further research to determine the factors that influence rural intent and ability to study medicine at a tertiary level.
Theme 3: The use of advanced skills in rural areas

A number of policy considerations around the use of advanced skills in rural areas have been examined. The first is valuing the role of advanced skills and addressing the current policy inclination (by governments) to prioritise or value certain skills, namely procedural, over others. This is currently impacting skill acquisition by rural GPs who wish to address patient and community need. A second focus area relates to career stage and timing to acquire advanced skills with differing policy consequences and requirements for the practising GP compared with the trainee (intern or registrar). The issue of specialist competition will require attention by governments, particularly where the GP-proceduralist is locked out of providing services.

The focus in recent years on acquisition of advanced skills in the early training years in response to workforce maldistribution and workforce projections has left little room to meet the existing workforce needs. There is now an urgent need to build a skill-acquisition pathway for practising rural GPs. It is broadly accepted that advanced skills are those that are required to meet community need beyond broad generalist skills; therefore the advanced skills needed will depend on the context or the health care needs of a particular community. In providing the supports for GPs to train or upskill there is a need to recognise the context of where the GP works and extend the focus beyond procedural skills to encompass the full range of advanced skills including, but not limited: to mental health, Aboriginal and Torres Strait Islander health and palliative care. Limiting supports to a narrow set of procedural skills will continue to produce focused rather than holistic care for communities.

Flexible training that enables choice for those at the early career stage, in terms of advanced skills acquisition, is supported. System rigidity and uncertainty caused by workforce-driven policy, such as some rural medical generalist models, needs to be addressed. Time constraints on acquiring skills and an overemphasis on securing positions early in training is providing for a very uncertain environment. A broad and varied training experience is required to meet both the needs of the learner and the community.

Recommendations

3.1. Define advanced skills. Establish funding support for both procedural and non-procedural skills.

3.2. Restructure training: Prioritise the core general practice standard in rural Australia. Advanced skill components of training are decoupled and can occur anywhere in training or within the career cycle of a GP.

3.3. Develop a specific skill-acquisition pathway for practising GPs, which will ensure access to training opportunities for GPs who identify a new complex need in their community so that they can acquire the skill and access the training to address it.

3.4. A new incentivised program aimed at qualified GPs wishing to work as a locum in an Aboriginal or Torres Strait Islander community. Potentially, this would be a targeted 3-day CPD program with clinical and cultural content specifically related to working in an Aboriginal or Torres Strait Islander community. This strategy would encourage greater mobility among existing GPs, providing specific and targeted educational support in the skills most relevant to remote health and particularly Aboriginal and Torres Strait Islander Health.
3.5. Address competing specialist obstruction through the protection of roles for GP-specialists and develop retention guidelines so that those who have undertaken training cannot be restricted from using those skills in areas of identified skill need.

3.6. Provide a skills-investment and return-to-work fund to enable those GPs who may have lost a skillset due to under-utilisation, or are returning to work after a period of absence, to go back and retrain in an identified skill-in-demand area.

3.7. Value the GP VMO role through facilitating more support and opportunities in rural and remote areas.

3.8. Address the current disconnect between the training and role security through providing a clear and flexible pathway for trainees, one which shifts the responsibility for finding positions onto a central coordinating body.

3.9. Build a key role for the GP colleges in credentialing ARST posts.

3.10. Explore options for establishing dedicated general practice community-based advanced skill training posts, including ongoing support mechanisms.

3.11. Develop a dedicated, clear pathway for the acquisition, use and maintenance of advanced skills.

3.12. Broaden existing supports to encompass the full range of advanced skills needed in meeting the needs of rural communities.

3.13. Provide ways to encourage local leadership in identifying and structuring advanced skill training requirements, with a focus on retaining the trainee in the community and maintaining a continued link to general practice training whilst undertaking the training.

3.14. Provide for more formalised structures to enable rural GPs to undertake advanced skills training with recognition in areas that address a specific skill or service need for their community or in an area of interest.

Theme 4: GP-rural generalist – defining the role and pathway

The current procedural focus of the various state-based rural generalist models is designed to address a specific workforce problem. A workforce solution for a specific system issue, or demand for a narrow set of skills, holds certain risks. An overemphasis on the qualifications and supports from one narrow pathway will potentially limit the creation of an efficient national workforce. The literature identifies primary care as cost-effective and efficient in improving the health of communities. In order to increase access to general practice and primary care by rural patients, future training investment will need to encompass a broad range of approaches to produce the doctors with the generalist and advanced skills needed, to provide both primary and secondary care. The consultations reached a near-full consensus on the need to prioritise a broad generalist focus within training, which must include incorporation of more primary care into training. The current policy preference to value certain skills over others is at odds with the profession. Shifts are required to ensure a more balanced approach to general practice workforce planning to address any unintended consequences for the profession, rural patients and communities.


Recommendations

4.1. Provide incentives to encourage the acquisition of advanced skills in rural areas. This includes supports for those who wish to upskill to meet a need in their community. Additional funding support and program focus should value broad generalist skills and not focus only on procedural skills.

4.2. The rural generalist pathway complies with Recommendation 3.2 above: Restructure training: Prioritise the core general practice standard in rural Australia. Advanced skill components of training are decoupled and can occur anywhere in training or within the career cycle of a GP.

4.3. Provide flexible and ongoing support for the use and maintenance of advanced skills by GPs.

4.4. Explore options for increasing recognition (right to practice) and credentialing of advanced skills (secured positions) at both federal and state levels.

4.5. Ensure RMG pathways do not have a detrimental impact on the broader rural general practice training positions.

4.6. Replicate the supportive qualities of the Queensland RMG model to other training pathways, but with a focus on more generalist primary care skills. Ensure the focus also allows appropriate terminology reflecting the generalist nature of the training.

Theme 5: Embedding more primary care in the training

The importance of primary care must be reinforced from the commencement of medical training. This emphasis must continue throughout training with shifts in the current arrangements to enable interdisciplinary training. Community-level investment is warranted to enable communities to develop localised training solutions, which match their healthcare needs and service construct. This will include development of partnerships and arrangements to train across a broad scope to meet continuing comprehensive patient needs.

Recommendations

5.1. Provide the funding environment for large-scale commissioning of community interdisciplinary rural training hubs that facilitate primary care experience across the training continuum.

5.2. Provide the funding environment to support vertically and horizontally integrated approaches to teaching and facilitate innovative local approaches to supervision (mindful of relevant standards).

5.3. Embed primary care into the medical curriculum as a key component of training with emphasis on coordination of care.
Theme 6: General practice training capacity

The investment in interdisciplinary training hubs in targeted locations together with the provision of a coordinator position will address many of the current impediments to teaching. However, the constraints of the small business model of general practice on building training capacity in the rural and remote context remains a significant challenge. Reforms including use of available expertise (community partnerships) and enabling tailored training relevant to the community setting should be considered. Communities ought to have flexibility to design local training solutions and trainees must be empowered to make career decisions. Neither can occur with the current restrictions to incentivised conditions. There is a need to build on successful approaches that promote training integration and ensure the current incentivised schemes similarly support integration.

Recommendations

6.1. Build on the successful teaching models that are working in the rural and remote context and encourage the integration of RTPs and universities to facilitate teaching across all training stages.

6.2. Develop and implement models of regional training that support integration of vertical and horizontal teaching, multidisciplinary teaching and include hospital and community partnerships. These models will include local community teaching hubs (with support funding for accommodation/teaching venues). Ensure a responsive system for learners at all stages of training, which must include appropriate supervision. Build supports at a regional and community level that focus on retaining general practice viability, including the provision of private practice infrastructural support to accommodate the expansion of training. The models will be established using evidence-based best practice and include evaluation of all programs.

6.3. Streamline the processes for accreditation for teaching (student, prevocational and vocational) to reduce the administrative burden on general practices, particularly for practices teaching across the training continuum. Reduce ‘red tape’ for all educational providers.

6.4. Trial and evaluate innovative and flexible supervision models to support on-site supervision in the rural and remote context. The models will include broader community partners and expertise (outside of the practice) to enable niche-teaching models (e.g. aged care or diabetes management).

6.5. Review the current remuneration and incentive schemes to ensure incentives support the vertical integration of training across the full training continuum including: enabling payments for multiple students (PIP restriction); addressing payment restrictions associated with prevocational intern rotations; and considering the broader policy constraints associated with running a small business.

6.6. Provide encouragement/incentives for GPs to undertake professional development and upskilling in teaching and supervision as part of their career path.
2.2.4. Research component: Key learnings and recommendations

Quantitative and qualitative research was undertaken to ascertain the nature of advanced skills practice in rural communities and understand the training needs of rural GP members. The 1722 survey respondents represent a significant sample of Australia’s rural general practice workforce, providing information vital to future policy development.

The major findings of the research are provided below, the recommendations follow.

The key research outcomes provide a substantial contribution to inform future policy concerning targeted advanced skills supports for rural practice. Importantly, in prioritising future funding, the research offers clarification of a number of policy contradictions, specifically relating to (a) the current approaches that favour certain skills over others, (b) helping to define an advanced skill and (c) clarifying the scope of skills practiced in rural and remote areas. This has been achieved by asking the profession to identify the key skills applied in their community. Through testing the current skill bias (e.g. the Rural Procedural Grants Program is only available for obstetrics, anaesthetics, surgery and emergency medicine), the study has shown that advanced skills extend well beyond the current procedural skill emphasis. Further, GPs practise advanced skills in response to community need and therefore the skills are determined by context. Given there has been a lack of focus on the full range of advanced skills practised by rural and remote GPs, access to support for skill acquisition is lacking for the majority and focused on the minority. Supports for the acquisition and maintenance of skills differ according to career stage. Practising GPs identified access to training opportunities as the key requisite, whilst trainees (registrars and prevocational doctors) saw the need for a supported training pathway. These differences highlight the necessity for separate training strategies depending on stage of medical career.

The research presented many significant findings, which help to provide clarity around the extent of advanced skills used and required by GPs in rural and remote Australia. The number of skills acquired and used across most areas increases with rurality. Mental health is the most commonly practised advanced skill, followed closely by emergency medicine and chronic disease management. Emergency medicine is the most commonly acquired (not applied) rural skill, followed closely by mental health and chronic disease management. Examination of the national distribution of skill use identified mental health as the leading rural advanced skill in five of the states and territories, followed by emergency medicine, in two states, and chronic disease management, in one. Of those GPs who have acquired an advanced skill, most are continuing to use that skill with the exception of anaesthetics and obstetrics, for which there is a notable drop-out rate. South Australia has a significantly higher percentage of proceduralists (both acquired and continuing to use the skill) than all of the other states and territories. Of those skills that GPs would seek to acquire to meet a community need, emergency medicine was the most prevalent, followed by palliative care, paediatrics and mental health.

There were a number of notable factors in the study affecting skill retention. Training opportunity was identified consistently as the leading factor for acquisition and maintenance of the skills and to regain competence. Financial incentive and professional support were also important factors. Factors that impact the ability to practise skills differed between age groups. Older persons were more likely to report skill maintenance, lack of remuneration and credentialing arrangements as impediments to practice, whilst lack of a career pathway was more of an issue for younger responders. The need to address these retention factors with a focus on career stage is reinforced by the intent to stay in rural or remote practice. Ninety-three per cent of those with an advanced skill intend to continue to apply these skills in a rural area. Importantly, more than half of those surveyed plan to remain in rural general practice for 5 years or more, with 30 per cent intending to stay 10 years or longer.
Recommendations

1.1. Definitions for advanced skills fail to reflect the full scope of skills practiced. Skills beyond procedural skills, as identified in the study, must be acknowledged and fully supported in future training and workforce planning strategies.

1.2. Future workforce positioning by governments must factor the full definition and scope of advanced skills practised in rural and remote Australia and acknowledge the distinct and separate learning requirements of the practising GP and trainee.

1.3. Fund further skill acquisition and maintenance support for the existing workforce, taking into account the extended skills identified and prioritised by the profession through the study.

1.4. Provide a supported pathway for trainees to acquire advanced skills, ensuring flexibility and broad skill choice, thereby empowering the trainee to make informed career decisions.

1.5. Support further research on the correlation between advanced skills acquisition and retention, both in terms of retention of skill and retention to community, with a particular focus on recognition, motivation and supportive factors. Regulatory and non-regulatory options and impacts, including mandatory ongoing QI&CPD requirements and remunerative issues, should be explored.

2.2.5. Conclusion

The leadership and input received over the six-month project period, both through the policy consultation process and research component, has helped clarify many areas of rural and remote medical workforce policy. In almost all areas examined, the advice received indicated a need for flexibility in the policy approaches. This reflects the vast differences between rural and remote communities in terms of patient population, infrastructure and service capacity and capability. There are differences too at an individual practitioner level in terms of training needs and how these are met, with distinctions between learning stage and time in career.

The lifelong learning requirements of the GP to address the changing patient and rural and remote community need should underpin funding decisions for a more targeted policy response. The trainee (medical student, prevocational doctor, registrar) will benefit from a more streamlined, coordinated national approach to rural training, which encompasses flexibility and choice.

There is a need for much larger-scale and more targeted investments. The interdisciplinary training hub will help facilitate the integrated rural training approach, lifting many of the current barriers for both teacher and learner, thereby creating a strong teaching culture and quality experience for the learner, translating to local workforce retention. Overall, a balance is required to ensure future policy meets the needs of and values the existing rural and remote workforce – 8322 dedicated GPs – and builds the next generation of rural GPs.
Section 3: Policy input component

3.1. National consultations

Five consultations were undertaken with the RACGP rural membership to identify the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter general practice in regional and rural communities. This included the structural requirements and advanced skills training for new entrants and the existing general practice workforce. The consultations were held in Brisbane, Darwin (two sessions), Adelaide and Sydney from October to December 2013.

3.1.1. Brisbane consultation

The first member consultation was held in Brisbane on Wednesday 2 October from 11am to 3.30pm. This session was contained to a small policy group of eight GPs to help test and refine the questions. The group provided some useful insights into the workings of the medical training system and provided a number of solid and practical solutions to the many issues experienced. In terms of the Department imperative to capture career-stage and locational aspects, this group were all experienced fellows of the RACGP (FRACGP), with a number holding an advanced skill, procedural and/or non-procedural. All were very involved in teaching either in the community or at a state or regional level, or within the university or training system. Whilst the individual has been de-identified, detail on the advanced skill and location is provided where relevant. The discussion is captured against theme.

Theme 1: Access to quality care for rural and remote communities

Introduction

The Commonwealth’s increased focus on ensuring education and training matches demand and reflects the way health services are delivered in rural areas is an agreed policy priority. This extends to securing more equitable outcomes through enabling and supporting innovative responses to meet service and distance constraints.

The discussion

The idea of matching service to demand is not considered a new innovation, but a core characteristic of rural general practice. Not every town is the same and different solutions are required. There is a strong reliance on GP leadership in meeting the broader needs, often falling between or outside of funded program areas. Most interventions are therefore self-funded and led by the private practice, GPs or the broader medical community. This is particularly evident where additional training or upskilling is required to address a workforce or service gap, or where broader service solutions are needed to address distance or isolation issues. The idea of skill-specific registrars or linking specific skills training in areas of need to help build sustainable services was discussed. The discussion brought to the fore the important requirement that the training needs to provide ‘the all-round GP’; acknowledging the many and diverse focuses over the GP’s career. Therefore instilling resilience at an early stage was deemed very important. A summary of the discussion follows.
1.1. Access solutions

1.1.1. Access through technology

Service solutions varied in this group, as these are location-specific and distinctive to an area, but the use of technology to provide medical care was seen as an important innovation for rural and remote communities. These new technologies or approaches included telehealth and even the adaptation of common devices such as the use of iPhone images. These types of technological responses are now widely available and seen as essential, particularly in the more remote locations. These provide access to medical care for rural and remote patients in a different way. Huonville in Tasmania is an example of where these services ensure outreach to nearby island communities. In this case, the use of such technologies was comparable to direct-service health outcomes. These arrangements depend on structures being in place (computers, internet and mobile phone access), which are almost entirely incumbent on the GP and local area to set up and sustain.

1.1.2. Access through building sustainable networks

One concept, thought to be often overlooked, is the importance of establishing ‘area resilience’ to support service continuity. This includes the building of relationships to establish and sustain networks. The face-to-face trust established between GPs and specialists for the area of Proserpine was used as an example. This medical community has ensured these connections and relationships are maintained through frequent workshops and education events which coincide with specialist visits. These self-funded activities enable GPs, other specialists and broader healthcare teams to come together regularly. They provide a benefit for the rural patient, by ensuring stable, sustainable services can be delivered locally. The services are reliant on supportive networks outside of the immediate community, and provide a broader training benefit, by ensuring skill maintenance through upskilling events and weekend workshops. This ensures the continued application of advanced skills, which allows a higher level of care to be provided locally.

The skills currently include obstetrics, anaesthetics and surgery, and whilst these procedural skills are acquired elsewhere, such as in Mackay or Cairns, the ongoing requirements to ensure service sustainability and quality care are achieved through the self-directed, networked arrangements and opportunities. This also supports succession planning by ensuring ongoing service provision and capacity to both fill and sustain a precise skill match. For example, 2.5 FTE obstetrics service allocation equates to 300 births per year. Whilst initially a maternity-led program, the planning in terms of skill and service continuity has carried over to a well managed plan by the local area’s GPs. The local doctors have identified the current hospital allocation is inadequate for a facility delivering almost 300 babies annually and efforts are underway to help another SMO at the hospital to gain Advanced Diploma level training (DRANZCOG advanced) and to return to Proserpine.
1.1.3. Access through skill-specific care

Many in the group made the point that skill-specific care extends well beyond “big P” procedures (obstetrics, anaesthesists and surgery) and can include population-specific areas such as Aboriginal Health, palliative care, mental health or paediatrics as well as specific chronic disease focus areas such as diabetes. Advanced skills are used more frequently in rural and remote areas and it is often these areas where the health needs are not being met. Needs analysis for each rural town will inform the skill-specific registrar training responses and ensure appropriate targeting to help build sustainable services. The following example against an advanced skill in chronic disease management was used to illustrate the point and in addressing an unmet need.

The example in Diagram 1 describes a solution to a current health burden with known cost impacts that are increased by distance. The provision of a clean environment for dialysis, somewhere to store the resources and a GP with a clinical interest provides the service solution. An initial telehealth consult with a renal specialist and the equipment are all that is required for establishment. This enables treatment closer to home, thus meeting broader cultural considerations important in supporting Aboriginal and Torres Strait Islander communities. An example was cited to justify the service need in Cunnamulla where two youths died in their 20s from renal failure. Broome and Derby have these services and they could be replicated in places like Cunnamulla.

Diagram 1: Advanced skill chronic disease management

Obstetric services are another example for this population group. The cultural imperative of women wanting to give birth in their own area and who would go bush rather than being transported away from their community requires careful consideration. The consequences of infrequent or non-existent antenatal care for these women are well known and include gestational diabetes and increased perinatal mortality and the burden builds. Chemotherapy access is another example; again, establish the service locally and ease the burden of extensive travel for country patients. This can be established initially through an oncologist linked with GP and nurses. The initial oncologist consult takes place in a major centre, perhaps by telehealth, then all services thereafter are provided by the GP and nurses in the rural or remote location. Townsville has successfully implemented this model.
1.2. Skill-specific registrars

The previous discussion leads in well to the vocational training discussion and idea of skill-specific registrars being placed in rural areas. This approach is viewed overall as something that would work well for rural areas. It would support recruitment aims by helping to inform choice for those with a particular skill and interest by providing experience in that skill or field in a supportive community environment. Principles are important, including balancing the training time against addressing the workforce need. There are risks in an approach with an emphasis on addressing a short-term workforce answer in a training environment. The focus should be ensuring the core elements of general practice and the advanced skill are covered, as opposed to a focus on how early you want someone applying skills. Put another way, ensuring the core primary care skills are incorporated into the training in order to gain sufficient and broad exposure to the skills required for rural and remote practice.

The recruitment benefit may not end up being in the actual training location, but the approach could work to entice a registrar to another similar rural area or service. Widening the skill choice or opportunity to encompass all advanced skills whilst ensuring flexibility was seen as essential, with recent workforce responses viewed as too narrow. It was the group’s view that skill-specific registrar recruitment would work well for those areas where a particular skillset is required for location or population specific need, such as in Aboriginal Health, Defence and Refugee Health. The risk in the approach is the potential for the registrar to gain insufficient exposure and training in other areas of general practice. An unintended consequence of a short-term 6 or 12-month placement is that it may create a complicated and temporary change in arrangements for the training location. It would be important that registrars are rotated through the service continuously.

1.2.1. Building broad skills

For the Shepparton area (RA2), GP-obstetrics is vital for the town and the service is sustainable with good support from specialist obstetricians, but there are issues with recognition of GP-obstetricians by the hospital. Issues with specialist competition caused a decline in the number of GP-obstetricians in the town and there is certainly scope for existing GPs to enter obstetrics training. It is important to broaden the skill focus, with an example provided of a doctor who shifted career from ophthalmology to general practice and now that advanced skill is an important part of their practice. An area requiring development is in aged care, where registrars seem to struggle. There is a need for a champion to instil an interest and work on building a broader skill focus around care of the older person.

A further example of a shift in focus as well as rural resilience and determination to continue to meet community requirements was provided from the Riverlands. The GP, in this consultation, holds two procedural skills in anaesthetics and obstetrics. The hospital service for those skill areas shifted some years ago to the regional hospital 20 km from her town. Although an experienced proceduralist, this doctor now uses other advanced skills to meet community need. For this South Australian town (RA2) of 8000 people, it is the non-procedural advanced skills that fit best and fill the pressing service gaps. The GP now has a broad area of focus that covers mental health (adolescent), aged care (over 65), palliative care and chronic disease management. This demonstrates the wide range of skills used and varied focus over a career.
In terms of training, this Riverland practice currently has a significant GP training role and ongoing commitment to its student cohort who are predominantly from small town backgrounds. Their students are already committed to rural practice despite negative perceptions around the role – negativity which has come about as a result of sector cuts to small rural hospital services over many decades, resulting in little continuity in the health system. Developing skills around the ongoing care considerations are the areas that best serve the community. The statistics around early childhood intervention from a rural paediatrician show the huge differences that can be made and the impact these interventions have over a lifetime. It is not only the need for obstetric care, but skills in providing the next phase of care are where the biggest differences are made. It is important to stretch registrars to gain skills and experience in other areas of medicine, not just the big “P” procedures and the breadth of skills that build resilience.

A broader area of skill focus includes public health, which is not often included in the advanced skillset, but the students (Flinders) who are motivated to remain rural based also want a role in addressing services through advocacy or broader policy participation in public health roles. Other considerations include the current time restrictions on student and registrar placements; the short-term nature translates to difficulty in ensuring the student and registrar can truly become part of the community. There is a need to find solutions which allow students to get further involved in the community, and ways to attract and retain talent. Communication skills are important elements to enable the registrar to manage the professional networks, including consultant colleagues. This helps to gain the resilience and confidence through training and over time to be able to advocate on behalf of their patients.

Theme 2: Integrated rural training program

Introduction

Seamless transition from undergraduate training to rural general practice by linking the different stages of training in rural settings is considered a key reform to address both the missing links in the training and past failures in approach. Strategies to promote connectedness, support of rural intention and maintaining a link to community are vital aspects of a successful model, and these are the areas which need further policy focus.

The discussion

The discussion highlighted that the training ideal of an integrated training approach is already occurring in some areas, but only through great determination and commitment by the local medical training community, and often at significant personal cost. The creation of learning hubs in rural towns, across all medical disciplines, is seen as the key mechanism to support this change more broadly. The discussion captured ideas which emphasised key structural shifts and further investments that need to occur. Two case studies are provided to illustrate the point. These are provided at Case Study 1: Proserpine and Case Study 2: Emerald, in Section 3.2 of the Report.
2.1. Influencing career choice

Early exposure strategies to provide a quality experience must incorporate flexibility, including sensitivity to choice by the learner. It is important to realise that many students don’t necessarily know at an early stage that they want to pursue a career in rural or remote practice and it can be a decision that comes with confidence and maturity. There is also potential to limit the rural pool by not providing that chance for individuals to make the choice for themselves. But this also needs to be balanced against the current trend in some states, with South Australia being the case example, where students advise that by year 1, a decision needs to be made or they won’t get into a postgraduate program.

Encouraging choice and take-up by addressing some of the barriers placed on students is another consideration. Rural origin and review of entry scores are seen to be important strategies as well as addressing the financial constraints on students and families in the context of rural disadvantage. Families are already under significant financial strain from years of drought or other climatic events, as well as the broader national economic impacts felt more acutely in these areas in recent years. Increasing rural intake to 35%, in line with the regional (against urban) population split, and tiered to funding is another important strategy. The University of Queensland is planning to increase rural intake quotas to 35% in coming years. The use of community advisory groups, including rural doctors and rurally inclined medical students, to provide career talks to year 11 and 12 students is seen as a good approach to increase interest in rural general practice career.

Opinion is both divided and uncertain in terms of predicting rural inclination – often cited as the biggest predictor of ‘going rural’ is a spouse from a rural area rather than rural origin itself. But the only clear indicator from the research is for those who have undertaken primary school in a rural area. The University of Queensland is currently undertaking further research in this area and is tracking students over time, which may help clarify perceptions and in turn help hone recruitment efforts. In terms of coercive strategies, there is a strong view that the stick only works if the experience is positive when you get there. The restricted forced linkage programs must be evaluated and monitored to ensure the student is well supported and that there is variation and flexibility in a quality training experience.

2.2. Building resilience

The idea of ‘super doctor’ should be discouraged. The resilient doctor, the product of varied training experience, should be the key aim. Getting the critical mass of students, prevocational doctors, registrars and GPs supporting each other helps develop a network and community connection; then the students may be more likely to return and stay. But there is a need to accept that at times there will be leakage and some will not stay rural due to life circumstances and choice. It was agreed that ensuring varied, quality training experiences with flexibility is invaluable; for example during an intern job, providing an opportunity to undertake a general practice rotation in a rural area for those so inclined.

The Rural Clinical Schools (RCS) have helped remove the perceived negativity of rural practice. Whilst initially there can be a perception that the training opportunities are better in the city, actual experience has shown that the student realises the value of the rural training. Many Melbourne students now want to come to the RCS (Shepparton) as they can achieve better marks that way. The shifts are now occurring and the benefit is starting to show through the student-led initiatives to pursue rural training. The Shepparton RCS has many recent examples of students previously less rurally inclined shifting to Shepparton due to the academic benefit and quality of the training.
Overall student placements are seen as too ad hoc, and are certainly too short, with clearer feedback to supervisors from the universities required so that learning outcomes can be matched against curriculum. Short-term placements for 4 days in a practice is viewed as medical tourism and approaches like these, which aim to meet Commonwealth requirements, will not get the results. Therefore shifts toward longer placements in the same community providing high quality education are required. An example from Tasmania; one practice currently has third year students for 2 weeks plus few others in fifth year, which doesn’t work for rural exposure.

Extended placements of 6 months in a specific location would provide for better outcomes. North Queensland promotes connectedness through keeping faculty staff (JCU the example) with their rural students as much as possible. This ensures a straightforward progression throughout the training years and provides the required community connection by keeping that student in and around the same places and medical community from medical student through to registrar years.

2.3. Facilitating community connection

It is important to provide early linkage between hospital and private general practice through blended placements for students; for example, half time with hospital and half time with the general practice. Sometimes the barrier for GP participation is because the supervising GP cannot take a full-time placement and this provides a solution to that issue. Another opportunity could be students or interns from other states undertaking their training in a different state. Shifting toward a national system of placements and coordination should be encouraged. Currently there is a lack of a national mechanism to do this. Students who make a connection to a community or region should be able to return there for their intern/resident years.

Education should not be displaced by the need for workforce solutions. The drivers and focus should be the quality of the training and positive rural experience for the student, intern, or registrar rather than a relief of workforce shortage. Early training should not just be in general practice. The student can learn medicine in its entirety in the local community, including valuable experience in hospital, as well as in general practice. It is acknowledged that in hospital speciality term training, many students are disenchanted with the hospital system – partly because students need to be able to achieve their goals and it can be difficult to access clinical experience in large hospitals with competition by many learners. Plenty of students want to do general medicine and the key is to get them in early. More effort is required to set up these programs in identified key towns.

Therefore one solution is to create a community of multidisciplinary health students in a town with safe, comfortable accommodation in order to provide a critical mass of students. This helps to build the culture students need to make rural a more attractive option. To create the community connection to a place, it is important to provide maximum exposure throughout undergraduate and post graduate years to that place. The rural clinical schools (e.g. Kingaroy site) are the success stories, but there is a need to build and invest in expanded structures.
2.3.1. Learning hubs

The creation of learning hubs in rural towns would provide the critical mass of students and the supportive structures required to ensure positive early rural experience. This model is dependent on a coordinator position, a director of clinical training. The coordinator could manage what are currently the key barriers to facilitating training in these communities, including sorting through accreditation and making sure the curriculum is achieved. It would need to be a clear and delineated role and doesn’t need to be a doctor, but someone who knows the local medical workforce. The coordinator could also provide the linkages, facilitate different training arrangements, ensure flexibility can be retained and manage rotations, so not to over burden supervisors. It provides the required support structure both for supervisors and students.

Such an approach would help to draw out the vast untapped general practice teaching workforce. It could encourage a team approach within the community and varied and quality experiences for placements. It will help to engage GPs in teaching and passing on skills. It brings the university to the rural doctor and not the other way around. There is a need to bring university and its resources to the community. General practice is traditionally an apprenticeship model and it is time to get back to it. Block learning away from patients doesn’t work and there is a need to factor in an integrated curriculum.

A community hub enables the community to train the student as if they are staying for the rest of their lives. Integrated peer learning (student, intern, PGY2, registrar, GP) is proven and this approach allows junior doctors to teach students. The benefit of peer learning is already observed in the PGPPP program, which is highly valued, and students enjoy being taught by registrars. Importantly this model enables different exposure and learning, thus building resilience. Building resilience is vital to cope with the multiple changes that occur throughout a whole medical career. The frequency of change was attested by this group. Six of the participating doctors cited 10, 6, 5, 21, 10 and 7 career changes to date, with only one remaining in the same rural location for 46 years.

It takes time and a lot of energy to create a teaching culture in a town. The Kimberley provides a good example of how it can work, with every doctor in the town involved in teaching. It is now entrenched there, but much work was undertaken to shift the culture to support this leadership over many years. Students want to come back to these places when they are registrars. The approach encourages innovation and is general practice-based and community led, so that sense of belonging will prevail.
Theme 3: Advanced skills

Introduction

Investment in the full range of advanced skills is required to meet the complex health needs of rural and remote communities. Finding a policy approach that broadens the focus and investment in advanced skills training, which is inclusive and not limited to the procedural skills (surgery, anaesthetics and obstetrics) is a significant and pressing challenge for government.

The discussion

The current funding bias toward procedural advanced skills has a detrimental impact on the provision of health services for rural communities. This concept was agreed on unanimously despite the group diversity, including GPs delivering both training pathways, the FACRRM and FRACGP/FARGP. As the disease burden increases and population ages there is a need to shift thinking toward provision of broad and vital services (aged care, palliative care, internal medicine) sometimes at a distance from a regional hospital. The scrub-centric (big “P” procedures), politically palatable view is eroding essential skills in the community and this will become more apparent as the population ages and unfortunately, if not changed, at a great cost to the community and governments.

3.1. Breadth of advanced skills used

3.1.1. Non-procedural skills

GPs need to be supported (financially and professionally) when they are increasing their expertise in a particular area or addressing a service gap. The common non-procedural skills being used by the consultative group include aged care, mental health, chronic disease management, paediatrics, Aboriginal health, population health, public health. One key skill not often considered but vital is hospital in-patient care. Too often rural patients are transferred to major centres inappropriately. Sending patients to a city for management of end-stage dementia, for example, is a waste of money and distressing for the patient and family. It is the GP’s role to take clinical responsibility for end-of-life care and keep palliative care patients out of hospital in their own home.

More emphasis should be placed on gaining general physician or those generalist skills which can see the patient through their end-of-life experience and at home in their community. Palliative care or end-of-life care is one example and another is caring for a patient through an A&E incident of care, to in-patient care or continuous care. These were seen as vital skills. There seems less policy focus on ensuring doctors are supported financially, by infrastructure and political will to continue to provide acute care in rural communities. A further example was provided in adolescent mental health, where in one community a patient comes in regularly to the hospital for a one-day stay. This is intensive support for an individual and not commensurate with the single Medicare payment. This is where the unfair remuneration resides.

Paediatrics attachment/upskilling/maintenance of skills is another example, and again the individual self-funds the training. There are doctors who want to practise advanced skills, but the facilities aren’t available. Part of the issue is that these skills might be viewed as less of a political imperative and therefore less visible. There is a lack of definition of ‘advanced skill’ and there is a need to fully define what ‘non-procedural advanced skills’ look like. This issue is discussed again in section 3.2.
3.1.2. Procedural skills

In contrast, the procedural skills are well known and currently well supported (e.g. Rural Procedural Grants program, rural obstetric and anaesthetic locum schemes). Whilst undoubtedly these skills are vital for those communities with a regional/larger rural hospital, there is a need to balance procedural and non-procedural advanced skills. There will be a huge problem in the next 30 years in aged care, chronic disease including diabetes, respiratory and heart disease if generalist, non-procedural, advanced skills remain underfunded. We know these complex chronic conditions are managed in the community a lot better than in hospital. Therefore registrars must have these advanced skills, skills in managing all stages of the diseases including end-stage and palliative care both at home and in hospital.

Whilst the procedural skills are more supported, there are still barriers and gaps in attaining and maintaining the skills. There is a need for increased awareness of eligibility criteria for the Rural Procedural Grants program funding, and greater collaboration between training providers and state health departments to allow shared accreditation of courses. This would help to reduce duplication of courses and standardise approaches between communities and between states.

Emergency medicine should be delivered better than it is currently delivered. For those communities without a hospital and where transfer takes a few hours, there is still a need to have skills in emergency medicine. The particular need is in stabilisation and preparation for transfer to hospital, then the post-acute care afterwards. These skills must be available in any community and therefore tying the training to the regional hospital only is flawed. The risk in the current hospital or ‘scrub’ focus is that the community deliverables, the important palliative care for example, are lost.

There are two key questions that arose from the discussion.

- Should we be raising the bar and making these advanced skills part of general practice? Or
- Should there be a special focus and investment on acquiring these skills to address the gaps only in rural communities?

3.2. Defining advanced skills

3.2.1. Community deliverables

The advanced skills are contextual and that needs to be the focus. A focus on advanced skills that are delivered outside hospital, within a practice community and at home, are quite separate from hospital-based advanced skills. Build on this idea and contextually the hospital focus can be built in. This needs to form the underlying base curriculum for registrars. The overall management of the acute disease must be emphasised, as well as the additional skills depending on what your community needs are. The skill acquisition can be motivated by a particular interest, meeting a skill need or in upskilling for the remunerative imperative or improved practice viability. Regardless, the rural GP needs to be supported. Supported financially to both acquire and maintain the skill, supported professionally to ensure continued use (specialist competition) and remunerated appropriately for skills applied in patient care.
3.3. Delivering the training

3.3.1. Define a basic standard and optional component

There is a need to define a basic standard for rural training, incorporating an optional component to encompass an advanced skill or interest, but at the same time retaining flexibility. The rural generalist program, whilst currently too narrow in terms of skill and approach, does provide direction for the doctor in training, but is considered by some participants as inflexible. Queensland Health was used as an example; the rural generalist program in Queensland is delivering purely to meet a specific workforce need. It is entirely a state workforce approach and not about the skill the learner wants. It is also delivered in larger centres with less exposure to rural practice. New ways are needed to ensure the training can be delivered in a rural town and in rural general practice. There may need to be a mix of state and federal funding arrangements.

The pre-training in an advanced skill area could be provided early as an optional component. But there is a need to understand the context in which your advanced skill will be applied, before you do the training. Therefore, placing greater emphasis on general practice and providing a few solid years in practice to fully understand the context in which the skills will be used is more effective. It is then that the advanced skill training could provide the flexibility – at the end of training. It would be at this point where the individual could go back to a hospital and complete anaesthetics training, for example. Given the early community connection, it is likely that the upskilling will focus on needs of the town.

This approach helps to confine the training of one area instead of trying to do as much as you can. The group considered this a benefit of the FARGP because training can remain broad. The FACRRM on the other hand is inherently inflexible and holds a sole-skill focus, which can be limiting for some. In terms of coordination, the RTPs need to provide training with solid guidance from the RACGP. The acquisition of advanced skills is currently deemed too ad hoc and arrangements should not be incumbent on the registrar.

Theme 4 GP-rural generalist: Defining the role and pathway

Introduction
Clarify the skill mix required for safe, high quality generalist practice by doctors in rural and remote practice.

The discussion
The group discussion tested the rural generalist term, the role and implications for both the profession and community. The issue lies in what the term rural generalist should mean against what it has evolved into. These are two very separate meanings, one with the patient and community in mind, with the other a workforce imperative to fix an issue in a few specific skill areas and locations. The need to put a strong primary care focus in the training was unanimous in this group. Valuing certain skills over others, for example procedural skills over other non-procedural skills, was seen as a concern for the profession, given that most financial incentives are already tiered to the hospital skills and the current rural generalist approach deepens the problem. The importance of retaining the central role of GPs as the primary physician, as no other area of medicine comes close to breadth of care provided in general practice, was stressed.
4.1. The term, role and pathway

4.1.1. Defining rural generalist

The discussion highlighted that the problem with the ‘rural generalist’ concept lies in the current definition and arrangements. Generalist skills are more than procedural – it is about doing a job, being able to manage resources, team communication and undifferentiated circumstances with limited resources. Core rural general practice skills include the ability for GPs to get themselves and the patient out of trouble long enough to get them to tertiary care. Being part of a wider local team and being able to lead that team in managing the care of the patient is essential. FACRRM is a very skills-based qualification, and does not necessarily train people to lead medical teams.

A definition offered by one participant:

A rural generalist is a medical practitioner who is providing medical services in a rural community to both primary and advanced care roles, usually involving both private general practice and hospital based acute care or inpatient management. It implies skills in emergency medicine, obstetrics or anaesthetics due to historical demand for these skills, but more broadly applies to whatever advanced skill may be required for that particular setting. If not the definitive care provider for each acute care episode, the rural generalist should be able to appropriately assess, stabilise and coordinate ongoing patient care, including transfer or retrieval to other facilities, especially in defence or Indigenous settings.

Currently, it seems, the rural generalist is the ROMA Agreement definition, which defines a workforce need, hospitalist doctor in a rural setting who is not a specialist. This has been applied by Queensland Health in this narrow way in order to meet hospital workforce shortage needs. There was agreement on the need to put the broader generalist focus back as part of the training focus which must include incorporating primary care.

The Rural Generalist Pathway is currently a Queensland Health hospital-based activity, and it is not meant to impact on private general practice, although it currently does. There is a distinct and powerful industrial lobby attached to the identity of a rural generalist, but the role has no definition. There is a need to value general practice skills and value non-procedural advanced skills the same way we financially value procedural roles in general practice. It is clear from recent external discussion that the original policy intent of the rural generalist is very different to what has now transpired as the service outcome. The shared hospital-based and community-based primary medical practice goal has not been delivered. The model has evolved into a solely hospital-based and Senior Medical Officer (SMO) role for Queensland Health.¹

4.1.2. What does it mean for the profession?

The current term – GP-rural generalist – is a concern for the profession. It devalues the role of the GP by introducing another concept or branding to define what rural GPs are already doing. It is seen as part of a push for a separate rural discipline. The branding was described by one participant as ‘GP with special procedural skills’ whereas ‘generalist doctor who can do things’ was cited by another.

There is an equity issue emerging in training registrars with quarantined posts being made available to generalist positions only. Registrars are being blocked from training posts, because a whole lot of doctors are being recruited to hospitals. This is to the detriment of the role of general practice and general practice services for rural communities. It further inhibits choice and the ability to upskill to support a community for a practising GP.

There was a strong view that the focus needs to be on valuing broad generalist skills. Therefore at least half of the registrar training time should be spent in private general practice. Otherwise, those trained as rural generalist will not have the broad skillset. Some may enter it (general practice) reluctantly should they need to shift when the hospital closes or when the funding stops along with the current lucrative salary.

4.1.3. What does it mean for the community?

There is a definite advantage for rural communities in being able to access more advanced care in their own community, without disruption and expense of travelling long distances to access the same level of care in specialist outpatient clinics of major hospitals. Its current application is considered a real issue for community medicine though. General practice in rural communities is vitally important, and only putting people in a hospital setting devalues the role. Those communities need general practice.

One member stated that from Queensland Health’s perspective, the Rural Generalist Pathway is a Queensland Health hospital-based activity. There is no interest in this having anything to do with private general practice in any of these towns; it is not opposed to that developing, but it is not the goal. But it is entirely a Queensland Health hospital-based activity with a purpose of having doctors servicing Queensland hospitals in a full-time capacity.

The North Queensland participant advised that the hospitals are filling with these generalist roles, that they come through having finished their pathway. We are now finding they are now meeting this critical mass and starting to spill over into general practice. The issue is that unless they have been properly prepared, then they come into it reluctantly. Queensland Health cannot continue to fund this model – it is too expensive – so the imperative is to ensure they stay grounded and receive the broad exposure they need. This commentary described a view that the Rural Generalist Pathway is a ‘hospitalist’ pathway without general practice skilling.

4.1.4. Competing interests

There is institutionalised specialist competition, which continues to devalue the advanced skills of the GP. This means the institutional barriers within other parts of the medical sector that block out GPs. Professional discrimination exists, with the example provided around the containment by others over which clinical decisions can be made. Another example included not being able to keep children admitted for more than 24 hours without the hospital accessing a paediatrician.
One participant stated that the discrimination is built in to the PBS, that it is institutionalised. For example, the PBS telling you that you can’t diagnose rheumatoid arthritis officially or put somebody on the medication to treat it (referring to the monoclonal antibodies or s100 medication). He stated that he managed insulin diabetes far better than most metropolitan GPs would and probably far better than any endocrinologist registrars, but he is still unable to sign off on it. The GP stated that these are institutional obstructions which are entrenched in the system, which seem to have no objective other than to devalue the GP.

It is considered that there is a lack of understanding of the need for these skills in the rural context. Overall, that support comes back to the goodwill of the colleges. Others have been endorsing upskilling of doctors in the rural generalist program, but not all. It seems to come down to who is willing to give up training for their specialist registrars. The remunerative inequities are a further issue. GPs in rural towns often fill the service gap for psychiatrists. Headspace do a small amount of this work, but the rest is done by GPs and more so in after-hours care. Yet these skills are not rewarded, differentiated or supported in the way the procedural skills are. There are differential rebates for people who work in Headspace against general practice.

Theme 5: Embedding more primary care in the training

Introduction

Incorporating more primary care across the entire training continuum to ensure there is an appreciation of the role of general practice early in the training. This section feeds in to the discussion on the Integrated Rural Training Pathway at Theme 2.

The discussion

There is a firm view that primary care should be learned first. Primary care equals primary teaching. It’s the basic first port of call for everything in health. It is acknowledged that governments now place a stronger emphasis on primary care investment and understand the overall population health benefits from that, including the requirement for less secondary care. But everyone eventually needs secondary care, just later in life and for more complex situations. It is also about capacity. How do we resource practices to allow this to happen and how do we make it the focus? Aboriginal medical services do this because they are funded to do so. There is a need to find a way to fund this so that it works in general practices in rural and remote areas.

5.1. A more networked approach

5.1.1. Resourcing rural-based community education

There is an opportunity to build on the community models already developed through rural clinical schools (RCS). One GP shared his favourite anecdote on the RCS success: they now have four RCS graduates who trained in Bogong all working in the one practice in country Victoria.

It was recommended that governments take advantage of the surge of graduates coming through. For example, future projections suggest there will be more interns than places, therefore, there is a need for blended terms (PGPPP or elsewise) where residents do half in rural hospital and half in rural general practice.
One member stated that trainees in Wollongong do all of their undergraduate year completely based in the community. It works well and the program is oversubscribed. There is a need to find a more sustainable way to provide the training. Changing the way we have traditionally done things should be embraced, to increase the amount of general practice utilisation in undergraduate training. This is a challenge to the current models and paradigms of teaching undergraduate medicine.

This approach requires a resource focus to allow training to be embedded more in primary care. An education-coordinator or facilitator is one human resource cited as an example. Senior medical students and junior doctors require that education coordinator to make sure that they are getting the training they need. For the student, it supports them to know where they should be at this time in the community and provides the link back to ensure the curriculum is being met. For the GP, it takes the pressure off providing that coordination support, reducing the organisational impact in organising students and placements. This was discussed against Theme 3, but it is also relevant here. Medical schools have a curriculum that must be met, as does vocational training. There is this nebulous gap between medical school and vocational training and there is a need for guiding principles between the two.

Practices need the supports in providing the teaching infrastructure as well. Flinders built two rooms to support a South Australian practice. From a broader funding perspective, more focus on first-level care at the community level is required. It was considered that the current fund-holding arrangements, the Medicare Locals, were doing a poor job. There is little engagement or work to identify need and no evidence of community coordination or commissioning with a disinterest in the smaller players. There is a need for large scale commissioning at a community level to support these training hubs.

5.1.2. Multi-disciplinary team-based care

Supporting a critical mass of students and having a culture of teamwork is the key. A culture of teamwork is a theme through which primary care training locations, networks or hubs can reach critical masses of students and build the teaching infrastructure. If the rural workforce is to work in teams, then training should be in teams. It comes back to training hubs providing for that critical mass. Scenario-based training, working with nursing and allied health students through cases and understanding the roles and learning to communicate and work together to get the best outcomes is needed. This provides a good example of interdisciplinary training; students have to communicate, understand others’ roles and work together with other health professionals. Scenario-based training provides feedback on what would happen in an ideal situation – if it went exactly as it should have.

Multi-disciplinary team-based training teaches the respect, understanding and communication skills required for instilling training resilience and the broad scope required to meet continuing comprehensive patient need. Resilience in providing the doctor who can recognise when they are out of their skill depth and is confident enough to communicate that to others to ensure safe patient outcomes is essential. This approach provides for safety and confidence, in knowing their limits and importantly where to go to meet the gap between patient need and GP limit. A Toowoomba practice has just started a new multidisciplinary teaching and learning practice. This includes general practice, dental, physio, speech and mental health all working in one area training students together. They are working in team education sessions once a week, it is in its early stages but represents a model to be built on and replicated.
Theme 6: Training capacity

Introduction

Addressing the factors currently limiting rural GP training capacity and exploring the supports required to encourage greater take up to support a new national rural training pathway.

The discussion

There are explicit requirements on supervisors at each level of training. It was considered that cumulative shared teaching arrangements would be much easier. The broader discussion covered the need for flexibility in teaching, valuing the role and ensuring practice viability. There was an interesting discussion about defining need first in order to increase community capacity and service level, which would in turn provide a training benefit through building capacity. Building the culture of teaching again includes effort around establishing the shared teaching hub.

6.1. Current constraints

6.1.1. Time, space and housing

The space required for teaching needs to cater for the principal teacher in a practice and accommodate a number of students. This can sometimes be the greatest impediment. Clinical time is also limited; doctors are already overstretched and teaching impacts and places a further burden.

Payment for teaching is currently not commensurate to earning while consulting. There is strong willingness to teach but rural practices must also remain viable. Accommodation, building housing for students and registrars are equally important.

6.1.2. Flexibility in teaching

Restrictions are also found around the medical curricula. Some curricula force learners to spend quality time on an area that could be taught on the internet. There is a need for more flexibility in teaching, particularly for rural areas. For GP registrars, for example, it can be quite limiting. It is not always all that interesting for them as the learning is quite staid.

6.1.3. Valuing the role

Valuing the role is another important aspect. Considered currently undervalued, payments are low and accordingly GP-supervisors have little standing when compared against other academic teaching roles. There is a need for more effort to shift these negatives, acknowledge the importance of the role and provide recognition, including access to the university; a shift that would enable doctors to view their role as 0.8 clinician and 0.2 supervisor. The responsibilities rest with the universities, colleges and government.

An initiative to increase GP participation in supervision could be developed and be reasonably cost effective through a national recognition scheme. This could include in-kind institutional subscriptions (Clinical Online) to recognise those who teach, including access to university resources, college libraries and teaching resources. Aligning the teaching role to fit within an academic role that provides some career structure to supervisors may help in formalising the role.
Develop a FARGP in teaching, an RACGP and peer-recognised qualification. Recognising examiners is seen as important as well. The value is indirect and personal. It doesn’t have to be just about money or title.

RTPs also lack a full understanding of the role of supervisors and it was considered that GPET and the RTP network undersell supervision. Certainly the extra, unfunded components go unrecognised. That is, understanding when a student/registrar is in trouble when they don’t realise it themselves, and being available to work through those issues. Often these are times that don’t fit neatly into allocated teaching hours and this requirement of supervisors is not understood at all.

6.1.4. Making it viable

Restrictions should be lifted so that teaching can be incorporated into the everyday work of the practice. Teaching is currently something the doctor squeezes into their busy life, in addition to a full clinical load.

A Tasmanian practice which is currently at capacity in terms of teaching load, but is able to take up to 3 registrars, suggests provisions could be made within the PIP payment structure for registrar-level teaching to encourage greater take-up at that level. A GP1 registrar could see 50 patients per week, ultimately bringing in more patients and more income to the practice. This is a practice in which a former registrar is now a partner. A practice which understands the benefits of ensuring the training provides a sense of belonging and attachment to both the host practice and community. There are currently no more allocated funds in Tasmania for PGPPP, yet there is capacity to provide the training.

There is also a strong view that the current rural classification system could potentially cripple a national rural training pathway. The loss of district or workforce shortage status is also an impediment which can result in not being able to take on a registrar because there aren’t enough patients.

6.2. An expanded sector

6.2.1. Improve access first

The concept of differential rebates was raised as a way to increase access for rural patients to primary care, which in turn would help build up service viability to also accommodate teaching. One proposal was to provide the people in that town a Medicare Card that is tied to a stronger claim return (1.5 times the rebate, for example) as a way to acknowledge access and financial burden particular to rural and remote areas. Incentive payments are always tied to something and you usually get them retrospectively. But if we get the definition of rural right (defining disadvantage and where) then this would put the incentive in the hands of the patient rather than the hands of the doctor. This may be more politically viable but would depend on having the right system to properly define rural and disadvantaged areas, and ensuring it is not based on financial greed or merely ticking off the government requirement. By improving access you also improve teaching capacity, and it empowers the community to attract services they can access.

Perhaps improved access needs to be about the patients’ ability to buy the service, rather than the profession’s ability to provide it. This is not about doctors being able to do what they like, it’s about allowing a citizen in a difficult access area to be able to attract services that they need to access. Teach the community about their expectations of a doctor.
There are so many metro GP registrars and fellows who are doing sessional practice (part time) which is distorting the numbers for everywhere else. That is the bulk of general practice (service), and it devalues the argument for those who are actually full-time and teaching and going above and beyond. We need the right system. ASGC-RA doesn’t work and neither did RRMA – both fail to define rural and disadvantage effectively.

6.2.2. Building the culture of teaching

The group explored the key requirements to supporting an expanded sector brought about by a new national rural training pathway. Building the connectedness and leadership in a town to support a teaching hub or integrated model for the broader region to attract a cohort of students and registrars is certainly seen as the answer. We should be funding towns sufficiently to enable the GPs to have the time to see their patients and time to teach. The funding models need enough money to provide for adequate workload, and teaching, and still earn enough money for the general practice. Acknowledge the success in Proserpine, for example, and staff that area appropriately to be the clinical teaching place for the region.

Teaching is fun; you learn a lot, the brain stays active. How do we convince really good GPs who are disinterested in teaching that this is something that will enhance the work they do and their lifestyle? Show that it is cost effective once they are settled into practice, because the registrar can see some patients. Instil that culture of teaching through learning satisfaction. It is about peers supporting each other, how we communicate and how we see ourselves as educators and teachers. The mentoring component and the modelling that go with it are important so that our learners, at every stage, see the possibilities. How do we make that sort of interconnectedness work in a reasonable way? Invest and build the successful training models. A success indicator is a hospital which is overstaffed because all SMOs do teaching as part of their role. Find a way for the teaching to be shared and incorporate delegated teaching sections in the model.

6.2.3. Locations ready to implement

The group offered the following locations which are either ready or could be easily developed to provide a learning hub. This would be reliant on an FTE education facilitator. Proserpine is an area seen as currently working as it already incorporates GP intern rotations, and is ready for further expansion. Emerald was proposed as a start-up one, as it is an area ready for the investment and expansion to develop a regional teaching and learning centre. Atherton Tablelands is also well established. Longreach, Stanthorpe, Mt Isa and Goondiwindi were other areas put forward as worth exploring.

In South Australia, the Riverland region was identified as a current teaching hub working well, but would benefit from effort in coordinating the area’s champions for greater integration. In north-east Victoria, the Murray to Mountains Program is again ideal and already successful, with further integration needed to introduce a formal rural internship (20 week term), a super-charged PGPPP. Push others through similar 20/30 week terms through Albury or Wangaratta, and then move into Bogong GP training. The coordination is what is required; the structures and capacity are in most cases already there.
3.1.2. Darwin GP13 member consultation

The RACGP National Rural Faculty (NRF) Member consultation was held in Darwin on Wednesday 16 October from 2.15pm to 3.30pm as part of the GP13 event and NRF Annual General Meeting. The group examined two of the six project themes with Themes 3 and 6 discussed. This was an open session with a total of 35 participants, 31 GPs including two facilitators, and included four non-GPs either working in training or a health-related field. Whilst individuals have been de-identified in the transcript that follows, location, career stage and advanced skill detail is incorporated where appropriate. From the participant group, 29 GPs were Fellows of the RACGP (FRACGP), one with a FARGP; 27 of the 29 were practising GPs, two semi-retired GPs and two GPs educated in Papua New Guinea.

In terms of geographic spread, for this participant group the national distribution was as follows:

- eight members were from New South Wales – Sydney, Lennox Head, Wagga Wagga, Woolgoolga, Nambucca Heads, Northridge, Bathurst and Bungendore;
- five from South Australia – Adelaide (two), Barmera, Tea Tree Gully, and Waikerie;
- five from Victoria – Melbourne (two), Shepparton, Kilmore now Sydney, and Bendigo;
- two Queensland – Dalby and Clifton;
- three Western Australia – Meekatharra (RFDS), Kununurra, and Mandurah;
- two from Tasmania – South Hobart and George Town;
- two from Papua New Guinea;
- one from Northern Territory – Darwin;
- one Remote Vocational Training Scheme (RVTS) overseas member;
- The two facilitators were from Victoria – Lara; and the Northern Territory – Tiwi Islands and Darwin; and
- Of the 4 non-GPs, two were from Queensland Rural Medical Education Limited (QRME); one RACGP FARM Committee member; and a health-related discipline from Orange, NSW.

Further demographics of the GP group included: 10 females – 21 males, the majority currently in rural practice, the majority involved in training. Of those in practice, individuals identified specific advanced skills throughout the consultation, which is captured in the transcript as relevant.

Theme 3: The use of advanced skills in rural areas

Introduction

Identify key policy requirements for improving rural GP access to advanced skills training, both procedural and non-procedural.

The discussion

There was robust discussion around both what is and also what is perceived to be core general practice skills, particularly those skills which are essential to meeting community health needs in rural areas. It was broadly considered there was a real need to change the discourse and reinforce that GPs are experts in the undifferentiated patient presentation. The fact that GPs have a much better knowledge of the patient than someone with an episodic view, which therefore enables a more efficient and safer patient outcome, should be the theme leading the discussion. It was acknowledged that state governments are mostly interested in saving money and not paying too much for hospital admissions, which drives the policy response. The procedural emphasis that has dominated in recent years is due to the tertiary cost impacts. Efficiency at undifferentiated presentations needs to be brought forward rather than a discussion around proceduralism. GPs tailor their practice for the community they serve. Partialists have a much narrower vision. Generalists such as GPs have a much greater scope and this needs to be valued.
3.1. Clarifying the skills used

In clarifying the skills used, many highlighted the fact that it is about discerning the
skills needed for your community. So it depends on where you are and the needs in
your community. But another important factor is in the timing and the stage in your
career in relation to upskilling opportunities and the limitations and system constraints
around these. Key issues here are the acquisition of additional skills for practising GPs
and the lack of a career pathway for those undertaking specific skills training at an
undergraduate or post-graduate level. This discussion brought out the key impacts
including specialist competition, valuing the role of the GP, role certainty to utilise skills
and the fact that skill requirements fluctuate over a career depending on community
need and funding changes.

3.1.1. Specialist competition

There was a strong view that there is an impact from specialist-level care on
general practice services that were traditionally done by GPs with advanced
skills, both in regional areas and smaller areas close to cities. Specialists
have taken over a lot of the turf in that area and this presents a barrier, as
many of the GPs who were utilising those skills have now lost them. An
example was provided by a GP who was working on the urban fringe area
of Melbourne to illustrate the point. The example is summarised below.

This area on the Melbourne fringe was considered unique as it is close
enough for specialists to come out and patients to go in to the city for
care, but still far enough away for patients not to want to go to the city
for every procedure or specialist consult. Currently the key skillsets are
in anaesthetics, obstetrics, emergency skills, surgery, oncology and
palliative care. In this location there was a stalwart GP who really pushed
for the retention of general practice proceduralism and this individual has
successfully retained and protected these skills. But it was thought that
should he retire these skills would be lost by GPs and provided in the future
by specialists. This would occur due to the desire of other doctors to take
over VMO appointments at the hospital and therefore the power base of
this key individual. If you can’t recruit GP-proceduralists into the area, then
skillsets will be lost from the local GPs.

This issue was reinforced by the GP from Wagga. In Wagga, although
not considered particularly remote, they have all the specialists they need
except for gynaecology. Registrars are really interested in obstetrics and
gynaecology and those who have undertaken the training are now facing
issues with those three specialists around practicing in the hospital. This
is a specific community skill need, yet the registrars are not able to practice
despite having undertaken the training. There is a definite attitude that the
GP specialist is only the gap-fill – and this situation illustrates that dilemma.

As the GP from Wagga further explained, the specialists control the system.
This is an entrenched cultural issue which needs to change. Specialists
are in control of the hospital. They will influence midwives, and provide
barriers at every step. The system is unable to respond to skill shortages
as a consequence. This is a significant barrier and not unique to this
specific cohort of doctors. Most hospitals can accept that there
are different types of specialists and GPs who will do scopes, for
example. But when it comes to skills such as a GP-obstetrician
delivering babies or a GP-paediatrician delivering child
health services for example, then the issue that
always emerges is that the GP-specialist is
only accepted if there is no-one else
available.
The GP from Bathurst, NSW, had a differing view. He felt that if your skills are good, your specialist colleagues will recognise them. If they are not up to speed then you need to get the training so they are recognised. This doctor returned to anaesthetics after a gap of 10 years to address a shortage of anaesthetists in the local base hospital. He has regained skills and learnt a lot from specialists who now refer patients to him, particularly for global assessments of those patients. His generalist skillset is well regarded and he believes that a good level of mutual trust has been gained. He does not need to worry about being judged for not having the ultimate skill in a particular area and feels he can rely on his specialist colleagues for support.

3.1.2. Valuing the role

As discussed above, there is a need to shift the perception that GP-specialists in rural areas are the gap-fillers. It was considered that the College was in a good position to advocate more on this. Particularly, it was thought important in regard to GP-obstetricians who hold the same skills as FRANZCOG. There is a need to reinforce this more and support it with the known evidence around safety and deliveries in the rural context. This same argument can also be broadened with evidence from other procedural and non-procedural areas.

Overall, there was a level of frustration expressed around the fact that there is a value placed on certain skills while others are deemed lower. All GPs are practicing advanced-level internal medicine, which is what general practice is, yet there is more emphasis on the skills involving hands and less for those between the ears.

The discussion needs to shift. As one GP explained, we talk about skills but the terminology needs to be changed to be about knowledge in practice. Skill is something that is physical and it limits the discussion. This GP works in Kununurra and not in obstetrics or anaesthetics but in Aboriginal Health. To illustrate how such skills are valued in her community, she explained that the local hospital has not employed non-proceduralist GPs in the past, but they will be employing her next year. They value her skillset and she is able to impart her knowledge to help develop more junior colleagues. She explained that she is unable to physically demonstrate her skills, but perhaps the communication element is more visible, which confirms that skills can encompass a knowledge component as well as the practical. While this is an obvious observation, the current discourse tends to lose sight of this.

3.1.3. Role certainty

An important issue was raised by a former GP-obstetrician from South Australia around the need for role certainty at the undergraduate and postgraduate stages. It is considered unfair to train individuals in skill areas when there is currently a disconnect between the training and role security. Doctors acquire the skills, thinking they are needed, only to find the specialists taking off the ‘top bits’ but not wanting to live in the rural location. Then as less-qualified GPs look to do the easy bits, the GP with additional training finds there is no room for them in the middle. So there is a continual state of mismatch. If you cannot assure those who have acquired the skills and knowledge with the expectation that they are going to use them, then it is unfair to expect them to undertake such study.
Further complexities are around the limited time to undertake such training. For example, if the skills haven’t been acquired by a certain time (undergraduate/immediate postgraduate) in their career, then it is incredibly unlikely that they will go back to get them. It is unlikely that 15 years down the track one would consider such upskilling, and regardless, there is no mechanism or incentive to go back and retrain. The GP used his own experience as a former GP-obstetrician who did two surgical lists a week, stating it would be incredibly difficult for him to go back now. This is partly due to lifestyle and age considerations and the associated professional risks, but also that there is really no incentive to do so. But if he were 10 or 15 years younger he said he would consider re-skilling.

There are two policy imperatives here, the first to provide some career certainty at the undergraduate/immediate postgraduate level for those acquiring procedural and other advanced skills. The specialist competition issue is a key factor. The second is the lack of mechanism in the current arrangements to go back and retrain should you want to meet a skill need for your community. Therefore there is a need to build a skill-acquisition pathway for practising GPs and prioritise training for those in rural practice.

One GP from Tasmania further emphasised the career pathway issue, with several examples of registrars with a year of anaesthetics equivalent to the Diploma, but once acquired they then need to move intrastate or interstate to be able to use those skills. It’s a good idea if they want to move, but disastrous if they need to move a family, for example. Victoria was another state where you must figure out a job for yourself before you go about doing procedural training in anaesthetics. The potential role needs to be there before you can train for it. It is an inherently negative approach. The onus should not be on the individual, but instead a clear and flexible pathway needs to be provided for trainees.

3.1.4. Skill priorities and fluctuations

One member with 25 years in ‘advanced’ rural general practice challenged the language around needs of rural communities being more complex than urban. He stated that many city doctors hold an advanced skillset and this is not acknowledged. All GPs need to be delivering advanced skills, not only consulting with specialists when required but also when patients are referred back. Further, he challenged the assumption, which he feels is driven by the rural generalist approach, that someone is born knowing they want to be a rural GP. His analysis of the old RACGP training programs, pre-GPET, was that this might have been true of perhaps 25% of GPs but absolutely not for the majority. The solution would be to ensure exciting opportunities for everyone and then have a health system that allows them to fit that into their careers.

From his own experience, the advanced skills were acquired over time and were really just gaps he saw in his community, as well as those areas of interest. He further explained that he had over the years the opportunity to do obstetrics until they shut the unit, then high-level emergency medicine until they shut that too. He now finds, being older, that patients no longer look to him to deliver babies, but now come to see him about their diabetes and Parkinson’s disease. Therefore there is a lot of flexibility required over a career, both in terms of shifts in government priorities such as ward closures and shifts in meeting patient needs or a specific rising disease burden.
These fluctuate over a career as the doctor responds to community needs. Therefore there is a need for a flexible system that allows people to gain the skills they need at the time that is appropriate for them and their patients.

A further example of how skills and career direction shifts over time was provided by the GP from Nambucca Heads, NSW. He came to general practice with the idea of being a jack-of-all-trades, perhaps the master of some. But he decided on proceduralist practice and became a GP anaesthetist; however once gained found in his community the scope of practice was very limited for GP-proceduralists. He found he couldn’t consolidate his skills in his own community so he moved elsewhere. There was a lack of flexibility which meant he couldn’t service the hospital adequately and an on-call system which was particularly difficult. His community then lost his skillset.

This was a difficult decision for someone who came in with such grand ideals. He saw procedural medicine as a key element of rural general practice and a return in service for the effort put in to his training. He is now a medical educator, taking on an advocacy role rather than servicing his own community. But he stated that he still does some procedural work and is one of the first GP-proceduralists to get rights in the private hospital in Coffs Harbour in 15 to 20 years. Even so, within the next 12 to 18 months he will probably cease this work just due to the lack of access to lists.

3.1.5. Realistic expectations

There was a view that there is a duty of care to our trainees to give them a realistic picture of what rural practice is. The government impression of a ‘super doctor’ pervades medical schools and junior doctors. In many states they are being asked to sign on to these rural procedural pathways at a very early stage in their training. They need to be protected from the let-down when reality hits a few years into their practice. They also need to be given permission to be specialist GPs with a skillset that doesn’t need to include obstetrics/anaesthetics/surgery.

It was thought that the ‘super doctor’ issue has been pushed to some extent by the colleges. It was stated that both ACRRM and NRF have at times pushed this. But it is also a government perception. It was suggested that perhaps part of the drop in rural workforce is because new young doctors get intimidated by that. They think if they can’t deliver a baby or put a tube down then they won’t be able to cope. They do not have the confidence to practise with little backup because they do not see themselves as a super doctor. But if you look at what GPs are actually doing, despite the ideology the government is currently running, it is general practice.

The GP working for the RFDS said that trainees have a perception that they are ‘super doctors’, but the reality for them is that a lot of what they do is monitoring, sitting and listening to machines. A second example was from a GP who was a former proceduralist but had to adjust to meet community needs, though still works in a community hospital. This is the reality which really is rural practice. Specialist training is becoming highly specialised and there needs to be room to ensure there are general specialists with the training to just do general work. The focus is on the big ‘P’s yet the vast majority of rural GPs aren’t doing these, so there is a mismatch on what we think rural GPs should look like, which is exacerbated by the generalist programs, against what really happens. GPs essentially respond to the communities they are assisting and this may not necessarily include procedural work.
3.2. Skills investment

The second part of the discussion of this theme brought forward a number of opportunities through analysing the key system gaps. These are outlined below, but include support for upskilling for those currently in practice and stronger roles for the GP colleges in credentialing of posts, thereby ensuring greater certainty for trainees.

3.2.1. Support for upskilling

A prevailing theme coming through is the need to ensure upskilling opportunities for GPs already in practice. A part of this issue and an often forgotten element is the absence of return-to-work strategies. A north-west WA GP raised the issue of the difficulty she has experienced as someone who has recently returned to the workforce after raising a family. She is now undertaking locum work in the north-west region (WA) and has found training opportunities limited. In particular, accessing skills training and upskilling (procedural skills) to a level to be able to provide safe anaesthetics, for instance, is severely limited. The skill is in great demand in her area, yet there are major barriers for experienced GPs to upskill to address that need.

3.2.2. College role in credentialing of training posts

Another clear barrier is the uncertainty in terms of securing training posts and in this group it was felt that the RACGP needed to take a much more active interest. Both GP colleges, RACGP and ACRRM, need to replicate what the other specialist colleges currently do well. It is essential that these uncertainties are addressed and trainees have better surety, otherwise it is considered too much of a risk to do surgical training, for example, if you can’t actually apply those skills. There is to be a definitive role for RACGP and ACRRM in credentialing such posts.

This issue will need to be addressed to support the increasing number of trainees, particularly in regard to the current trend for advanced rural skills posts (ARSP) to be undertaken early as interns. But also for GPT1, 2 and 3 registrars with extended skills, finding a post within a hospital to allow you to practise an advanced skill will become more and more difficult. Thus the problem is how to utilise the specific skill that they have acquired early while doing GP training. All these capacity constraints need to be addressed now and in consultation with the specialist colleges, with the GP colleges taking a stronger and leading role.

3.2.3. Facilitate role for GPs as VMOs

A further example was provided by a WA GP who explained that his practice reflects the demography. It is now very different to when he started there with a population of 15,000, which has now grown to over 90,000 over a period of only a few years. There are more specialists now and one by one the GPs were dropped off the ED roster. There is a growing trend of registrars not wanting to do hospital work; they are not applying for visiting rights as they don’t want the pressure. This is a significant issue from a workforce perspective. This doctor is a great believer in the value of community hospitals, but this trend means that this value is slowly being lost. He no longer views his hospital as a community hospital. Previously it was very efficient, quicker turnover, fewer tests and certainly cheaper, but none of this is ever discussed from a policy perspective. GPs as VMOs are really the most cost efficient.
This view was further reiterated in that a presentation treatment of a myocardial infraction is cheaper when treated by a GP than most cardiologists.

3.2.4. Shifting perceptions

In response to addressing the procedural emphasis, the GP from Clifton suggested that whilst he was not a defender of the rural generalist pathway, he felt it has had some value in terms of raising the profile of rural practice. But he noted that it is a government perception of what the community needs, with a focus on maternity and emergency, and suggested we should be moving to guide that toward a more appropriate and realistic view. The GP felt that the current narrow investment or proceduralist focus is frustrating and it is predominantly a Queensland State government perception. It is a good idea but somewhat misguided. So we need to now guide Government to shift the perception to something more realistic and closer to the reality. The doctor identified this as a key responsibility of the National Rural Faculty.

Theme 6: Training capacity

Introduction

The group considered the key factors currently limiting rural GP training capacity. This included working through the additional local level requirements in implementing a new national rural training pathway and finding ways to build capacity through vertical integration.

The discussion

The discussion highlighted the value of the apprentice model but identified some weaknesses in the current system, including in the incentives which act to impede progress toward vertical integration of training and in building teaching capacity. Again it was considered that a more streamlined approach to accreditation was required, including standardisation to reduce the administrative burden for those practices supporting teaching across the full training continuum. This would include simplifying the current complex and differing arrangements between each learning stage (undergraduate, postgraduate and prevocational). The need to build a prior standing or recognition status into the accreditation process for practices with a good training record was considered important. In addition, there should be provision of enablers to encourage community-level responses to support coordinated training within communities. Finally, developing innovative supervision models to support onsite supervision in the remote context was seen as essential.

6.1. Current constraints

The discussion identified a number of structural constraints including the constraints of a small business model in building training capacity in rural and remote areas.

6.1.1. Structural constraints

It was highlighted that it is much easier for practices to host more than one registrar and more than one student, however the current PIP process doesn’t support additional students. The restriction to one payment for one student is problematic. Further, the process of getting registrars into the local hospital is extremely difficult, particularly in NSW. It is difficult to get GP registrars into hospital places as credentialing takes a long time and usually by the time you’ve managed to work through the system constraints, the registrar is about to leave.
6.1.2. Accreditation of teaching

One member suggested a need for some sort of standardisation in the accreditation of teaching. This is a role that has only just come back to the RACGP, which now has oversight of education programs of RTPs. The shift has provided an opportunity for review and as it is a new process, will be evaluated over time. It was considered that accrediting a practice to teach across the full training continuum was ideal. Currently, there is one standard for students (under development), another for interns and a further one for registrars, with each standard different and requiring separate application. Having the one system rather than having to be tested for each training level would address a significant current barrier. Prior recognition schemes to acknowledge accredited practices, quality cycles and years of training should also be considered.

It was highlighted that the new standards will allow for more flexibility for supervisors and enable vertical integration across the full training continuum. Most practices currently take both students and registrars, which is consistent with the curriculum and requires registrars to learn about being a teacher. Some practices already take interns and are already working across the full continuum. One key issue is that many registrars, given the increased numbers coming through, will end up in big cities. This needs to be managed and the majority rotated through rural areas with the incentives biased towards the rural sector.

6.1.3. Flexibility of supervision

The member who worked for the RFDS in WA suggested that flexibility of supervision would assist in addressing current constraints. Where she is based, Meekatharra with a population of 800, the hospital is being run as a fly-in-fly-out GP service through the RFDS. RFDS are accredited for advanced and subsequent training registrars, but there is not enough capacity for onsite supervision. Further, there is a problem attracting GPs to these roles, even with the RDFS brand. It is important to acknowledge that someone relatively inexperienced in a remote location will need some supervision. It was also acknowledged that NT General Practice Education are doing good work in the Northern Territory on innovative supervision models using a team approach, particularly in NT Remote Health clinics. These need to be used elsewhere in other remote locations.

6.1.4. Community partners for tailored training

More flexibility needs to be built in to the training so that practices are able to better utilise broader available expertise as required to provide more tailored training. For example, specific training around aged care would be enhanced by bringing in community partners from the health system. The opportunity to train in broader areas would be a huge advantage to government. Aged care is just one example where there is an increasing need as the community ages. Specific disease focus would be another area of value such as in diabetes. Broome has an oversupply of people applying to go there because they are very good at flexible work practices tailored to meet community need.
6.1.5. Constraints of a small business

Further, there needs to be more acknowledgement of the fact that most GPs are operating within a small private business. This can be a huge constraint in terms of increasing teaching capacity. The time constraints around sitting in with a trainee are such that unless there is adequate alternative manpower and remuneration, your business will fail. Infrastructure is another key constraint as many premises are at full capacity. The GP from Woolgoolga in NSW has increased the surgery’s capacity to include students and registrars. But to do this he has had to build a new surgery and, being a coastal area, where land costs are high, this has been at a huge personal cost. There can also be a cultural constraint. For example, in corporate practices you might find there is unwillingness on the part of the GPs to become a training practice. Reluctance to submit registrars to that environment, the lack of focus on quality patient care, and instead a focus on the primacy of dollars would not be considered ideal.

6.1.6. Robust health system

A South Australian GP cited that stability in the health system is another key factor. We need to be telling governments at all levels that we haven’t got a robust health system. We need to know what governments are prepared to deliver on behalf of local communities, what they want centralised and what will be distributed across the system. Unless we build towards a system to deliver appropriate local care to our patients, which is what this ought to be about, not turf, not anything else, the exercise is futile in his opinion. He added, we are currently trying to deal with various parts of the problem in isolation, but we can’t know what we are training people for unless there is some stability in the health system. There have been numerous examples put forward in this consultation of the impacts from closures of services by the states, and strategies such as proceduralists which have associated impacts on both training and service delivery. If we lose the duplication, cost shifting and double dipping, we might have the money to determine what services are needed in an area and then the training dollars available to train people in these areas.

6.2. Expanded sector

This discussion focused on regionalised approaches which encourage more training across the full training continuum. The main recommendation was to build on the approaches that are already working and to encourage those models to be replicated elsewhere.

6.2.1. Build on successful approaches

Western Australia was highlighted as a good training model with demand for places very high. The Rural Clinical School (RCS) has a successful longitudinal generalist approach combining the RCS and registrar training. It was considered that having the RTP and university working together improves the quality of training. The RTP covers the whole state, but has allowed different regions to have individual control to build in particularities related to local requirements. The programs are designed to meet particular needs for the community in terms of health service, but act also to allow a registrar to obtain broad experience.
This was compared to Queensland and the University of Queensland (UQ) specialist-term based program highlighting that the arrangements are entirely reliant on the model the RTP provides. In contrast, a remote WA GP stated that she has students in fifth and sixth year and PGPPP with her PGPPP doctors asking for references because they are entering the general practice training program. There was a strong view that these types of successful models need to be duplicated elsewhere so that particular regional responses can be further developed rather than using some of the more rigid responses opted for by the RTPs in other areas.

The shift back to the RACGP for the accreditation of teaching was considered positive in terms of helping to allow for more regional responsiveness to occur. But it was noted that there is a need to balance the innovation of regional solutions whilst maintaining some standardised structure overall. It was stated that the RACGP does a good job at recognising the capacity of the RTPs in this regard. But a broader issue was the inefficiencies caused by some RCSs, the WA example above being the exception, by fractionating resources with the universities and RTPs separately. It was suggested there was a need to address the resistance to integrate training in some areas, particularly in rural areas. The benefits and efficiencies found through these more integrated models are significant and need to be encouraged.

6.2.2. Remuneration

The final discussion focused on incentives to facilitate training across the full training continuum and particularly the ability or willingness of practices to take on interns. Overall it was thought that most practices would be willing, but it would depend on the financial model that the RTP offers. The lengthy accreditation process is a definite deterrent and this relates to the standardisation discussion above. It was thought that the existing vertically integrated teaching practices would have more capacity. A concern was the inability for interns to bill with the example provided: ‘If you have a PGPPP on offer and an intern on offer and limited space, you take [the one] who can bill’.

3.1.3. Darwin GP13 NRF board consultation

The RACGP National Rural Faculty (NRF) Board consultation was held in Darwin on Thursday 17 October from 4.00pm to 6.30pm as part of the GP13 event and NRF Board Meeting. The Board examined two of the six project themes with Theme 1 and 2 discussed. A total of 19 GPs participated in the discussion, including two facilitators. Whilst individuals have been de-identified in the transcript that follows, location, career stage and advanced skill detail is incorporated where appropriate. From the participant group, 16 were Fellows of the RACGP (FRACGP); two held a FARGP and one working toward a FARGP; with one member holding a FACRRM. There were three student members present.

In terms of geographic spread, for this participant group the national distribution was as follows:

- Seven members were from New South Wales - Armidale (two), Congarinni, Woolgoolga, Lennox Head, Wagga and Bathurst;
- Three from South Australia - Barmera, Tea Tree Gully and Walkerie;
- Two from Victoria - Shepparton, Kilmore now Sydney;
- Three from Queensland - Gold Coast, Dalby, Proserpine;
- Two from Western Australia - Kununurra, Perth;
- One from Tasmania - George Town; and
- The two facilitators were from Victoria – Lara; and the Northern Territory - Tiwi Islands and Darwin.
Further demographics of the group include: three females, 18 males with 15 currently in rural practice, two metropolitan-based, one retired from practice but in academia; with the three students, two regionally-based, one metropolitan based. Further, amongst these there was one female GP of Aboriginal origin and two male IMG GPs in the group. All Fellows identified specific rural advanced skills deemed important to their practice and these have been captured in the transcript. The skill mix was diverse and much broader than listed here, but included three in Aboriginal and Torres Strait Islander Health, seven in obstetrics (six with DRANZCOG and one with DRACOG), two GP-anaesthetists, two in surgery, one in emergency medicine and a further three were senior medical educators. The discussion is captured regarding the theme below.

Theme 1: Access to quality care for rural and remote communities

Introduction

Working through the requirements of ensuring that the delivery of education and training matches the nature of demand and reflects the way health services are delivered in rural and remote areas.

The discussion

The discussion highlighted the difficulties in securing equitable access for all in such a diverse and expansive country. However, there was some consensus around equity in terms of equitable access in any one town and ensuring a doctor for that specific location. Ensuring realistic expectations around minimum service obligation was relevant to this discussion. It was considered that optimal access outcomes, rather than equal access, were more within reach. Despite this, the access discussion identified some innovative local solutions to addressing disadvantage and to enable access across broad service areas. In providing training to match demand, whilst there was differing opinion around this idea, the discussion provided some useful strategies that are currently being used to ensure those with a special interest can access that experience during their training, whilst also ensuring a focus on flexibility and choice. It was also noted that while the Mason Review focuses on the ‘big P’ procedures in addition to emergency and Aboriginal and Torres Strait Islander health, broader areas emerged in the discussion in terms of facilitating access for rural patients, which needs a wider generalist skill focus.

1.1. Access to quality care

There was a shared view that certain lower socio-economic groups do not have access to general practice healthcare at the same level and often regardless of the location or whether services are in place. This is a large cohort and includes Aboriginal and Torres Strait Islander patients, those with a mental illness, those from disadvantaged backgrounds including refugees, as well as adolescent, male and elderly populations, and women in domestic violence and sexual abuse circumstances. It is important to note that equitable access is not always achievable in metropolitan areas either. For some of the more complex patient populations, alternative service models such as salaried options are often required to address the financial risk of low turn-up rates. However, salaried options are not always effective as one GP working with Headspace explained. In this example, the practice attendance rate (for mental health) was 100% against that at Headspace being 50%. The GP stated patient attendance can be dependent on the quality of the service. Each practice that has such a service needs to work through a strategy that best fits the community.
1.1.1. **Addressing the gaps**

The discussion highlighted a number of innovative approaches to responding to need in rural areas. One doctor explained how he works to address these gaps in his community through analysing the Medicare data provided through their network. The data provides actual numbers and these can then be compared against expected delivery needs. This practice based in Lennox Head, in the Northern Rivers region of New South Wales, makes an effort to find where the gaps are and works to close these. The problem is approached collaboratively at the practice level, with the team working through the issues and the strategies to address these, and allowing time for solutions to be tested and measurable improvements to show in future data sets.

1.1.2. **Workforce sustainability**

A further example was provided for Proserpine, an initiative also captured during the Brisbane consultation, where collaborative arrangements between doctors in the town ensure adequate service provision and also the facilitation of a community training model. While the majority of the doctors in the town are employed by Queensland Health, there is considerable local effort in finding service and training solutions between practices as community training partners. Particular effort goes into ensuring registrars get community practice experience in the region. This includes two practices that provide medical cover for the hospital, which enables them to rotate obstetrics and surgical Advanced Rural Skills (ARS) Fellows through their practices. This is helping with retention by ensuring the registrars stay in the region and do not have to rotate away for their community practice terms. But what they do doesn’t quite fit with the Queensland Health approach to training and sometimes issues arise from that. This is an example of where the community GPs have taken the lead in managing workforce sustainability despite some structural obstructions.

1.1.3. **Addressing skill gaps**

The issue of addressing skill gaps when a specialist leaves the community was an important discussion around access. The GP often fills this void so it is important to have the appropriate skillsets in the region. These doctors get to know each other well and work through a service solution. Obviously it is much harder if the obstetrician leaves, which is an identified current risk for one remote community as his (specialist) wife is also likely to take on a position elsewhere. This is a community where there are a lot of deliveries and provides an example of the impact this type of change can have in a remote area. This example also highlights the issue of skill gaps in a community. Should a GP need to fill this gap in obstetrics, then how can the GP acquire obstetrics skills if the training requirements are such that the doctor is required to leave the community for a period to gain these skills? The generalist void that is created is not thought to be addressed in current policy thinking. Note the point is around acquiring the skill, not skill maintenance.

However, it was noted that generally if a skill goes from a clinic, then patients do adapt. An example was provided in one clinic where the female doctors both took leave at the one time. The male doctors saw an increase in pap smears, which demonstrates that patients do adjust their expectations. Another example was provided (Proserpine) where they had lost five GPs in the last few weeks, which resulted in patients presenting to hospital sicker as they are waiting longer for appointments.
They also lost obstetrics but adapted to a different model which includes transferring patients out earlier. The primary care service reduction issue highlights the importance of having community GPs who from outside the hospitals can improve quality outcomes and decrease impacts on the hospital.

The gender-based discussion is also important to cultural access with some cultural groups refusing care unless provided by a doctor of the same sex. One doctor stated that he was aware that this is a real risk where oncologists are seeing large numbers of cervical cancer patients coming from a rural area. A frequent response to this is to set up programs where gynaecologists control a roving team undertaking smears. Whilst this service intervention is understandable, it is not a sustainable solution for rural areas. In one case, the rural GP from South Australia took direct action on the issue and contacted every rural doctor in the area (those failing to provide more than 85% biannual smears) and worked with them to set targets and get numbers up by 75% within 6 months. This was achieved and the more expensive service intervention (gynaecologists) was cancelled.

It is important to note that the smear example was just one of many examples cited where there was a realisation of a service deficit which then produced a real attempt to address the gap. In the case above there was an intervention – a series of calls to colleagues – to provide a solution for better access. In other cases, collaborative models were used to fix the gap to ensure there was more equitable access for the community.

These examples show how rural GPs may use a population health approach to plan and execute health service needs for their community.

1.1.4. Aboriginal and Torres Strait Islander healthcare

The GP from Kununurra in Western Australia explained that one of the most important factors for her community is that the medical service is safe and accessible. If it is considered so then it works for the Aboriginal community. If the service is good then they will walk to get there, if not then they will not come, dispelling the myth that Aboriginal patients don’t turn up to appointments. It is also important to differentiate that Aboriginal Health Services (AHS) were designed to provide good primary healthcare for the community, but that not all Aboriginal people access these services in the same way. In Kununurra they have a range of services, primary health care, private practice, the AHS and the hospital. The hospital provides a lot of general practice and ED, which is not ideal. Many Aboriginal patients identify the hospital as their primary care service, which is problematic.

The major issue in Kununurra in terms of access is in attracting locums to the area. Retention and the locum workforce is a huge problem in the Kimberley. It is certainly better to have a GP who works and lives in the town, but that also means consults can occur in unusual places including the local shopping centre. Aboriginal healthcare workers are vital and viewed as the eyes and ears of community. Their place within the community ensures the doctor can be well prepared and alerted to issues. This certainly helps to plan consults and the time required for each. But a big part of it is ensuring you have realistic expectations of the type of clients you have. The Kununurra GP described it as a dance: the doctor’s expectation against theirs of where they need to get to and how. Allow the patient to come back when they are ready, but be comfortable that you have done what you can without loading them with drugs.
1.1.5. Cost, time and capacity factors

It was noted that a major factor is costs for patients, and for privately billing clinics there is a need for a policy about addressing disadvantage through selective bulk billing. Often the onus is on the patient to identify these concerns, but it highlights that disadvantage extends well beyond current Health Care Card criteria. Another way GPs ensure patient access is by allowing provision in their books for urgent and walk-in cases sometimes referred to as a ‘fast lane system’. A common strategy was for principals to see the complicated cases, registrars the more straightforward ones, but provision left for urgent presentations which might otherwise unnecessarily congest a hospital ED.

1.2. Skill solutions

1.2.1. Skill-specific registrars

Whilst the big P procedures usually dominate the rural skills discussion, the key message coming through from this group was the need for broad generalist skills. This does not deny the importance of viable maternity and surgery services near where you live. However, for this group, most important in terms of optimal access to healthcare was to ensure that skills which provide for broad generalism were available. This is best achieved by the presence of quality GPs. In examining the concept of placing skill-specific registrars in rural areas as one strategy for addressing service need, it was agreed that maintaining a broad skill mix with appropriate experience should be the first priority. But it is acknowledged that any practice may have a specific area of focus or disadvantaged group which could be better assisted so that registrars in that region could elect to access that type of experience with appropriate guidance. Getting such an inflow of skills does depend to some degree on the skills of doctors working in the region.

It is important to ensure an adequate training balance so demand for the generalist skills of GPs does not outstrip the supply. There was evidence cited of the risk of practitioners closing their books or restricting their scope of practice to one skill-set. It would not be ideal if doctors only did skin or sports medicine and that focus restricted the care available for diabetics, for example. There is a greater need for generalism than specific skills and it is important not to lose sight of that. The concept of skill-specific registrars is acceptable providing it fits into a broader generalist framework. The Wagga member stated that psychiatry is a significant skill gap area and it would be useful to create a post for a registrar around mental health or even refugee health for the town. In this instance the additional skills and experience would enhance the pool of generalist skills in the town.

1.2.2. Advanced rural skills post

There was discussion around the evidence from the evaluation of the RACGP Graduate Diploma in Rural General Practice (now FARGP). The confidence gained from doing a year of supervised practice in an advanced rural skills post was significant for participants. Whilst it is unknown if that gained resilience was more to do with the individual than the place, it was agreed that it works well to support retention. The Graduate Diploma gave registrars the skills and confidence, which resulted in improved retention outcomes.
One doctor provided his personal experience to illustrate the point, stating the supervised year was important as doctors don’t tend to stay if they don’t have the skills or the confidence required. This doctor wanted to be able to do an emergency delivery even if he wasn’t doing obstetrics. Also, if he wasn’t doing surgery then he at least wanted to be able to deal with an emergency procedure – to have some idea of how to do an airway, for example. Being able to do intubations on a difficult patient or some experience in dealing with phosphate poisoning was important. The issues might not come up often, but it is important to have some experience related to these presentations. The Graduate Diploma gives doctors access to this sort of experience and an environment to gain confidence even if they don’t deal with those areas often. The confidence gained is a significant determinant of ongoing commitment to rural practice.

In terms of current training capacity, the Proserpine GP advised that they are addressing their bottleneck in training, which includes difficulties in rotating positions to get candidates through to their FARGP. They are doing this by pursuing broader accreditation of their facility. This practice is already accredited in surgery and is currently pursuing accreditation by for the Joint Consultative Committee in Anaesthetics and the DRANZCOG as well.

Theme 2: Integrated rural training pathway

Introduction
Clarify some of the key requirements to providing a comprehensive rural training experience and seamless transition from undergraduate training through to rural practice.

The discussion
The group discussion tested some of the structural adjustments needed in facilitating a pathway for medical students into rural practice. It was generally agreed that a minimum period in rural areas should be introduced. But in terms of ‘negotiating the maze,’ an approach which allows for flexibility is required. Adult learners should be put in charge of their own careers, but currently support to bring about these outcomes is lacking.

2.1. Negotiating the maze

2.1.1. Coordination and support allowing for flexibility

It was recognised within the group that a lot of this territory has been covered over the past 30 years. The main stalling point has been with the universities. The universities are diverse and they obviously have control over their own students and therefore may not want a one-stop shop that coordinates a rural training pathway. The discussion highlighted the need to fully consider how practice exposure as an undergraduate might work in terms of preparing for rural practice. Further, if the approach is supported, then at what stage or year should the rural exposure be best undertaken? The sector is suffering a real surplus of students and lack of teachers, which is why allocating them in this coordinated way is beneficial. One GP said that they overcame this issue by setting the terms for placements – Bond University being the institution involved. The coordination and rotation was organised at the community practice level.

The concept of creating a one-stop shop – a central body to coordinate all the training whilst prioritising rural experiences and making the training opportunities more attractive and viable – was raised and the concept was broadly supported by the group.
This body needs to be able to match the most appropriate training path to fit with each individual and provide assistance to navigate the funding structures. It would provide assistance in speaking to the training providers and in organising interviews. Rural practice would be prioritised and the body would ensure that those with an interest are appropriately supported. If there is an interest in rural work then it would be encouraged by individualising the training pathway and facilitating it: ‘I will give you an interview with x, y, and z and if that doesn’t work, come back to me’. A national central body would ease difficulties created by differing state arrangements. However, there would still need to be enough flexibility so that individuals have the option of moving between states and regions. Where possible the trainee should have the ability to choose where they would like to train.

The group noted the difference between streamlining and structure. Streamlining is the facilitation task which can be resolved through the one-stop shop. But structure is problematic. There is little flexibility in the current approach. A GP-anaesthetist in the group said that over the 10 years since graduation many changes had occurred in terms of his career direction, with many of these changes complicated by rigid arrangements which are not conducive to supporting someone towards rural practice. This issue is one of the major problems in the current arrangement with long-term programs for medical students, interns and registrars failing to address the fact that the medical student/doctor is going to change and develop. Further, there is the need to recognise that rural towns can also change significantly over time. The rural generalist program in NSW was cited as an example. There is currently a 7-year lag between entering and completing the program. Potentially, in rural regions, so much can change in that time. It was recommended that the focus needs to shift toward allowing the ability for flexibility and a body or process to help facilitate that flexibility.

2.1.2. Attractive models that work

A student representative stated that the way different states approach the coordination is what is making some states more attractive than others for those with an interest in rural practice. This student, from NSW, stated that he has tried to pursue the rural scholarship path in Queensland (rural generalist pathway) as the continuity it provides is attractive. Queensland provides financial support for external rural placements over a 2 week period each year in the same community to complement the skills acquired at university. This is all facilitated and managed for you from the one central office. It is well understood that if you get a rural scholarship at medical school in Queensland, then you have continuity from the start of medical school, and from intern year to fellowship. But in NSW they would tell you to go and find your way yourself.

Registrars want assistance to get through the maze. They like the structure of the rural generalist pathway, but not necessarily its current approach and procedural focus. But it is about bringing out the best aspects of it, the coordination and continuity it allows, then further refining it to allow for more flexibility. One doctor stated that some of her best doctors never wanted to be a rural GP, but came to it later on. Ensuring there is enough scope to provide for the late-decision makers is essential.
The key is to enable flexibility to choose what suits the individual, and if it happens to be within the one community then varied exposure should be provided. The model needs to allow for as much movement as an individual wants in terms of the how, when, where and why. Market the type of model that would allow individuals that flexibility, flexibility which enables richness. This would support recruitment and retention outcomes. Allow for movement in the program so the adult learner is empowered to make career decisions. Open the market between all providers and let the learner determine their own pathway. Allow individuals to get their education the way they see they need to and that way you will produce the doctors to best suit the community in which they are going to choose to work.

2.1.3. Minimum placement and increasing exposure

Differing arrangements between universities are an issue, some universities allow for a 4-week placement, others might stipulate 6-weeks while others might offer 6 months. The shorter period is not enough for a student to grasp what is going on in rural health and it was generally agreed that some sort of minimum period has to be introduced. This would also work to the benefit of practices, who will want to take more of the longer-term placements. Students need at least a month in order to provide any value from the practice perspective.

But it was also highlighted that exposure must depend on the level of training or training stage with the location determined by the stage of learning as well. For remote areas, for example in Kununurra, they find they have students wanting to come back because they are given a great deal of supervised responsibility. They are given an opportunity to actually practise their art. But given its remoteness, first and second-year placements are not as successful as they haven’t yet got enough knowledge or skills. It is considered, for a true rural experience, that having the ability to see a patient, make decisions and be supported is more ideal.

Provide the enticer early, however not too early in remote or very remote medicine, but if you want the student to gain valuable experience and a real understanding of general practice rural medicine, then the real clinical exposure needs to be later. The recommended approach is to increase exposure to rural practice as skill levels increase. Therefore students should be provided some early exposure to rural medicine but the emphasis needs to be on ensuring they are able to return to rural areas for greater exposure later on, once they have developed that maturity. Otherwise potentially this creates a disincentive for rural practice as the student will be ill-prepared for the level of skill required or turned off due to the complexity.

2.2. Getting the balance right

2.2.1. GP intern rotation

Clarification was sought early in the discussion around the potential to pipeline interns straight into general practice without hospital exposure. It was agreed this type of approach would not be supported. However, the intended approach which is part of a rotation has broad support. It was noted that this is effectively what PGPPP already does, but there is a need to roll it out further. Flexibility again was a key point to the discussion with the need to allow a lot of flexibility for students and interns to try lots of different specialist areas.
One recent FARGP graduate stated that the exposure he had in hospital was absolutely vital in obtaining the understanding he has now as a GP. It was important to have that exposure to work through what specialists, hospitals and GPs could do. This experience ensures interns are enriched when they become a generalist. It also helps set career direction in terms of splitting those who don’t want to be limited (specialist/generalist) in terms of scope of practice.

2.2.2. Enabling flexibility

The student representative stated that there needs to be a provision for those who may change their mind. If a doctor wants to go from general practice to general surgery then this should be possible without disadvantaging the candidate. A further point was made around the perceived disadvantage for those undertaking community-based internships compared with those in hospital-based terms. The example cited was that with a surgical rotation you will be able to receive a surgical reference. A student member advised that the University of Melbourne pilot project is working through some of these issues with General Practice Student Network (GPSN) coordinating feedback from a student perspective. The student went further, advising that there are a lot of these types of issues but confirming that the basic principle, rural GP intern rotation (part hospital/part community), had wide support.

The concept of combining intern and registrar years and providing a contract for a couple of years instead of one year at a time received mixed support from the group. It is considered that this approach would only suit those who are really committed to rural general practice – that it might work to pipeline a select few that way, but may not result in the best doctors doing general practice. On competency-based training against-time-based system, it was considered that competencies are not always the endpoint and that maturity is a significant endpoint for doctors. There is some advantage in the time-based system in terms of learning and maturing.

It is sometimes found, particularly in Aboriginal health, that when students go into communities they may not be well suited. The risk in streamlining students will be a missed opportunity for the specialty they should have chosen, as they are now trapped in an area of practice not suited for them. Fortunately for the Kununurra GP who raised this issue this was not the case. She did all of her training in Kununurra but had previous opportunities in other places in an earlier role.

This doctor values her Perth-based hospital experience, as it equipped her with the required skills to navigate and negotiate various parts of the system. It means she is able to negotiate positive transfer outcomes for her patients. For Aboriginal patients, it is important to work through their specific requirements, which are often not well understood in the city. If arrangements fall through then often the patient will just return to community. The more rural and remote you are, the more understanding of the system is required for successful transfer outcomes.
2.2.3. Identified risks

The issues with the community internship relate to concerns as to how doctors are going to get the core competencies in surgery and emergency medicine. Some of the broader identified risks included the capacity of training and the need to only go to rural areas that are ready to take on training across the full continuum involving students, interns and registrars. A further risk for community interns is poor supervision. The student will be placed for an extended period of time, so if issues occur it is feared that there will be a lack of support structures. It will be important that professional, peer and personal supports exist and that formal mechanisms for peer support are provided. It was stated that there is a need to ensure the same level of support that is currently received in the hospital system, where there are more peers to rely on when difficulties arise. If trainees are able to look after each other, then it was thought it would be less likely they will walk away from rural practice.

Community placements for interns full time, at PGY2 particularly, are seen as a significant risk. The doctor could go into one practice for a year and come out with a much skewed view. There would be the potential to have major deficits and this not to be realised due to a lack of exposure to comparators. The hospital system allows the doctor to pick and choose teaching and learning styles. The doctor is thus more prepared, more rounded and ready to launch into an area of interest. The need to be exposed to different training and different specialists is considered very important.

While it was considered positive to enable medical students to remain to undertake internships in the same location, there was a mixed response to taking these on. For some, hosting PGPPP interns in their practice was not desirable. General practice should not be seen as substitutable for other experience such as emergency placements. It is great experience, but it is important that those undertaking GP intern rotations should not be forced to do so just because they are unable to get into something else.

2.2.4. Regional solutions

The earlier discussion around student placements highlighted the flexible nature at that phase in the training continuum. That is, student attachments and usually the agreements or arrangements with universities can be flexible and are reasonably easily to regionalise. But the internship concept moves into the pre-registration requirements and therefore inflexibilities will be much greater. The Rural Clinical Schools (RCS) do provide a structure to facilitate such an initiative. Rural internships can occur in catchment areas of the RCS around Australia and could be broadened out further without much adjustment.

While it is accepted that there will be a need for different scenarios across Australia, it is important to look to the areas currently working well when considering expansion. Increasing primary allocation places for internships in regional Australia was considered highly valuable. If investment had been focused there in the first place then many of the capacity issues currently experienced would have been reduced. It was considered that there is huge capacity in regional areas to take on more interns as an alternative to city-based internships. However, providing room for variations in the structure to allow for different scenarios will be needed. The same structure is not going to work in contrasting places, for example, somewhere outside of Sydney against somewhere near Alice Springs. Building on and expanding current successful models in regional areas was recommended.
2.2.5. Targeting areas of critical need

One of the biggest challenges in the future in Australia is in aged care. General practice could support further broad (generalist) training in this area. It was noted that much specialist training is becoming extremely narrow. Physicians’ training is one significant area where there is currently very little training on aged care and perhaps specialist trainees would benefit from a 3-month rural placement. The concept that PGPPP should be for all so everyone gets exposure in primary care might be a good strategy to address future skill shortages. It was proposed that governments could look at not only rotating general practice interns, but look more broadly to involve specialist trainees in general practice as well.

3.1.3. Adelaide consultation

The fourth RACGP National Rural Faculty member consultation was held in Adelaide on Friday 29th November from 10.30am – 3.30pm. The participant group comprised 13 experienced RACGP Fellows, who all had several procedural and non-procedural advanced skills and were involved in training at various levels, one student member and three observers (one from the Project Advisory Group and two RACGP staff members). The group provided some useful examples of training and service-delivery models currently being implemented in their local regions, and outlined some of the issues for students and early career doctors in navigating the existing pathways to rural general practice. All information has been de-identified, with location-specific exampled identified where necessary. The discussion is captured against the theme below.

Theme 1: Access to quality care for rural and remote communities

Introduction

Discussion around equitable access to quality care in rural and remote communities that is linked to GP experiences in local areas and in various settings, including practical examples of the issues, barriers and solutions. Looking at demand to ensure that what we do in education and training matches the population needs and produces the multi-skilled workforce required to meet community needs.

The discussion

The discussion highlighted some detailed examples of strategies being implemented to address issues relating to access to primary and secondary care in their local practices and community settings, and produced some proposed models for piloting. Innovative approaches to enhancing rural training experiences through multidisciplinary team environments were identified and links with universities which had been successful locally in increasing access to services and could be widely replicated were shared. Varying opinions surfaced around matching training to community need, particularly in relation to skill-specific registrars and the most beneficial time for doctors to acquire advanced skills. It was noted that skill-specific registrars do have the potential to create service through consistent skills being used in an established role. Flexibility was highlighted as a key component in any strategy to address workforce distribution, given that skill demand will change often and sometimes quickly during the career of a rural GP.

1.1. Use of technologies

The use of teleconference facilities over the past 2 years has increased the access patients have to healthcare providers and reduced patient travel requirements. There are some issues with particular specialists, as not everyone has access to the government-provided systems and there are no standard protocols around technology and software use, so there are barriers to the types of teleconferences that can be used. The group is also encouraged by the use of cameras and other simple, effective technology options.
1.2. Outreach clinics

The group expressed the need to improve infrastructure for outreach clinics and branch practices, supported by incentives to encourage multidisciplinary health teams to also provide outreach services in conjunction with local GPs. An example was provided of an outreach clinic in Swan Reach (45–50 min drive to nearest centre) in South Australia, which has access to government funding and is now building a purpose-built clinic. However, they have trouble encouraging allied health professionals to visit the area because it is not profitable and often not even cost-neutral for them. This outreach is important for that particular community as it promotes access and addresses multiple barriers to accessing healthcare. It is also becoming a hub to which other professionals are moving and visiting. The provision of outreach clinics with adequate infrastructure satisfies broader community needs, allowing for other facilities such as nursing homes and pharmacies to be established and providing benefits that extend beyond improving access to a GP.

1.3. Increasing access to primary and secondary care services

1.3.1. Multidisciplinary teams within general practice

Multidisciplinary teams within practices are seen to universally increase patient access to healthcare. They allow for internal referring systems where the referral base is not only from GPs, but other allied health professionals who share medical records and results. This approach means that patients are not lost in the system.

One GP participant explained how this approach works in his practice. For this practice, two primary healthcare coordinators have been employed – one focused on chronic disease management and one on mental health. These roles facilitate access of patients to both primary healthcare providers and specialist care with health professionals looking not only at health needs but also social needs and socioeconomic barriers to accessing care. Based in practice, the primary healthcare coordinators organise teams and logistics, and ensure that patients have regular reviews and health checks are up to date.

For this case example it was explained that the approach works to enhance the training and education experiences of medical students and registrars, who are orientated through this system from day one. As part of their training, students are immersed in this structure and exposed to the entire multidisciplinary team, building their understanding of the whole system rather than just the general practice component.

1.3.2. Local access to secondary care services

There are also areas in which local GPs co-exist in providing a secondary care model, using referrals between local practices to improve patient access to secondary care services. An example was given from the UK (late 1990s) whereby a few practices in close small towns had GPs each with different procedural skills, and these GPs referred internally to each other (examples given were colonoscopies and endoscopies). Each procedural GP had a list every 2 weeks and gained enough experience to keep their skills up to date. This approach is consistent with other RACGP consultations where GPs advocated for critical masses of GPs with advanced skillsets. The UK example could be applicable to both smaller regions and larger locations around Australia as it saves patients having to wait for specialist access from the city, or needing to travel to the city to have their procedure.
Other GPs reported contracting secondary care specialists to their private practice, whereby visiting specialists use rooms and reception staff to conduct their own private business. This approach allows for a more seamless interaction between the two levels and provides improved access for patients. The result is more ready access for the patient to face-to-face secondary care consultations and more access for the GPs to specialist advice. Given they are private businesses, it is up to local practices to decide whether such an integrated model is appropriate for them and their business model. Ultimately, access to GP services is the most valuable asset to private practice; it has the most demand and will generate the most income.

1.3.3. Training centres to increase access to services

The group acknowledged the role of training as a rural health workforce strategy, more specifically using an integrated model based around training that is also providing a service to the local region. One example was a superclinic in SA, which has been made a training centre by the University of Adelaide and now attracts psychology services not previously available locally. Psychologists supervise medical students where appropriate, and as part of this approach the service is now being sent counseling and psychotherapy Masters students as well. This approach to improving service access could work more broadly with the right incentives, referral system and infrastructure, along with assistance to support students in undertaking rural placements.

1.3.4. Aligning training pathways and workforce solutions

One GP described his local setting in which there were three GP anaesthetists’ and no GP-obstetrician, and similar scenarios were common across the group, highlighting the need for greater focus to ensure that investment meets demand. There is potentially a role for workforce agencies to coordinate training, supply and demand (against community needs).

1.4. Skill-specific registrars

The timing of acquisition of advanced skills was the focus of this discussion, and cases were made for both sides of this argument. Care must be taken in terms of how skill-specific we get, as we need to ensure that doctors are trained first and foremost as generalists and have the flexibility to pick up and change skills as required or desired. While registrars with an advanced skill are undeniably valuable, it is primary care which makes the greatest difference to rural communities.

Some group members felt that having an advanced skill before going into GP training is advantageous. It enables the individual to take the basic secondary skills and then adapt them to what works in primary care while still under supervision. There is a sense of vulnerability in moving from an environment full of specialist support into general practice unsupported and further into rural general practice where one is relatively isolated. It was proposed that a mentoring approach be established to ease the transition.
Others report that the excitement and interest in acquiring procedural skills early is making it difficult to bring registrars back to the general practice training program to gain their primary healthcare general practice exposure. Difficulty can also arise in locking in specific skills too early without being able to guarantee the workload necessary to maintain advanced skills while undertaking general practice training. Training registrars in advanced skills requires the more experienced GPs to give up some of their work, to supervise, which is not always happening. In NSW there is also a resistance by specialists to share patients, and consequently registrars that are undertaking advanced skills training are having trouble accessing an adequate number of patients. Junior doctors are of less value to the specialists providing the skills, whereas an experienced GP registrar doing advanced skills is more valuable.

The local RTP has started to buy their own training positions because they can’t access them in the hospital. They are in the process of introducing the concept of a rural fellowship whereby registrars undertake a 12-month training block; the hospitals have agreed to release the doctors for 1 week every quarter to go out and perform their skill in a rural setting with a rural mentor. One of the great dilemmas for the registrar is the ability to switch between general practice and their procedural skillset. There is tremendous difficulty in switching mindsets, and there is a need to address this issue in the training.

There is also an imperative to introduce and reinforce in the trainees’ mindset that skill requirements are going to change quickly, and that is a skill which is not often acknowledged but should be understood. There is also a need to bring this skill, that is the ability to multitask and shift focus, into the teaching, as the skill and ability to rapidly shift one’s thought pattern according to the circumstance and presentation can be a challenge.

There was a general consensus that the skills acquired by GPs are dictated by the community that the GP works in. This view is consistent with what has emerged in the earlier RACGP consultations held in the other states. A different approach would be to determine the skillsets required and then to attract the GPs with that skillset, and this approach could work, however it requires some flexibility. For either approach, from a broader workforce policy perspective, workforce planning must be matched to local community need. There is no point having a community with several GP-anaesthetists if they are not matched with the other procedural skills necessary to provide services.

Theme 2: Integrated rural training pathway

Introduction

The integration of training to ensure a comprehensive rural training experience from medical school, pre-vocational years and vocational training through to career as a functioning rural GP.

The discussion

The discussion for this theme focused on the need to revitalise and rethink the antiquated junior doctor training system. Rural general practice training in Australia is maturing, and needs to be supported by integrated approaches to training that provide enhanced learning experiences for both the learner and the teacher. Training models need to produce a streamlined solution in which medical graduates are training to meet workforce demands and fulfilling the needs of communities.
The group called for strategies that provide GPs with the flexibility to have more rural experiences or to opt out, so that resources are not used up on people who are not rurally inclined. Compulsion isn’t an ideal strategy, given that so many people with a city background end up in rural general practice. Early-year medical students are a heavy burden on practices, however there is value in early exposure to primary care settings, so placements involving GP teams and other multidisciplinary clinicians with shared responsibility for supervision may be viable for pre-clinical years. Working through ways that students and junior doctors who are mapping out their careers can be given positive rural experiences and high quality rural exposure is essential.

2.1. Integrated teaching models

2.1.1. GPs as teaching consultants

Early medical student placements and interns in particular, requiring one-on-one supervision in every consultation, are particularly difficult for rural GPs to supervise while running a viable practice. Flexible arrangements such as engaging GPs on a consultancy basis to manage supervision of interns across both general practice and rural hospital settings need to be put in place, as well as strategies that allow for shared supervision responsibilities with other GPs and multidisciplinary clinicians where appropriate. This consultancy approach would encourage a gradual increase in responsibility of interns and registrars for patient care.

2.1.2. GP educator support

Quality teaching requires quality, paid GP time. The fee for service funding structure impedes any innovation in attracting junior doctors to rural places; currently there is too much risk placed on private general practice and this needs to change. In the absence of an integrated training approach, payment needs to be consistent across all training levels. However, a salaried model is more widely supported, where the liability sits with a third party (perhaps RTP to hold funds) and not with private general practice.

The need for increased support for GP supervisors in the form of remuneration and recognition, training and resource access, was considered essential. Clinicians need to be trained to be trainers, teachers, educators, or supervisors, and though some resources are available, they need to be more readily accessible. Trainers require information around the expectations of curriculums including the learning stage of the students, and require support to adapt to newer methods of learning and teaching. Having quality teaching is essential, particularly for longer placements, the outcomes of which are an increase in the number of graduates pursuing a career in rural health.

2.1.3. Shared teaching systems

The group supports strategies that encourage sharing the burden of teaching and supervision, particularly through group practice. With requirements varying between students, PGPPP, interns and registrars and issues in ensuring each level can access adequate patient numbers, the system requires greater flexibility for supervisors in order to have the capacity for vertical integration in general practice. External factors also impact upon this supervision capacity – reportedly 6000 physicians are currently in training in Australia and there is a strong push in many specialties to be more general. This will have an impact upon training places across the entire structure and put pressure on the system, with a likely associated push into rural areas.
The group therefore supports an integrated rural training pathway that encompasses several specialist colleges which value the generalist approach (see 2.2).

There is a need for a consistent, vertically integrated approach to teaching which promotes shared teaching responsibilities. A need for an approach that offers flexibility for both students and supervisors to adapt their teaching in order to address curriculum requirements in a way that reflects the local context. Policies of state jurisdictions currently impact on the ability of supervisors to facilitate integrated training and this needs to be addressed in future system reviews.

2.2. Generalist-focused integrated prevocational training

The concept of an integrated rural training pathway across colleges was raised and generally supported by the group. An integrated pathway was viewed as providing foundation generalist training for junior doctors in a well supported rural environment. A pathway could be developed through a consortium of specialist colleges, particularly those with common generalist principles, who agree upon and endorse generalism as a foundation of junior medical training.

In facilitating such an approach, it was proposed that the intern year be replaced with two years of foundation generalist training, whereby the training of junior doctors focuses on teaching generalist skills and provides exposure to a range of experiences, including introductions to various advanced skill areas.

The generalist skills required to manage patients and address complex patients can be enhanced by mapping the training process to ensure a wide variety of experiences, in major hospitals, regional hospitals and rural general practice.

The PGPPP is a good example. One GP explained that in the Northern Territory PGPPP isn’t viewed as a workforce solution, but rather the opportunity to experience remote living and remote primary healthcare, and has given birth to innovative ways of supervision (remote supervision).

The pre-requisites and parameters for being accepted into each college’s vocational training programs after completion of the 2 years of generalist training would be agreed upon by the relevant colleges, and generalism endorsed as a foundation to the vocational pathway. It was stated that the College of Physicians wants every one of their registrars to spend 1 year in general practice as part of their training to give them a broader range of experience, therefore they would be one college who may endorse generalism as a foundation to their pathway.

2.3. Coordination of training

2.3.1. Coordinator and career development positions

The employment of a coordinator and career development positions was unanimously supported by the group, who all identified a current lack of responsibility in helping junior doctors to structure career pathways. The coordinator role would be responsible for determining the skill mix required in particular areas in response to community needs, and coordinating the generalist training pathway. The development roles would assist junior doctors in navigating this pathway and mapping their experience, matching what they want to achieve with a structured approach to achieving it.
2.3.2. Linked stakeholders

The disintegration of stakeholders described by the Mason Review was challenged in the consultation, with many participants reporting good connections between rural clinical schools, RTPs and universities. In the Northern Territory, relationships have been enhanced through local arrangements between the university and RTP, with the RTP renting rooms at the university and therefore increasing its accessibility for the medical students and university staff.

2.4. Early exposure strategies

The group emphasised that whilst recruitment of people of rural origin to medical school and back into rural communities is important, caution must be taken to ensure that any planning does not discourage those from a city background from going to a rural area. This ensures that urban-based students are fully considered given that they make up two-thirds of the rural GP workforce. Many city-based students consider rural careers after quality placements, so care needs to be taken not to dissuade city students from undertaking rural opportunities. The group, including the student present, supported the abolishment of the 4-week mandatory rural placements in support of providing longer placement experiences for those seeking rural opportunities.

The need to influence students in a timely manner was reinforced by one GP involved in student and prevocational training who highlighted that medical students (especially those in postgraduate courses) are choosing their career intentions very early on, tempering their ambition and enthusiasm for wide scope rural general practice. Undergraduate and postgraduate medical curriculums need more focus on general practice and rural health because it is currently intermittent, appearing late in medical school and insufficient in length of exposure.

To facilitate such an approach, the group proposed giving junior medical students opportunities to undertake rural placements that are focused more around environment immersion than clinical exposure. This would involve 2-to-3-month attachments with shared experiences locally that include allied health, community medicine and hospital medicine, plus the experience of living in a rural town. Small group sessions utilising rural volunteers are also seen as a useful rural exposure tool, where students can gain some knowledge around the health needs and access issues of a rural patient.

Theme 3: The use of advanced skills in rural areas

Introduction

Working through the requirements to improve rural GP access to advanced skills training, defined as both procedural and non-procedural, and identifying some of the barriers to obtaining and using advanced skills.

The discussion

Trainees will provide vital rural services in the future, yet they are currently undervalued. Support and mentoring by rural GPs is required during and after advanced skills training to ensure that skills learned are transferrable to their rural practice and that the training experience continues after the completion of training posts. Dedicated and clear pathways for GPs to acquire advanced skills and utilise them in a way that is valued and recognised are important factors in attracting and retaining a skilled general practice workforce in rural areas. The provision of community-based training can be achieved through some fundamental structural changes, and would better link skill acquisition with the context in which they will be applied. Procedural skills account for a narrow portion of the broad range of skills required to practice safely and confidently, and to meet the broad range of needs in rural communities.
3.1. Skill acquisition

Acquiring advanced skills has perceived difficulties for rural GPs, given that it often requires 12 months in a training position in a public hospital and the training is not tailored to the specific skills needed by GPs in rural communities. Despite re-entry programs being run for some time, the skill solutions are not yet addressed. The group advocates for investment in a dedicated, more coordinated career pathway for people in specific areas to meet specific needs. Hospital-based training positions don’t recognise the special needs of those who fill them, nor do they consider how those skills might be applied once the registrar moves into community settings. A profound change in approach is needed to ensure that acquiring and maintaining skills is a supported, streamlined and meaningful process.

3.2. Dedicated training position for GP registrars

3.2.1. Connecting advanced skills training with community settings

Career planning and a clear pathway to rural general practice and into advanced skill practice are vital in addressing workforce shortages in rural areas, yet GP registrar skill acquisition is occurring more haphazardly than it should. There are inconsistent approaches across states. For South Australia in particular, there are no dedicated training positions for GP registrars in procedural advanced skills. As a result, training places are being purchased by RTPs in order to secure a pathway for the registrars who want to achieve certain skillsets; however, as a provider they have no influence in the tertiary hospital system and securing positions is out of their control and in the hands of the specialist. There are places nominally reserved for general practice registrars, however these are not guaranteed, nor are they considered secure.

Current arrangements also lack a formal rural mentorship component, which would facilitate a community-based, continued training experience. Moving training positions out of hospitals and into general practice may also allow for registrars to gain, for example, advanced skills in obstetrics from a rural GP-obstetrician. Training subsidies would also be required for supervisors, not linked to fee-for-service system. The accreditation of such community-based training positions is problematic given that patient numbers cannot be guaranteed and GP-obstetricians need to keep their numbers up for skill maintenance, so sharing caseloads may not be viable. This issue is not just reserved for community settings, as anecdotally patient numbers are already an issue within the competitive tertiary environment.

Community based training models would require a policy change (specifically within GPET), allowing for the GP term and advanced skills term to be undertaken concurrently. One GP in South Australia already has an advanced obstetrics training position running out of his general practice, and this pilot concept may warrant further consideration.

3.2.2. National coordination

The group made several arguments for national coordination of specific skills training, based on the importance of matching community need and workforce demand and ensuring that registrars are undertaking the right training to meet community needs. Career counselors were again mentioned, with a role in advising on community requirements to ensure these are captured in workforce and career and training planning.
3.2.3. Non-procedural advanced skills

Procedural skills are undeniably important, but the consensus within the group is that they are a narrow part of the system. Queensland in particular has put significant financial incentive and emphasis on procedural skills, without rewarding those who have acquired non-procedural skills, and this has caused some discontent within the profession. Recognition is needed for the role that non-procedural skills play in addressing healthcare needs of rural communities, and mechanisms for acquiring and maintaining these advanced skills expanded to include the full range of skills. Some skills in particular are uniformly required by every rural GP such as emergency, mental health, chronic disease and palliative care, and training in these skill areas must be made more readily accessible. College collaboration should occur for a broader range of advanced skills in order to develop curricula and training endpoints outlining what is required from advanced skill registrars. This approach is currently being undertaken by the RACGP and RACS for the development of a GP surgery curriculum and could be expanded, however there is a risk of unintended credentialing issues and failure of the system to recognise skills without formal qualification.

Theme 4: GP-rural generalist – Defining the role and pathway

Introduction

Generalism as a whole is a positive, supported concept in an environment of increasing overspecialisation. The principles of generalism reflect the nature of rural general practice, but the definition of a rural generalist is not clear.

Discussion

While participants brainstormed and shared ideas about what the terms rural generalism and rural generalist should potentially mean, there was an evident lack of consensus and understanding around its current definition and frustration over its inappropriate use. Concerns were raised around origins of the generalist language, both internationally and in Queensland, and how it became applicable to general practice in Australia given that it was originally used by specialists practicing in rural areas, not GPs.

4.1. Definition of rural generalist and GP-rural generalist

Several interpretations and perceived definitions were suggested and discussed by the participants, varying in detail but conveying a common theme in meeting the needs of the local rural community. The focus moved away from procedural skills and rural general practice as a specialist medical field toward a more context-based definition, which acknowledges the lack of specialist access and promotes resilience in taking responsibility for the whole range of patients that come through the door of a rural general practice. The group emphasised the need for skill acquisition to be responsive, with doctors trained first and foremost as generalists and then supported to obtain extra skills to respond to community needs. One participant suggested that a generalist is someone who can deal with the needs of their community, adapting their skillsets and practice style in line with changing community requirement, service availability and policy environments. The requirements of on-call services and emergency response can be stressful and demanding, and highlight the need to remain focused on enhancing generalist skills that enable GPs to meet these rural community needs.
The current definition of a rural generalist was challenged through the suggestion that a GP with a particular advanced skill whose practice becomes too narrowly focused with that skill discipline is in fact a partialist, not a generalist. Someone with an advanced skill in obstetrics, for example, is not necessarily a rural generalist because there are gaps in what they see and they are not necessarily dealing with the whole of their community, using only part of their skills. They are instead a workforce solution, necessary to run a rural hospital while practicing general practice on the side, and not a generalist using a wide variety of general practice skills.

4.2. Training requirement of the generalist

The discussion took a natural progression into training requirements and skill acquisition, with the group agreeing that some form of training is required for recognition of skills. GPs upskilling to substitute other specialties require formal training which is assessable, examinable and offers recognition as well as a skill-specific continuing professional development requirement. However, the group noted that the risk in this approach is that the system will then require a formal qualification from those least able to access training without leaving their rural community.

GPs feel that consultants are dealing with more basic presentations that could be cost-effectively dealt with by GPs with an advanced skill, and as a result specialists are not utilising their time efficiently during their visits to rural communities.

Theme 5: Embedding more primary care in the training

Introduction

Identifying and developing models to support incorporating more general practice terms into basic training.

The discussion

Existing avenues for embedding more primary care into training provide good models for expansion, with particular reference to rural opportunities provided through the John Flynn Placement Program, University Departments of Rural Health and university rural health clubs. These initiatives provide early exposure to rural health for a range of health students in an ongoing, supported way.

Vertically and horizontally integrated training within primary care settings was an approach widely supported by the participants, who see great value in introducing concepts of primary care into training at an early stage through multidisciplinary learning and teaching. Community-based rural general practice training is being increasingly promoted in medical schools, however there is no systematic application of this approach in the training with primary healthcare teams rarely incorporated into GP registrar training. In providing training of this nature, case-based education is perceived to be a useful tool, as well as using technology and simulation-based medical education with primary healthcare care emphasis. The participants agreed that there are opportunities for synergy and collaboration here.
5.1. Local coordination

Consistent across the themes, the currently fragmented approach to coordination and the need for coordination at the local or regional level was again discussed. An essential consideration for embedding more primary care, given the range of stakeholders involved, is a role responsible for coordinating clinical placements who can utilise local resources for education and training. Team-based training doesn’t necessarily require a critical mass, given that a critical mass of professionals is not always reflective of rural community reality. Positive outcomes can also be achieved if there are a smaller number of people or a more narrow range of health professions. One risk of team-based training is that while it may be more cost-effective, not all skills are multidisciplinary so there is a need to ensure that the education being provided is relevant to all participants to some degree. Stronger incorporation of preventive and population health into primary health care training, including skills to study population data, was considered important as is the need to recognise and remunerate services of this nature provided by GPs.

Theme 6: Training capacity

Introduction

Working through the factors which limit rural general practice training capacity, and addressing issues impacting on the sector’s ability to cope with additional requirements of a new national rural training pathway.

The discussion

Addressing key constraints limiting supervision capacity in rural general practice will be vital to the success of a new national rural training pathway, with the current system limiting implementation in a number of ways as outlined below. Local knowledge is essential for local solutions, and again local coordination is highlighted as an important feature of increasing rural training capacity.

6.1. Models of supervision

Accessing patient numbers is already an issue for registrars, who already compete for case loads with students and other prevocational doctors, and current models of supervision don’t allow for an ideal distribution of patient load. The group support models of supervision allow the GP supervisor to take on a consultative role, allowing every individual in the practice to be utilised to the best of their ability in a supportive environment (including students, nurses). Leading the training, a supervising GP could then make more adequate use of allocated training time by, for example, providing 5 minutes of input into patient care in the context of a 25-minute consultation with a registrar. GPs are limited in their capacity to adjust the training in order to meet their specific practice needs and/or local context. One example was given by a GP from South Australia who has recently piloted a remote supervision approach with their registrar, and believes that remote supervision could be one possible model for expansion.

Local doctors from four well-established teaching practices in Alice Springs tried to set up a registrar-level regional practice-based teaching roster, and while logistics inhibited its success, this approach would work well in many areas where the registrar would benefit from the experiences of various GP supervisors with their various additional skills. A regional approach to registrar training which promotes an ongoing flow of registrars undertaking longer, established placements was suggested, with caution taken not to move registrars so often that it affects their ability to establish themselves.
6.2. **Support for teachers and supervisors**

6.2.1. **Remuneration and recognition**

GP teachers and supervisors require increased support in a number of ways. Changes to recognition and remuneration for supervision are required, with participants describing the inflexibility and inadequacy of the fee-for-service model for supervising, and expressing support for a salaried model to support teaching and innovating supervision models. GPs are limited in their ability to adopt innovative methods of supervision, given the inflexibility of the system and inadequate or inconsistent funding arrangements. These issues result in a lack of engagement by the corporate sector, whose business models do not justify or support taking on students.

Funding needs to be clearly archived for the designated purpose, and held by an entity with good general practice representation to prevent funds being re-arranged to suit non-specialist organisations’ (such as universities) needs. In the interest of holding funds locally, RTPs are likely the best advocates for their trainees. They can access what the registrar needs for training and can access what is required to provide the training services. RTPs are a good option provided funding is channeled into communities and practices rather than regional hospitals. An independent broker was also suggested for holding funds; and again the use of a local coordinator would be ideal here for either scenario.

6.2.2. **Teaching clinicians to be teachers**

Defining the role of a supervisor so that expectations of registrars and trainees align with achievable deliverables may encourage more rural GPs to take up some supervision work. Being a great clinician doesn’t automatically make someone a great teacher, and clinicians need support to gain teaching skills and to feel confident in their ability to use new and innovative ways to supervise.

6.3. **Support for students and registrars**

Access to quality accommodation is an important and sometimes underestimated element of rural placements. Encouraging registrars to establish themselves locally promotes interest in rural life and works to improve rates of retention for the future rural general practice workforce.

3.1.4. **Sydney consultation**

The final member consultation was held in Sydney on Tuesday 10 December from 10.30am to 3.30pm. The session involved a small yet diverse group of eight GPs from Queensland, New South Wales, Victoria and Western Australia. Seven were experienced Fellows of the College with the eighth participant a registrar. Two participants in the group were solely involved in medical education, both attached to a university, including one dean. Interestingly one of the rural GPs in the group started her medical training late at 36 and now works in a remote community in Western Australia. Three GPs were strongly involved in Aboriginal and Torres Strait Islander Health, two in remote communities and one in inner Sydney. In the summary that follows, whilst the individual has been de-identified, detail on the advanced skill and location is provided where relevant. The discussion is captured against theme below.
Theme 1: Access to quality care for rural and remote communities

Introduction

Trying to ensure the focus remains on securing equitable outcomes for rural communities leading to more primary care. Training responses need to provide for a broader response against addressing need.

The discussion

The group shared local innovative solutions and facilitators and service innovations that could be replicated elsewhere in addressing need. It was noted that the key aim of new ways of working should be in providing a more effective primary healthcare system with continuity of care and empowerment at its core. In providing a comprehensive training experience, the focus must extend to providing choice and opportunity in empowering the trainee to obtain the skills they need in the local setting. However, it is important to balance this choice of skills with a stronger emphasis on the much greater generalist skills requirement or primary care focus, and therefore favour those skills that will address the highest needs of rural patients.

1.3. Equitable access

1.3.1. Service innovations

The group shared similar service innovations to what had been discussed at previous RACGP consultations, including the use of telehealth to address access barriers. However, the limitations of holographic innovations were noted as well as their potential for unintended consequences. These include the deskilling of local teams and the risk of deterring specialists to rural areas. The service deficit and on-cost impact of a consultant thousands of kilometres away charging an enormous fee with no continuity of care and very little follow-up cannot be overlooked.

More positively, using the technology for follow-up in reducing access and time burden on rural patients and in emergency medicine is proving very effective. For example, for the weekend emergency cover locations for the Derby GP, including Merredin, Narrogin and Northam, there has been great benefit.

Those hospitals now have cameras over the emergency bed straight to the consultant. It is virtually the same as having the consultant in the room in these instances. New South Wales similarly has cameras used for this purpose in all health districts emergency rooms, which has also had a great impact.

Most communities still rely on fly-out services for certain emergency presentations and treatments. In terms of patient transfer, one member noted the costs of maintaining care flight services in Queensland, with the cost of running one helicopter at $4.5 million funded from various sources. As a longer-term goal, it was proposed that part of the air retrieval investment should be diverted to providing training opportunities against service need in some of these locations, which could prove more cost-efficient. The policy priority to target training investment in those areas should be pursued by governments, then over time the service will build and there will be less need for costly patient transfer for certain treatments.
1.3.2. Shared service arrangements

In terms of achieving more equitable access outcomes for rural patients, the Derby GP highlighted that every town is different. In outlining the medical service for the Derby community, with one hospital and an Aboriginal Medical Service (AMS), she explained that they have no consultants at all. The surgeons, O&Gs and paediatricians have moved to the regional hospital in Broome. This is mostly due to the area’s remoteness and the fact that consultants, with a rural inclination, tend to have a preference for more attractive locations including Broome and its beaches. By using those facilities that they have within reasonable distance of each other the three hospitals in Broome, Derby, Kununurra, and part of Fitzroy Crossing and Halls Creek. With Broome offering the specialist cover, they are able to utilise those networks for the benefit of the Derby patient community.

Further explaining that in these locations, on every desk in every ward there is a list of who is on call for Derby Hospital, the local person which may include the Derby GP (on neo-natal resuscitation, obstetrics or emergency) as well as details of who is on call for the Kimberley area, which includes an O&G, a surgeon and a paediatrician. So there is good access to a doctor who knows the community and understands the local situation. Whilst the RFDS is based in Derby, it is not always available in these areas when needed due to the expanse of the region. Therefore these arrangements provide a supportive network for the doctors, with a significant amount of the work done by phone in these areas.

Similarly, in Borroloola in the Northern Territory, they have put effort into building relationships with city GPs, each taking turns to go out and get to know the place. It offers a convenient model for the city GP, with less commitment required, but with ongoing benefit both in terms of locum relief and also in that Borroloola now has a connection with doctors in the Darwin Hospital who they can call on at any time. In addition, the community has also arranged to have a shared medical record, the same medical record for the GP and the hospital staff, which improves communication. It is essential in these communities to securely transmit information between remote providers and hospitals. Whilst the current arrangements are working well for Derby and offer a new way of working, the GP added that the ideal situation would be to have a senior registrar in paediatrics to be based with them. In Aboriginal health, child health in particular, third-world conditions may present, sometimes with unusual presentations, including rheumatic fever, cellulitis and strange forms of meningitis.

1.3.3. Training solutions

The discussion extended beyond telehealth as a service innovation to its uses and value for teaching (webinars). It was seen as important to find ways to provide access to training opportunities, which in turn bring in outreach services to the local community. The registrar reiterated the value in building a rural outreach component into more training programs. Noting the educational demands (general practice) are very different, stating that she would not have had any great opportunity to undertake extended skill exposure if not for an outreach ENT opportunity. These should be provided in broad areas including cardiothoracic and plastic surgery through encouraging specialists with the motivation to get involved in rural health teaching. Many specialists are already going abroad, but there is massive need in Australia as well, which should be developed.
In terms of ensuring quality training, the Sydney GP with 35 years' outer metro Sydney experience advised that the urban access to training similarly is at its limits. Rural locations may soon be the only areas where trainees can get their exposure to emergency medicine. It is thought being in rural practice at all will be a big innovation before long. Interns and residents in the Sydney metro area already find it difficult to get any clinical experience. If you are not a speciality registrar then the terms you get are in response to an immediate workforce shortage and are not necessarily aligned well with the training need; there is a real need in general practice training to provide paediatrics exposure. Both GP paediatric training exposure and hospital paediatrics exposure is manifestly inadequate and decreasing Australia-wide. As a consequence, paediatric consultation as a core component of general practice is diminishing.

1.4. Skill-specific registrars

1.4.1. Targeted training investment

The concept of skill-specific registrars is supported for some rural and more remote communities. For the Kimberley region, surgery or advanced paediatrics (discussed above) would be beneficial. There should be room in the training system to support this movement; provide the consultant and registrar who could do most of their rural work in Broome, but then provide outreach to one or two other points such as Fitzroy Crossing and Derby. This would enable the registrar to rotate up to these points (Derby and Fitzroy Crossing), and with multiple registrars rotating through the system, a service pool would ensue. Places such as Derby would always have a consultant and registrar on rotation but with Broome still providing the main training point (one-on-one training). However, it was noted there would be a need for flexibility, in terms of meeting the clinical exposure and specialist supervision requirements (sometimes requiring up to three specialists), to enable such a model to work. Therefore, it would be vital that there is enough support (in the training community) for their learning.

To facilitate this type of arrangement, an innovative model could be developed to send the registrar for 3 months on rotation instead of 12, which will provide the rural exposure to support further training elsewhere if necessary. This would help to identify what skills the registrar needs to go back and obtain. Further, depending on the size of the region and complexity, some rural locations might be able to do 6 months placements, with towns such as Tamworth having the capacity. However, the skill mix would need to depend on the community and not undermine what the local generalists provide, otherwise you will end up with a system which is all fly-in fly-out. Some of the key skill areas this approach could support would be in geriatric medicine, palliative care and Aboriginal Health.

The registrar highlighted the limitations in acquiring the added skills either of interest or of need within the current general practice pathway. Having initially pursued a sub-specialised area, almost 18 months in ENT, at an unaccredited level, and now having shifted to general practice training, she advised that to obtain the skills acquired earlier she would need to become an accredited scheme registrar. Of primary importance is being able to access a certain range of skills as a GP registrar that is either of interest or required. Stating it would be beneficial for GP registrars linked to a particular community to actually have those skill options available, suggesting it could be achieved through linking the visiting specialist with the local GP registrar while they are in town.
This would help, over time, to address specific skill gaps in certain areas. But there would be a need to ensure flexibility in choice for those wishing to acquire skills at a later stage. Mentoring support and having a learning plan will also be important.

The most important component, of course, is to get the registrar there (to a rural area) in the first place. The Sydney GP provided the example of western Sydney trainees who have done most of their schooling and then medical school, and subsequent training in the western suburbs. Once there they tend to stay there. The opportunity to develop specific skills in this situation is much easier than rural as there will always be much larger clusters of skillsets available in urban areas, and therefore broader choice. It would also be very important in bringing in new training innovations to rural areas that this doesn’t detract from the long-term sustainability of the medical workforce already out there. Further, the emphasis on certain skills must not detract from the more essential need for primary care doctors in these communities. Not to create in rural a situation where rural primary care becomes more like urban primary care with a much greater reliance on specialists. The key policy message is that we need more primary care generalists, not specialists, in rural health.

The New South Wales rural generalist training model was raised as an example of how a specific skill focus, in this case procedural emphasis, can take away from primary care generalist training. This model has taken GP trainees out of GP training and is now providing rural generalist pathways against a narrow skillset, which in turn has de-skilled GP registrars. The ‘ordinary’ GP registrar no longer has access to those training positions as they have been diverted to this one pathway. The model is also attracting some who, for example, didn’t make it into surgical training, so they pursue the rural generalist pathway but then go back to specialist surgical training. Therefore, we are actually losing potential rural GPs through this pathway, as those wanting to pursue the more fully rural competencies are missing out.

However, it was noted that the Queensland Rural Generalist Pathway through offering VMO positions has avoided this problem. Queensland was considered the better model as it invests in the whole package; however, achieving rural retention in terms of providing more rural GPs to rural areas is yet to be tested. It is therefore important that governments ensure these models don’t take away from those wanting to pursue broader rural competencies; recognising too that the training really starts as an intern not as a registrar. Both interns and registrars pursuing rural should be prioritised and provided the rotations they need and want to pursue. Support through the training maze for the full training continuum must be made a priority as well. The RTPs that have a complete package for those registrars to go really remote have the highest success rates because they provide a targeted and supported package.

The registrar participant stated that we are breeding generations of sub-specialists: ‘there is already a recent cohort of completed trainees out there who see that the only path is that you are either a generalist or a GP, and you have to know everything, or you are a left toe specialist or right nostril specialist.’ Further, emphasising that every other college is pushing to specialise and sub-specialise (‘partialists’ and urbanised) either by default or design without regard for the generalist workforce need. It is this push which is driving trainees in two very separate directions, and creating a big divide between trainees who see where their skills can be used and where training can be of use to them. We need consultant general surgeons, consultant general physicians, general paediatricians, yet we are no longer creating them.
Theme 2: Integrated rural training pathway

Introduction

Examining the key structural shifts required to link the different stages of training in the rural setting. Building on the Mason Review recommendation for an integrated national rural training pathway to work through the strategies required to support a more streamlined training approach.

The discussion

The discussion centred on the need to find more ways to provide the type of flexibility both the learner and community need. An important discussion around the proven enablers was provided by one participant who has undertaken significant research around the key motivators to rural health. The importance of clustering those known influences in order to better target individuals was stressed, but also to ensure they are nurtured and supported once captured. In terms of addressing the current constraints across the full medical training continuum, it is necessary to ensure broader skill-acquisition opportunities so that they can be undertaken in the rural setting. The system is currently structured in favour of the partialist and not the generalist focus it needs, and this must be addressed. Embedding more primary care and generalist skill emphasis are required. The need to invest in more innovative models, including interdisciplinary training hubs to provide that community connection, and to facilitate longer terms in rural, was raised. These hubs would facilitate the networks and coordination, address current competing factors and thereby provide for more sustained rural training outcomes. Prioritise rural through building quarantined places into the pipeline, while also enabling for flexibility for those seeking alternative routes. With effort overall to ensure incentives and supports are in line with a policy that provides for an ‘easy entry, gracious exit’ for rural.

2.1. Seamless training

2.1.1. More effort in targeting

Trainees need to have both entry and re-entry points. More flexibility around addressing an individual’s needs including family needs, part-time arrangements for young mothers, for example, is required in order to make rural a more attractive and viable option. It was broadly agreed that prioritised (or quarantined) places for rural should be built into the pipeline with targeted support through all training stages. In ensuring success, one member, who had undertaken significant research in this area, pointed out that the key word in the discussion is comprehensive. Most of the evidence around those key influences, in terms of key motivators to rural, are, in fact, mostly weak effects unless bundled together. Rural background, rural role models, rural curriculum, ruralised assessment and rural placements brought together will work.

James Cook University (JCU) has done this and the career outcomes in terms of specialty and geographic location is proving successful. On its own, just targeting early experience for example doesn’t do much at all. Simply putting in rural background is not a good long-term strategy. Early experience on its own has never proved to do much at all, other than raise awareness, which is very short lived. Targeting strategies and effort to the right areas is important. Sydney University, for example, is just not the right place to focus effort for rural. Just as if you were looking to train metropolitan ENT surgeons, you would not go to JCU. There is also evidence in that students who are older, female, married or partnered with children have much higher success rates for rural. Narrowing to this extent is illegal, but the point being made is that more effort around targeting works.
2.1.2. More flexibility enabling choice

In order to provide for a comprehensive rural training experience it was considered that Longitudinal Integrated Clerkship (LIC) at a distance is what works. For example, go to Wollongong then spend a year immersed in a rural community. This approach provides for better training and better outcomes. Providing flexibility so you can do an internship part-time has proven to work well for rural as well. But a significant issue in the current arrangements is the competing nature of vying for limited positions and the uncertainty this then creates in role security.

Building quarantined places into the rural pipeline is important, as well as lifting the jurisdictional barriers to allow trainees to return to their own state should they wish to for an intern job, for example. Victoria is considered the hardest state to secure an internship. The GP registrar participant reiterated the importance of prioritising places for rural, which is what already occurs in NSW and should be retained. Those seeking a rural pathway are interviewed and preferences allocated separately from the broader NSW ballot, and she believes this is the right approach.

However, the registrar questioned what we really want from a comprehensive rural training experience. She had the option to stay in a rural area beyond fourth year but chose not to and worked in about six different places instead. That is what worked for her and provided her with the skillset she wanted to pursue. She now has a valuable skillset for rural due to having sought out broad and varied skills (ENT, plastic surgery, paediatrics) experiences herself. But none of those opportunities would have been provided to her should she have stayed in the rural pathway. The emphasis therefore should be on enabling skill choice (broader options) throughout as well.

2.2. Influencing career choice

2.2.1. Early rural exposure

In Derby, they have students from Notre Dame for 1-week stays, the students get good exposure at the hospital and are billeted out on stations or in Aboriginal communities. They swap over for a few days in Fitzroy Crossing, for example, just to get a true experience of what country is; most have never been out of Perth. This exposure is important as it shows students the extended skillset and the great opportunity rural provides. They are in a remote area doing high risk obstetrics and can do so as a GP. Students are motivated by that and they are coming back to the Rural Clinical Schools (RCS). Once interested, it is the medicine and broad exposure which holds them to rural, but it is then those family matters (spouse and children) that can often be the deciding point. But certainly for the Derby experience, those who elect to go to the RCS were often those who were impressed during that early exposure. You will not capture them all and they take care not to overwork them, but still provide good experience and exposure in that short time. The majority want to go back (to city) to do other things but state that they will come back to rural. It was pointed out that there is a lack of data to support that these trainees actually do return, but the Derby GP argued it is working for them.

2.2.2. Longer terms in rural

One member considered immersion, not exposure, is what counts. That is the powerful experiences in order to change perspectives. The member was not convinced that early exposure is what works, and instead suggested we really must look at getting trainees into rural practice for a substantial period of time. Early exposure provides the vicarious thrills and may make a connection, but it must be followed up with more sustained immersion with a lot of role models around.
This is where the best metropolitan models, which have an RCS a long way away, with exposure to a different crew, are working. Currently, medical students are trained in an environment where there is a perception that you can only get certain skills in the city. But get the students out to rural for a period and it will make a difference.

2.2.3. ‘Super doctor’ risk

The registrar stated that we are currently breeding a generation of risk-averse doctors. From her perspective, of those going into rural careers of her generation there two types of doctors – the cowboys and the conscientious. We need the cowboys, those who are brave enough and see that a community needs a doctor. The person who recognises that they may not have all the skills or supports they may need but will have a go. This may not be enough, but they are willing to go and find out. Then there are the others, who want to do the right thing and serve the disadvantaged, those driven by social justice. Conversely, we have a generation of risk-averse junior doctors who don’t want to go west past Strathfield as they are afraid. But you don’t have to be a ‘super doctor’ to go rural. We need to ensure this message gets through and provide the role models. The experience doesn’t have to be entirely rural, providing primary care exposure is important as well (but won’t necessarily address rural).

2.2.4. Different models of supervision

Capacity in terms of training is difficult. For example, the Armidale and Tamworth area is now fully saturated, and we now have the registrars but not the training capacity to take them on. Therefore, there should be scope for a blended supervision model, to help address capacity constraints. Some local, some remote supervision; the Remote Vocational Training Scheme (RVTS) was the originator of this concept and it shouldn’t be separated out like it is. It was suggested to structure the program so that trainees could do 1 or 2 days a week remotely. An innovation would be to develop a partly rural scheme incorporating remote supervision.

GPSN has provided some remote models for Aboriginal and Torres Strait Islander placements. There are some remote areas where you cannot work within the current conditions (supervision) so we have had to adapt and develop an innovative model of supervision, where back in the local town a supervisor is available anytime, but remote supervision is possible via video linkage. One of the difficulties is in getting the registrar there for the whole term; they may not be averse to this if it is reduced to 1 or 2 days a week. Whether the system allows it or not, the dual practice, city and remote, already happens according to one participant. For the supervisor, if they know that a setting is appropriate then this model could work, but matching the supervisor to practice or extended setting is very important.

2.2.5. Research opportunities

It is important to recognise that in the sandstone universities there is more to the whole package. This is mostly where the best research is done. Making young people excited about going to the bush because of the research might be a way forward. Providing a PhD opportunity into the rural pathway might be a good attraction strategy to pursue. There is a lot of good work being done in research in rural medicine, but we need to get trainees involved and motivated as well.
2.2.6. Critical reflection

There is a need to provide support for those who may have had a negative rural experience, and ways to debrief those people so they are not lost. Poor medicine is everywhere and having a bad experience is not necessarily a bad learning experience, but you don’t want to turn them off. It is essential to get all involved, certainly supervisors, in order to critically assess what they are doing or where they may be going wrong. They also need to be upskilled so that they know how to make that experience rich and worthwhile for the learner. The RTP should build in supervisor-critical reflection so that supervisors can reflect on the richness and pleasure they get out of their vocation, and build in those aspects to the training experience.

Negative role-modelling has done some damage. We have some involved who are very competent doctors, but they are burnt out and should have retired. It is important to try to turn negatives into positive learning experiences. Be clear that they are not going out to a perfect rosy world. Debrief them – JCU does this well, providing the students who want it a remote e-mentor. Providing that community connection as well for the trainee to go to, and to ensure they want to return later on for longer-term placements. The JCU model is 20 weeks and they get up to 100 to undertake the training, but they only make a difference because of the rural background, with most teachers being rural role models, and a rural curriculum. This again proves that nothing on its own predicts much, as it is a multifaceted approach that is needed.

2.2.7. Interdisciplinary learning hubs

Provide the infrastructure, onsite accommodation and interdisciplinary team working together. Yarrawonga, on the Victorian border, was used as the case example of where this training hub works. It is in a rural area where interdisciplinary teaching is role-modelled more positively. Multi-level mentorships (intern and final-year medical students) and peer relationships and forming those life networks are critical. This is a huge driving factor. The College of Surgeons is doing this through ‘surgical societies’ and the approach works. Interdisciplinary study groups are another good approach between towns, and provide the collegiate networks that are needed. The RACGP might want to get involved to facilitate a similar rural network.

2.3. Community intern

2.3.1. Making it work

The discussion around the concept of community interns (combination of acute care and primary care) for rural areas highlighted the many system barriers in the current system making this type of community connectivity difficult. For the model to work there is a need for strong support across the states. A single national system of coordination would be one way to leverage the support needed to make it work on the ground. An example was provided where an intern accepted a late offer from a competing state. This has occurred as close as the day before commencing the first offer position, and consequently, the intern does not turn up for the placement. There needs to be tight parameters around acceptance of offers to avoid this type of disruption.

One member involving solely medical education in Victoria explained that the current system requires a lot of resources to just work through the interview process. The state-based ones are allocated first and they have interns based in Shepparton for a 10-week GP intern rotation, with Murray to Mountain a longer 20-week GP rotation including 10 weeks in emergency, general medicine and surgery built in.
There are coordination issues to ensure the community placement works, including ensuring the intern coming to general practice does not take leave in the middle of the placement and they stipulate at least an 8-week continuous practice requirement.

2.3.2. Supportive factors

Nurturing and looking after your trainees was deemed most important. There is a need to look after people better – the registrar participant suggests that the college which does this will do well in changing generational expectations. Offer really good rotations, with Bogong in Victoria being a great example. There is a need to make allowances for part-time internships, acknowledge the life stage of the individual and provide supports around this (young family and childcare requirements for example). A relocation bonus would also work. One member cited a scheme where a trainee moved to Darwin for fellowship year and was provided a moving allowance. Similarly, a completion bonus would also support take-up. More extensive relocation supports could be provided to entice some to stay, including providing a rental payment, which could be a proportion payment, but those who invest in the town, with a mortgage, can be paid double the rental payment as an acknowledgement. Some kind of retention incentive is needed.

Further, it is important to get them in early and interact often. The Queensland Rural Medical Generalist (RMG) process was provided as an example of an approach that works, both in terms of mentoring and providing a quarantined position and salary. Queensland Health interviews early and nurtures those individuals, and 2 years out they know where they are heading. For a proportion of trainees, governments should provide this mentoring support, nurture them on a long-term basis and quarantine that job for those with a strong commitment to rural. It was noted that the RMG model, in its current form, is expensive but some aspects of it should be replicated elsewhere, except with more generalised skill experience.

2.3.3. Skill acquisition and orientation toward rural

A significant focus needs to be around addressing the current resistance toward facilitating certain skills training experience in rural. There is a need to change the paradigm, one participant suggested; this mindset that if you want to do a plastics term, for example, then you should have chosen a different pathway (eg internship at Westmead).

An example of the many factors at play relating to both life stage and orientation was provided by the Derby GP, who suggested that it is only through experience or varied exposure that the potential to go rural can be realised. She was fortunate when she arrived in Fremantle from the UK that she was able to do 3 months-long jobs covering various skillsets. She had that opportunity of exposure on Christmas and Cocos Islands, which really started her remote career. Having already gained a Diploma in Obstetrics, she had to accept a drop in salary to do the Advanced Diploma, however, noting that this issue has now been addressed through a $40,000 procedural grant to undertake that year of study. She made the point that a lot of issues have been addressed and strategies are in place which are supportive of rural. This GP had three children growing up while at medical school, but by the time they were 15, she was able to go and do more remote and fly-in fly-out experience, providing different choices at the various stages.
2.3.4. Preserving the hospital term
It was considered important that at least 12 months’ hospital experience needs to be stipulated before you are able to leave that environment, ensuring the important elements are retained, including national curriculum framework for PGY1, the preservation of the medicine term, surgery term and emergency term. It was viewed that emergency was at the greatest risk if trainees are taken out of the hospital system and placed in community settings. It is acknowledged that this is time-consuming, expensive and imposes a large supervision burden, but the benefit to the intern should not be underestimated. For one participant, the registrar, the community was not considered an appropriate model to have interns.

Therefore care is needed in structuring the community internship model, noting that NSW currently only provides a PGY2, but that there is an intern GP rotation currently offered in Victoria, South Australia and Western Australia, therefore the states are at different stages and it needs to be developed well. In response to the registrar view, one member stated that the feedback from the PGPPP intern places is fantastic, albeit only doing one term. As a compromise it was suggested that a contracted system, 2-year fixed term contract for example, where general practice is incorporated later once hospital exposure has been gained, might be a suitable approach.

2.3.5. Readiness to provide intern term
Generally there is strong support to implement a community intern term. The NSW rural GP stated that there is capacity but it is very limited (Armidale). But if the accreditation for PGPPP is the same then most should be able to take interns. For Derby and Broome, the RCS provides experience between the AMS and hospital, but they don’t have any interns in Derby, only in Broome. It would be helpful to have interns in Derby and they believe that they would be able to provide good exposure for the trainee. The GP turned to the group for information on how you can go about facilitating this. It was explained that in order for your service to become accredited, there is a need to develop a supervision plan and demonstrate that you can provide the curriculum. This is something the Derby GP can facilitate and this side discussion demonstrated that a lack of local coordination support and her own clinical load has restricted her from pursuing this option in Derby.

2.4. Integrated strategies

2.4.1. Linking and facilitating the networks
Strategies where there are rural and urban sites that are linked work well. But there is a need to reverse the current urban-based control and provide more places in regional and rural RTPs. Reverse the relationship for it to be based out there, but still provide the option for trainees to do some of their training in the city should they wish. That is, facilitate more swap-back into metro settings. One member suggested that this approach could be extended to other specialties as well, but currently cannot occur due to restrictions on provider numbers. There is a need to work through those barriers so that other colleges can provide a GP term in their training. Some in the group felt that training capacity and an already overstretched rural GP workforce would make extending further impossible, and that effort should focus on general practice training.

The key issue in building the networks to facilitate interconnectedness is in the absence locally of an administrative type support to facilitate the training. For example, this would ensure the trainees have more structured time to go sit with the local physician, and then go to operating theatre. There is a need to provide the support to coordinate at a finer level and between training schemes and hospitals.
Link the universities and Rural Clinical School, link intern positions with registrar positions in a coordinated, facilitated way. Every dollar will have to be spent wisely, and facilitating this level of coordination (linking intern and registrars) makes sense.

2.4.2. Further considerations

It was raised by participants that there are potential issues that would need to be addressed in training in linking the stages. General practice in a rural town against training for DMO was used as an example of where balance is required and intervention needed to ensure diagnostic skills training can be transferred. Some of the hospital doctors who are always working in the hospital often can’t easily transfer to general practice. Acknowledging that there are two different types of training and the need to separate that because, for example, the hospital doctor might think anyone with a headache needs a CT scan. It was considered by the group that they have a responsibility and role to train doctors to know the difference. The essential skill of taking a thorough history to then know what to examine and the experience to know when to restrict investigation must be provided in the training.

2.5. Summarising the key factors

One participant of the group, who has undertaken significant research in this space, provided a summary of the key contributing factors to integration success. The key points have been summarised in the table below.

<table>
<thead>
<tr>
<th>Key Factor</th>
<th>Policy Context</th>
<th>Recommended Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum</td>
<td>Partialist risk</td>
<td>Medical curricula are often set against a narrow partialist focus. Look at the learning objectives they are not currently covering in the training, including an overemphasis on the hospital skills and acute presentations. Curriculum has to be delivered outside of the hospital as much as possible to set the core learning objectives against broader patient health needs. Hospital is still important although rural does a lot of the acute as well.</td>
</tr>
<tr>
<td>Assessment</td>
<td>Embedding more primary care</td>
<td>Majority of the assessment is context-free and this is regarded as best practice internationally, but at JCU they deliberately put a rural scenario in the exam. It is very important to ruralise the curriculum and assessment to enforce primary care. Include more primary care presentations to assess competency (JCU model: learn in rural context, assessed in rural context but still competent in the big towns and cities).</td>
</tr>
<tr>
<td>Clinical experience</td>
<td>Generalist emphasis</td>
<td>Evidence points to longer placements in community being better (eg Flinders, Wollongong, Monash, UQ, Newcastle all embracing longitudinal approach). Not just primary care learning but incorporating all generalist specialties (all visiting services being general specialties in a primary care environment).</td>
</tr>
<tr>
<td>Key Factor</td>
<td>Policy Context</td>
<td>Recommended Approach</td>
</tr>
<tr>
<td>-----------------------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>Innovative models</td>
<td>Confidence, competence, willingness and ability. Every single patient encounter in the whole country should be available for a student to learn in but not all students are willing, and not all patients are willing. Facilities and infrastructure are important. Remote supervision is also important.</td>
</tr>
<tr>
<td>Clinical placement capacity</td>
<td>Competing factors</td>
<td>Address the current training deadlocks where high demand and competing factors have impacted the training networks, compromising the training and experience provided (eg south-western Australia, and south-east Queensland and northern NSW where six NSW medical schools and two in QLD are competing for resources to service 250,000 people. NSW medical schools are now combined to lock out Bond and Griffith from NSW.) Look to private sector to address capacity, to unlock untapped clinical experience by opening up private hospitals in regional cities and some rural areas. But training providers would have to send supervisors and teachers in, as only around 1% of private consultants will give up time to teach.</td>
</tr>
<tr>
<td>Organisational structure</td>
<td>Vertical integration</td>
<td>Most of the new medical schools are setting up in rural and regional areas and need to harness this. There are too many players with potential interest, complicated by jurisdictional differences (eg medical school doesn’t just deal with one department, it falls across both health and education portfolios). Ensure infrastructure is prioritised to provide more primary care and more generalist specialists. RACGP needs to be a leader in this space.</td>
</tr>
<tr>
<td>Engagement</td>
<td>Community connection and engagement</td>
<td>Renegotiate some of the imposed rigidities to provide for the conditions to support a community connection for the trainee. Those community enablers that provide the grassroots supports to secure placements, with an emphasis on private practice (Atherton mayor welcomes students, interns, registrars to the area through civic reception). Build in requirements so they stay in the community over the weekend (e.g. facilitate community activity such as going to pub on weekend and writing a reflective piece around rural communities).</td>
</tr>
</tbody>
</table>
New approaches to integrated rural training for medical practitioners

Final report

<table>
<thead>
<tr>
<th>Key Factor</th>
<th>Policy Context</th>
<th>Recommended Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why enter, why stay, why leave?</td>
<td>Easy entry, gracious exit</td>
<td>[Three papers through Medline]. Recognise that there are multiple routes and a large number get there accidently. Capture those wanting to pursue rural through a nurtured pathway. Work in the compatible health careers and enablers looking at the key reasons doctors leave (oldest child 12 or partner wants a career). They stay because they have made a strong rural connection and hold that sense of place.</td>
</tr>
</tbody>
</table>

Theme 3: Advanced skills

Introduction

Examining the key policy requirements for improving rural GP access to advanced skills training and ensuring the training is targeted toward the skills that meet the needs of rural and remote communities.

The discussion

The discussion highlighted some issues and risks in providing the training early with the need to ensure core general practice skills are prioritised first. There is a need to define and clarify advanced skills in order to target the training adequately, but ensuring that core skills are prioritised and attained first.

3.1. Barriers and enablers

3.1.1. Community leadership

In terms of targeting the training toward the rural GP with advanced skills, it is important that while the trainee is acquiring their advanced skillset they remain connected to general practice. The potential to lose them to other specialist pathways at this stage is significant and there should be some policy responses in place to retain them. As with the mainstream training, mentorship, advice and coordination of training could be improved.

Registrars require varied ability matched with variable experience. In focusing on the advanced skills available, effort is required to ensure that a workforce which is broadly trained is produced, noting the current narrow procedural focus.

It is important to realise that you require advanced skills on top of your core skills. A good advanced skills term, therefore, should ensure you have consolidated those core skills first. The right progression for attainment should be basic grounding first then advanced skills component.

There is a need to better coordinate the training, through RTPs, Medicare Locals and LHDs. The RTPs need to be talking to registrars early to find out what they need. There is a further need for local champions who can identify a registrar’s need and provide the opportunity to cater for that. New and flexible ways to facilitate the training should be pursued such as split training (eg Newcastle 6-month term, 20 hours a week) and facilitate part-time progression through GP training and part-time ENT, for example. There is a need for someone to identify the opportunity and then argue for a funded position and be given the support to develop the training opportunity.
3.1.2. Upskilling opportunities

For the existing rural GP workforce, one of the major barriers to upskilling is locum relief. One reason GPs opt out of such training is that they cannot take leave when they need to. There is a lack of formalised structure to facilitate the training and it largely depends on the motivation of the individual. In most instances the doctor has to arrange their own training and work through how to provide the new service (e.g. rheumatology outpatients) locally. It is certainly acknowledged that for procedural skills, the rural procedural grants program provides great access to training, but it is largely targeted toward hospital skills. It is further acknowledged that facilitating access to advanced skills for rural communities works best in a group practice environment. That way, the practice can cover a broad range of skills including obstetrics, anaesthetics, mental health and aged care. It provides an environment where complementary skills can develop and become sustainable.

Particular attention is required in terms of the length of training, both in skill acquisition and maintenance, with different requirements and time required for the various advanced skills. The local hospital arrangements also need to be supportive of the GP proceduralist. Most hospitals are not designed to have people in them less than full-time. There is a need for flexibility to free up hospitals to enable for job-share arrangements and shared training (e.g. two people, 6 months each, geriatrics). In Victoria, O&G training enables for 3 days in general practice whilst training and the retention rate has been much higher with this approach. This helps the GP to build up their own patient load and service while in practice. This has been facilitated in consultation with Vic Health, the Local Health District, as well as the training provider. Therefore, the emphasis needs to be on the ability to negotiate locally and to adjust arrangements to fit the community requirement. Medicare Locals could be utilised to negotiate the requirements.

The shared training approach could work for non-procedural skills as well as with part-time shared training over a 12-month period. It takes the pressure off the supervisor in speciality skills areas. But at the national level, there needs to be agreement around the skills required for a well trained workforce of sufficient numbers to address overall disparities. Agreement at this level would ensure the training investment can be matched in a more targeted manner.
3.1.3. Recognition

Recognition is another issue for practising GPs. Currently the system is structured toward procedural skills only with a lack of recognised course (diploma/advanced certificate) available for the non-procedural skills areas. The use of technology, including webinars, should make it easier to get advanced skills training. This would need to be supported by the structural supports such as Medicare numbers attached to certain skills or services. It is important to acknowledge the broader benefits in such training. That is, once acquired the broad advanced skills focus would potentially expand the teaching resource for the geographical area. The RTP could expand its teaching base including those within it that can provide advanced skills training. Structured arrangement between the RACGP and the specialist colleges would be required, with the incentives based on a defined area of workforce need.

Theme 4: Rural generalist

Introduction

Clarify and identify the skill mix required for safe, high quality generalist practice by doctors in rural and remote practice.

The discussion

The discussion highlighted some of the equity issues associated with the state-imposed workforce model. There is a need to balance immediate workforce gains with the broader need to ensure more generalist skills are provided in rural communities. The Queensland model provides a fully supported pathway and parts of it should be replicated elsewhere. However, for some states care is needed to ensure positions are not diverted from general practice positions; they must be additional.

4.1. Clarifying the workforce model

There was some confusion within the group as to where or why the term had emerged or developed. One member stated that it appears to be general practice with an advanced skill, and then it is no different to the rural GP. Others explained that the role fits more closely to the public rural hospitalist model, DMO in Western Australia and SMO in Queensland. The conclusion was that it is the latest name for something that has been occurring for some time. But how it transfers to other states, with different geographical features, is uncertain. For example, in Tasmania, there is no job at the end for them as Tasmanian hospitals are not allowed to employ them; however, in Queensland there are hundreds of jobs for them.

Whilst all states have a different model, the high salary together with a secured position (SMO) in some states makes it undeniably attractive. There are certain questions in terms of equity that need to be addressed, including the future viability of such a high-cost model. Further, the (general practice) retention and ongoing benefit to rural areas is questioned; it is more likely that these RMGs will stay in the hospital system, but that may well be the intention. Full-time public SMOs on a $450,000 salary would stay in the hospital role rather than start up a business (in private practice). This aspect, the uneven remunerative nature of it, is creating a large divide.

The discussion also identified a key risk in the current RMG approach with its emphasis on collecting specific hospital skills against the more generalised core skills responsive to patient need. Some states are struggling to meet the community term requirements due to the stronger emphasis on hospital skills as a consequence. The model is currently just a workforce strategy to provide better trained doctors and retain them in hospitals longer in response to a very specific workforce need.
4.2. Broader benefits or limitations

In terms of impacts on training positions, it was pointed out that in NSW, instead of providing additional roles, the RMG roles have been taken out of the GP training scheme. There is evidence that those pursuing these roles are doing so to obtain the specialist skills (having not secured a hospital position) to obtain a state hospital position with very little general practice focus or generalist focus at all. If this is a continued outcome, then the rural GP training positions in NSW should be quarantined.

The advantage of the RMG model is that it packages the training well. Rural training is currently an optional extra, but through this approach it provides a fully supported career pathway and your life is set for you for the next 15 years. The recognition this model provides, the fact that it has placed GP-proceduralist on the same level remuneratively, and in terms of standing (in the hospital), as the other specialist (senior consultant package), is noted. It is also supportive of locations such as Queensland and Western Australia where communities and hospitals are spread over a vast geographical area.

The registrar participant stated that the program fits her own ideal and reason for choosing general practice, and not emergency or anaesthetics, for example. She has a procedural bent and likes to get her hands dirty. Queensland has actually picked up all these elements and run with them all at once: ‘we need our trainees to be well skilled, we need them to service a rural area, we need them to have a college recognition and we also need to recognise what they do and pay them accordingly’. She added that it provides the fully supported pathway and represents a model that would have been very attractive to her had it been available at that time. All the barriers have been removed and addressed.

Theme 5: Embedding more primary care

Introduction

The development of a more networked approach to delivering quality education toward primary care and ensuring more of an emphasis and value is placed on primary care.

The discussion

The discussion highlighted the need to focus effort strategically and the need to enforce the importance of primary care right from the start, in the first year of medical school. Currently, the official view is that they all have to do the same (curriculum) but more targeted approaches are now needed. We need to look at the approaches or models working elsewhere including the Longitudinal Integrated Clerkship (LIC) and Patient Centred Medical Home.

5.1. Longitudinal model

It was noted that we are yet to convince city students that they are missing out by not going rural, yet rural students are securing high marks through the RCS. There are going to be very different outcomes from a program delivered entirely in Melbourne than from Armidale. The GP academic advised that extending the LIC model should be pursued in Australia. Harvard Medical School has adopted the LIC model (Strasser, Hirsh) and this immersion model based in primary care is shown to be working from the recent research:
Research over the last decade has shown the potential educational advantages of LICs undertaken in both rural and urban clinical settings. Compared with students who undertake teaching hospital clerkship blocks, students who complete some LICs have improved academic results, enhanced patient-centredness, greater exposure to common conditions and more meaningful learning relationships with patients and academic mentors. In this edition of Medical Education, two papers report other potential benefits for student feedback and for general practitioners as educators.

The Patient Centred Medical Home Model (Starfield) is another effective model which should be pursued. The concept is that specialisation detracts from better healthcare outcomes, that the primary care model is cheaper and provides for better outcomes. These models are not necessarily just for rural, they can work just as well in the urban or urban fringe context. Melbourne University is looking at this for the third year of the medical degree. The group argued that multidisciplinary teaching should be built into all medical programs, not just in general practice, but provide more exposure overall to community medicine and primary care. Trainees need to see and understand why primary care is so important. The hospitals are dominated by specialists and their influence in advising trainees against general practice at early points in the training can be quite persuasive. They need to be redirected back into primary care following hospital exposure.

It is noted that universities are never going to secure rural outcomes so there is a need to target more broadly in primary care. We need to try to build the training resilience to implement these models in the community. The LIC model is later, towards the end of training incorporating a whole year of training in the community and these types of approaches should be embraced.

5.2. Diverse exposure

We need to build into programs the fact that primary care doesn’t just mean general practice, the importance of community medicine and that it is not all about the major trauma. We are currently training to address or fit within a specific health system structure, and not in response to patient need. For example, there is currently not enough focus on multi-morbidity and chronic disease. There would be significant benefits in getting the student to think more about the complex patient and complex patient groups. One GP stated that her registrar is involved with homeless support at the moment, which has provided a fantastic teaching tool not only in the complexity in engaging the patient and addressing multi-morbidity, but also in the coordination of care. Lessons including the requirement of a care plan and ensuring team arrangements are in place are coming through. This type of exposure would help build a more coordinated system, ensuring junior doctors don’t just drop a patient back into the community but have an understanding and appreciation that care will be ongoing and will return to general practice (continuity of care). It was stated that Notre Dame has a problem-based approach, which in turn produces broader-thinking graduates, against the more elite outcomes (with a preference for specialisation) produced by some universities.

Theme 6: Training capacity

Introduction

Address the factors currently limiting rural GP training in rural areas and finding new ways to address the burden of teaching.

The discussion

Time constraints in particular restrict participation in rural medicine, but there are also other issues, including the funding arrangements, which are seriously impacting on training availability. The system is too difficult to navigate with rigidity impacting on choice and opportunity. The jurisdictional barriers need to be addressed for both the teacher and learner, and the opportunity to connect with the full health networks or community partners built in. A trainee in pursuit of broad skills and experience in rural should not be deterred by complex arrangements dictated by narrow funding. There is a need to free up these restraints to ensure those pursuing rural are not ruled by system constraints and to ensure those willing to teach or supervise are also well supported.

6.1. Key constraints

There is a need to note that practice viability and burnout or sheer patient load play an important part on a rural GP's ability to take on training. There was mixed response in terms of remuneration, some stating it does not really make much difference at all. But cost in terms of space (infrastructure), in particular, is a factor affecting training capacity. For example, there can be conflicting demands to contain space for training against enabling an allied health professional to utilise the space and provide a service for the community. Time certainly is another barrier. The Derby GP, whilst wanting to get involved in training, advised that the demands on her were such (clinical load) that she was unable to provide the teaching reliably for her students. She further explained that she is often called away to the hospital and the disruptive nature of that was not commensurate with meeting the structured learning requirements. In response, the teaching was moved to Broome where there were three or four GPs able to share the clinical and training load.

6.2. New models

Flexibility should be provided so that a few practices are able to share their medical educator. Retired GPs, for example, would enjoy a non-clinical teaching role and represent an untapped resource. But this again would require adjustments; for example, there would need to be support to ensure they are up to date. Other ways, such as bringing in simulated learning and in-depth role play, offer more interesting ways to explore their learning. This approach helps to identify the gaps in their knowledge in a supportive way.

It is also important to prepare the learner for there being more to general practice than just the medicine; there is the business side (could be led by the practice manager) and the broader roles and healthcare teams (could be led by external provider). Further, the key teaching requirements that will develop a sustainable teaching practice include using all the resources you have, ensuring good planning (practice structure, framework of the day) whilst retaining practice viability. In addition, the need to plan fully for the 10-week term, bringing in care planning and health assessments, community partners and incorporating time-management aspects to the role for example. It is important to acknowledge that funding to bring allied health into the training is currently not provided and also represents a new and improved way of learning. Currently allied health professionals are expected to teach for no remuneration and this should be corrected.
6.3. Enabling interconnectedness

The focus needs to shift toward using all the resources you have in a region (Bogong is a good case example). Build the supports that will be required in terms of coordination and mentoring, look to different models and match the teaching practice to the needs of the registrar (level or complexity). In streamlining arrangements, the discussion highlighted the confusion in terms of funding for the various stages of training. There was confusion as to where the intern money comes from (GPET – to RTPs – RTPs then develop their own models). The interns and PGY2 on the PGPPP are paid through the hospital but the funding for the teaching comes via the RTP. This confusion highlights the layers of complexity, which even those heavily involved in training struggle to work through.

One of the difficulties in the prevocational years (PGY1, 2) is that they are not really owned by anyone and in each state there are different requirements. The differing arrangements are too complex and not supportive of integration, with a need to ensure that the funding is contained to follow the trainee wherever they are. The funding needs to be easily accessible by the trainee to meet specific skills needs either through courses or education grants, but all tied to them remaining in general practice. Find ways to connect the funding of that individual to the education they are receiving and find ways to keep them on that pathway. The only consistency through the layers of complexity is the trainee, therefore if the funding follows the trainee then incentives could be built in to retain them on a specific pathway. A completion bonus could be built into that structure as well. The difficulty would be in the impact on the RTP; how does it then budget, and how would the hospital then budget?

3.2. Case studies

Five case studies were undertaken for the project. The areas selected and listed directly below are all well established teaching centres, but each with the capacity to implement a fully integrated rural training pathway, although at differing stages of development and with varying potential in terms of developing an interdisciplinary regional teaching hub.

Case Study 1: Proserpine, North Queensland
Case Study 2: Emerald, Central Queensland
Case Study 3: Walgett, North-west New South Wales
Case Study 4: Nambucca Heads, New South Wales
Case Study 5: Shepparton, Victoria

The case studies were sought as written contributions from GP members involved in the project consultations and those connected to the nominated area identified for further investment.
3.2.1. Case study 1: Proserpine

Case study 1: Project: New approaches to integrated rural training for medical practitioners
Proserpine, RA 5 Queensland

Capacity for a fully integrated rural training model

✓ Ready now for pilot: The location is currently working across the full training continuum including a rural GP intern rotation.

✓ Priority site for development: Strong training capability, but requires infrastructure investment. Considered an ideal training hub given the right supports.

✓ Site identified for skill-specific registrar pilot: The location has training capacity to trial the skill-specific registrar concept

Key contact Dr Konrad Kangru (WDS) / Dr Shaun Grimes (QH).

Practice name Whitsunday Doctors Service- Proserpine / Proserpine Hospital-Qld Health.

1. Training capacity: current teaching capability

i. Current training capacity

Proserpine is a highly developed regional training hub which has been developed over time through collaborative arrangements between local practices, Proserpine Hospital, Mackay Based Hospital, James Cook University and community and training partners. Providing excellent vertical integration of teaching, the approach provides a clear pathway for medical students enrolled at James Cook University to undertake their undergraduate placements in the same hospital, practise and return to the community for FRACGP/FACRRM training posts through Tropical Medical Training. A GP-intern rotation is already a key component of the training.

The capacity of the two key training streams are outlined below:

QLD Health [QH] – Proserpine Hospital

- Three x second year James Cook University [JCU] medical students (one in community practice),
- Six x fourth year medical students (two in community practice),
- Second x sixth year medical students.
- Five terms x four interns from Mackay Base Hospital [MBH],
- Five terms of JHO placement (PGY2),
- Five terms x 0.5 PGPPP (shared with 0.5 at WDS) (allocated from MBH, administered by Tropical Medical Training [TMT]), and 1-2 FRACGP, FACRRM or Rural Generalist Pathway [RGP] registrars (allocated by TMT/RG process), with capability to expand the ARST posts to include DRANZCOG /DRANZCOG adv, and JCCA training
1. Training capacity: current teaching capability

Whitsunday Doctors Service – Proserpine [WDS-P]

- 0.5 PGPPP/RGP (shared with 0.5 at Proserpine Hospital)
- One x RACGP registrar (currently GPT1/2),
- One x 0.5 ACRRM/RGP registrar (PRRT term),
- One x fourth year Medical Student (on 2-weekly rotation from hospital),
- Two x JFPP bonded student attachments (at 2 weeks/year)

*These placements could also be replicated at WDS – Airlie Beach surgery if space was available.*

ii. Advanced Rural Skills Training (ARST)

ARST currently available through surgical pathway in collaboration with Mackay Base Hospital (MBH). Registrars undertaking the 2-year surgical ARST undertake the first year in Mackay and their second year at the Proserpine Hospital. Proserpine has outreach surgical services from MBH, and the incumbent registrar undertakes supervised and remote training utilising the facility’s surgical services. The region has identified the potential to expand to include DRANZCOG adv, and application to be lodged with RANZCOG in 2013, with training to be collaboratively conducted with MBH. 2014 will see the addition to the Proserpine Hospital SMO staff of an anaesthetist. Thus in collaboration with MBH, training could work collaboratively with MBH. Awaiting process of application and staff member to join the medical cohort, depending on appropriate funding through Queensland Health.

iii. Current constraints

**QLD Health**

Funding by QH to support additional PHO ranks/registrars.

**WDS – Proserpine [WDS-P]**

Physical constraints of one room allocated to full-time FRACGP registrar, one room shared between 0.5 PGPPP and 0.5 FACRRM doctors. Dedicated teaching time difficult to allocate to each of three trainees, so shared teaching utilised where possible. Allocated teaching sessions for PGPPP through Proserpine Hospital continuing education roster. Lack of clearly defined curriculum structure for ACRRM/PRRT makes formative assessment difficult. Lack of an established curriculum for PGPPP term being overcome with innovative collaborative program developed together with TMT delivered online across northern Queensland. Current training demands require significant time and effort by a relatively small number of senior doctors, where in larger centres access to dedicated medical educators, university facilities and hospital grand rounds sessions are freely available. Internet-based solutions, such as that outlined above for training of registrars and PGPPP residents, are very dependent on access to reliable computing facilities, with the available dedicated bandwidth to allow interaction between sites.
2. Implementation capability: national integrated rural training pathway

iv. Implementing an integrated approach

WDS-P is already working together with Proserpine Hospital to deliver an integrated learning environment across the medical training pathway. JCU medical students in their pre-clinical years are already undertaking terms at Proserpine Hospital, with sessional visits to community resources including private general practice. Fourth year students are undertaking a structured rural placement based at Proserpine Hospital, with rotation out to private general practice (WDS-P) and Mackay AMS for Indigenous health component. Senior medical students completing pre-intern placements at Proserpine Hospital. QH-funded intern and junior house officer (JHO) placements on rotation from MBH being completed at Proserpine Hospital, and GPET-funded PGPPP placement on rotation from MBH shared between Proserpine Hospital Acute Primary Care Clinic [APCC] setting and WDS-P. Rural generalist pathway trainees placed at Proserpine Hospital for accredited terms for either RACGP or ACRRM. Registrars enrolled for RACGP training terms 1/2, subsequent and extended skills terms, along with PRRT terms for ACRRM registrars accredited through WDS-P. ARST available at Proserpine Hospital identified at (ii).

Additionally to these formal allocations and arrangements, close communication and sharing of experience occurs between students and junior doctors at each of these levels. On-call duties, telehealth, special clinics and registrar teaching sessions all bring the GP trainees into the hospital setting, while residents and senior medical students on rotation at the hospital are encouraged to ensure adequate communication back to the private general practice regarding acute management of their patients, beyond the usual discharge summary.

Proserpine is an ideal site for expansion and further investment by government in implementing a national rural training pathway.

v. Clinical attachments

Proserpine currently provides, within its current training capabilities, the following placements across the full training continuum.

<table>
<thead>
<tr>
<th>Training stage</th>
<th>Optimum placement period</th>
</tr>
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</table>
| First or second-year undergraduate medical school | Hospital  
Second year medical students – three max in hospital and for six week rotations throughout year.  
WDS-P  
Occasional sessional exposures only. Would not be able to accept scheduled placement at this stage. |
3. Implementation capability: national integrated rural training pathway

<table>
<thead>
<tr>
<th>Training stage</th>
<th>Optimum placement period</th>
</tr>
</thead>
</table>
| Third-year or beyond in undergraduate medical school | Hospital  
Fourth year medical students, four max in hospital and for 10-week rotations throughout year, and sixth year students x four max, for 10–12 week rotations throughout year  
WDS-P  
Fourth year students x one; 4-week rotation would maximise learning experience if space were available |
| PGY1,2,3 year postgraduate medical school | PGY1- Intern x four through five terms (20 placements p/a)  
(WDS-P not accredited for intern placement)  
PGY2- JHO through 5 terms  
WDS-P: one x PGPPP rotation every 10–12 weeks, could increase from current 2.5 days/week to 5 if room available  
Could replicate at WDS-Airlie Beach if room available  
PHO/Reg – 1–2 full-year placements, with potential to expand to five.  
WDS-P: one x GPT1/2 registrar for full year; would also have subsequent term/ARST/RACGP ACRRM-PRRT registrar for full year if room available  
Could replicate at WDS-Airlie Beach if room available  
Provisional SMO – QLD Health–max three |

4. Developing a regional training hub: building links between trainees and communities

vi. Interdisciplinary training hub

As has been indicated, it is of benefit to students, junior doctors and registrars to spend training time across the community and public resources within our community. Education is supported by collaborative processes between GP supervisors within the WDS practice and within the Proserpine Hospital, recognising and utilising the different strengths and skillsets each of these senior doctors possess. Of benefit to our facility’s training capabilities is that we also provide the PGPPP education support (Dr K. Kangru @ WDS) to TMT’s cohort of doctors, and also the Proserpine Hospital (Dr S. Grimes @QH), is the rural medical educator for TMT.
Support to facilitate expansion to this program, requires funding for extensive structural practice redevelopment, estimated at roughly $200,000 to build additional rooms within the practice. Proserpine Hospital can develop Advanced Skills Training (AST) posts if additional funding of approximately $150,000 is provided to support the doctors in the training posts, and to better reflect the dedicated teaching role performed by senior doctors in addition to their usual clinical roles. Local co-ordination is already effective through the close relationship of the public hospital and private practice, and for the continued accreditation of these services for both JCU students and TMT doctors. If, however, additional institutions wished to place students or trainees in these facilities, additional coordination, such as by a allocated 0.6 FTE administrative officer as training coordinator would be required.

Access to appropriate curriculum content remains a continuing issue for students and junior doctors. Workshops, tutorial sessions and examinations are often held in larger centres, often with significant impost in terms of travel, accommodation and time away from work and family. Appropriate IT support, such as that proposed through the National Broadband Network into facilities such as Proserpine Hospital and WDS would be of immense benefit in allowing training doctors to better participate in these sessions, and reduce the disadvantages they may face by their rural location.

vii. Facilitating a training community

Proserpine is well progressed towards the capacity to deliver full longitudinal training from the senior undergraduate stage to vocational fellowship, pending accreditation requirements and further development of posts. Well established positions for students, interns, PGPPP residents, RGP trainees and GP registrars have already been described and are in current deployment.

ARST posts in surgery AST, appropriate rural obstetric skills to the level of DRANZCOG / Adv DRANZCOG, and independent anaesthetic competency as determined by the Joint Consultative Committee on Anaesthesia (JCCA) are all feasible with additional development and staffing. As such, with our collaborative models, it is possible for a GPET registrar to gain all of their training within our town, including ARST, and to meet their community practice requirements at WDS, in association with the accredited post at Proserpine Hospital with both RACGP and ACRRM.

In this manner, Proserpine is already developing a solid reputation as a hub of rural medical training, well suited to the integrated rural training model. Trainees through the Whitsundays have historically performed very well in undergraduate and fellowship assessments, and applications to undertake training placements consistently exceed available supply. We would be very happy to develop our model further, to better assist in training the next generation of rural GPs.
3.2.2. Case study 2: Emerald

Case study 2: Project: New approaches to integrated rural training for medical practitioners
Emerald, RA 3 Queensland  Capacity for a fully integrated rural training model

- **Ready now for first pilot:** The training location is currently working across the full training continuum including a rural GP intern rotation.
- **Priority site for development:** Strong training capability, but requires infrastructure investment. Considered an ideal training hub given the right supports.
- **Site identified for skill-specific registrar pilot:** The location has training capacity to trial the skill-specific registrar concept.

**Key contact**  
Dr Ewen McPhee, Dr John Evans and Sandra Corfield.

**Practice name**  
Emerald Medical Group, Emerald Hospital and Central Highlands Healthcare.

1. Training capacity: current teaching capability
   
i. **Current training capacity**
   
Emerald is a rapidly growing agriculture and mining town. Based on current population demographics, it is accepted there is a need for 12–16 GPs in the region, with expertise in community medicine and some of the other skills required such as obstetrics, anaesthetics, emergency, Indigenous health, occupational health, aged care and mental health.

Emerald currently provides teaching for medical students, prevocational GP placements, junior medical officers, Queensland rural generalist registrars and registrars with Regional Training Providers.

Medical students – both short-term and longer placements within general practice and Emerald hospital. Placements for 22 medical students last year across the region. Placements include integrated placements with access to mental health, aged care, Indigenous health, Queensland ambulance and community health services. The number of students placed has been a result of individual contact between universities and hospitals or general practice. The Emerald Health Education Hub will provide coordination of placements and support for training providers.

Pre-vocational General Practice Placement Program – Queensland Rural Medical Education supports one training position at Emerald Hospital, which is an accredited training facility. There is the potential to provide four training positions with medical education supported by both Queensland Health and training consortia. There is also potential to work with practices across the region to include a variety of general practice placements and also work with mental health, emergency, Indigenous and aged care services to provide specific experience in these areas.
i. Current training capacity (Cont.)

Rural generalist training – There are currently four rural generalist trainees working within the hospital and on rotation through general practice. There is potential to include placements across the region to broaden the experience available to rural generalist trainees as supervision and mentorship capacity is developed.

GP registrars – there are two GP registrars currently in Emerald with another three in other communities and the potential to develop a further 10 registrar positions as the integrated training programs and supervision capacity is developed.

ii. Advanced Rural Skills Training

Currently registrars have completed an ARST prior to coming to Emerald and will utilise and practise a specialist skill while in Emerald. In the future it may be possible for registrars to do part of their ARST in Emerald.

Anaesthetic training is not specifically available; however there are two operational theatres in Emerald with anaesthetic support from senior medical staff, a GP-anesthetist and visiting anaesthetists. Registrars are able to apply skills already attained or have access to support to develop early skills in this area.

Obstetrics training is not provided. Emerald has over 400 deliveries per year which are supported by GP-obstetricians and senior medical officers. There is also a re-orientation of services to included GP shared care. Registrars will have opportunities to participate in shared care programs as well as support to develop obstetrics skills and knowledge. There are also visiting obstetrics and gynaecology services where GP registrars can gain additional experience.

Surgical training is not provided in Emerald. There are three to four surgical sessions each week including general, orthopedic, gynae, obstetric and gastro-enterology surgical procedures. The intention is to further develop these services with opportunities for registrars to assist as part of the surgical team and also to provide support to pre-and post-operative care within the hospital and also within general practice.

Emergency medicine is a major part of the services provided in Emerald Hospital and also in surrounding smaller communities. Registrars will have opportunity to work as part of an emergency team and also to provide early diagnostics and follow-up through general practice.

In terms of adult internal medicine, there are visiting physician, endocrinology and cardiology services to Emerald who are able to provide opportunity for registrars and students to participate in clinics. As an isolated rural community most general practices provide a high level of medical care, which will give registrars opportunity for a variety of medical experience.

Paediatrics services in Emerald are limited at present with visiting services to be re-established. Most paediatric services are provided through general practice with referrals as required.

Telehealth services are available and provide an opportunity for registrars and students to work directly with specialists and patients. Aboriginal and Torres Strait Islander Health services are not significant in Emerald. Woorabinda is an Indigenous community located 2 hours from Emerald and offers opportunities for integrated learning within the general practice and health services in Woorabinda. Small town rural general practice (via ARST) can be accessed through an integrated placement program which includes smaller communities within the region.
iii. Current constraints

There is a significant need for improvement to health infrastructure in Emerald. While the infrastructure that is available can be shared across organisations, much of this infrastructure is dated and not fit for purpose. Infrastructure supporting affordable accommodation options for student and registrar positions also needs to be addressed. As Emerald is centrally located in a mining region it is subject to the extremes of accommodation shortages, with one-bedroom apartments costing $800/week.

There is a need for the appropriate allied health and nursing staff matching the expertise of the clinicians to be embedded in the community to provide comprehensive services. Consistent and reliable access to a locally based simulation training centre is necessary to respond to the advances in training programs. Skills development for supervisors and medical educators with funding specifically available to support medical education will allow education opportunities to be further developed in Emerald and rural Central Queensland.

2. Implementation capability: national integrated rural training pathway

iv. Implementing an integrated approach

An integrated medical education program is in place in Emerald. The program is currently limited by infrastructure, accommodation and workforce capacity for training and co-ordination. Opportunity exists for further development of the integrated approach to be implemented in Emerald with vertical integrated training used to increase available training places for students, interns and registrars. Horizontal integration with specialist and community services provides unique training opportunities for training extension at all levels.

A strong working partnership with the Emerald Hospital ensures capacity to provide rotation options for rural GP interns, registrars, rural generalists and medical students. The establishment of the Emerald GP Superclinic will provide additional consultation space until then some additional temporary space has been identified. Training space is limited, as is access to education supports such as video-conferencing and simulation training. Accommodation is not specific to training positions and is very limited. General accommodation is expensive and limited.

Development funding has been applied for to allow the fast-tracking of education development in Emerald leading to a collaborative integrated education hub. Funds (if approved) will provide 12 months funding for a medical educator, project officer and co-ordinator. Further details of this application can be provided. The intention of the Emerald Health Education Hub will be to facilitate training opportunities across the region. Work will continue to develop infrastructure, education models and supervision/training capacity across the region.

v. Clinical attachments

<table>
<thead>
<tr>
<th>Training stage</th>
<th>Optimum placement period</th>
</tr>
</thead>
<tbody>
<tr>
<td>First or second year-undergraduate medical school</td>
<td>4 to 16 weeks (6 to 22)</td>
</tr>
<tr>
<td>Third-year or beyond in undergraduate medical school</td>
<td>Up to 12 months (6 to 22)</td>
</tr>
<tr>
<td>PGY1,2,3 year postgraduate medical school</td>
<td>Up to 12 months (4 to 15)</td>
</tr>
</tbody>
</table>
3. Developing a regional training hub: building links between trainees and communities

vi. Interdisciplinary hub

A collaboration of community groups has initiated the project of the Emerald Health Education Hub to provide capacity to develop training to meet local needs of industries. The Emerald Health Education Hub is planned as a centre of excellence for inter-professional training, education and research in rural health. Its location also allows support to reach many of the smaller communities in Central, Western and Northern Queensland extending the capacity for training to be offered in these communities.

An inter-professional training model is already under development in the area and there is strong support from regional and state partners. Partners include universities, hospitals, general practice and allied health providers, Regional Training Providers, rural generalist program and Medicare Locals. Disciplines involved in the training program to date include medical, allied health, dental, pharmacy, paramedics and nursing. Options are currently being developed to provide interdisciplinary training suited to the education level and discipline of the student. Collaborative education sessions will be developed to provide education to comply with training requirements for each discipline, but will utilise the skills of local clinicians across disciplines and will be provided within a multi-disciplinary framework.

vii. Facilitating a training community

Emerald and the surrounding Central Queensland region has a limited team of dedicated senior clinicians who will undertake the initial development of training models and provide education supervision and mentorship. The development of an integrated education model will assist in attracting additional training workforce. Local medical staff are committed to providing opportunities for placements for the entire training period thanks to the number of senior medical staff working within the hospital and general practice providers, as well as nursing, allied health practitioners, pharmacy and Queensland Ambulance Service personnel.

Relationships with multiple training providers will ensure there are students from multiple disciplines involved in integrated training programs. These students may be for limited or long-term placements or undertaking the majority of their clinical experience through the Emerald Health Education Hub. As training numbers increase, support has been committed from all education providers to ensure there is local development for the roles of educator and co-ordinator. These roles will support the development of education programs across disciplines and across the region. Education networks will be established to support the planning and provision of horizontally and vertically integrated training opportunities within Emerald and the larger rural Central Queensland region.
3.2.3. Case study 3: Walgett

<table>
<thead>
<tr>
<th>Case study 3:</th>
<th>Project: New approaches to integrated rural training for medical practitioners</th>
</tr>
</thead>
</table>

- **Ready now for first pilot:** The training location is currently working across the full training continuum including a rural GP intern rotation.

- **Priority site for development:** Strong training capability, but requires infrastructure investment. Considered an ideal training hub given the right supports.

- **Site identified for skill-specific registrar pilot:** The location has training capacity to trial the skill-specific registrar concept.

**Key contact** Dr Karin Jodlowski-Tan.

**Practice name** Walgett Aboriginal Medical Service.

1. Training capacity: current teaching capability
   
i. Current training capacity

Walgett is located in far north-west NSW, about 700km from Sydney, and 280km north of Dubbo, its regional centre. The town sits near the junction of the Barwon and Namoi rivers and the Kamilaroi and Castlereagh highways. In 2013, the population is reported to be 2 300, of which almost half the population is Aboriginal.

Walgett has an Aboriginal Medical Service, which currently takes medical students from University of Western Sydney (UWS) for all seven rotations (5 weeks each rotation). At the moment there are two FTE GP's at the service, one of whom is a registrar on the ACRRM Independent Pathway. The doctors are supported by a team of Aboriginal health workers and a nurse. Walgett AMS is also a member of Bila Muuji, which consists of six AMS in the region.

There is a hospital in Walgett, which provides pathology and radiology (including ultrasound) services, acute care and eight aged-care beds. Attached to the hospital is a general practice managed by RaRMS (Rural and Remote Medical Services), a not for-profit company established by the NSW Rural Doctors Network. It currently employs one FTE GP who is also VMO at the hospital. There is another FIFO GP/VMO who does 2 weeks on, 2 weeks off. Both of these GPs are registrars on the RVTS program.

The supervisors for the GP registrars in Walgett include the chief medical officer at Walgett AMS, and a supervisor from NSW RDN (RaRMS).

Our regional centre for tertiary services is Dubbo Base Hospital. We have visiting specialists who come from Dubbo and Sydney.
ii. Advanced Rural Skills Training

ARST that can be provided in Walgett would include:

1. Aboriginal health – by working in the Walgett Aboriginal Medical Service.
2. Small town rural general practice – through working at either the RaRMS practice or at the AMS with VMO work at the hospital.
3. Emergency medicine – through working at the hospital, managing a wide range of presentations.
4. Chronic disease management – through working in either or both practices. There is no shortage of chronic disease burden with our high percentage of Aboriginal people and farming community.

iii. Current constraints

Current constraints include the lack of permanent experienced doctors in the town. There is one FTE experienced GP in town at the AMS, who provides supervision to the ACRRM IP registrar. The GP registrars at the hospital are supervised remotely. If we take on more junior trainees we will need more experienced supervisors on site. Currently we would only be able to take on experienced doctors for ARST, and medical students, which is already a heavy burden on the limited GP time available.

There is a lot of duplication with the two competing practices in town. If the practices can work in a more coordinated fashion in taking students and junior doctors it could work.

If the AMS doctors can have VMO rights to the Walgett hospital, that would provide more opportunities for taking on registrars who need to do supervised hospital work. It would also mean the after-hours burden can be more widely distributed, which would be better for the doctors to avoid burnout, and may also be financially more effective for the community in the long run, as they would not have to fly in costly locums to staff the hospital.

2. Implementation capability: national integrated rural training pathway

iv. Implementing an integrated approach

Walgett is already taking medical students and registrars. At the moment it would not be suitable for interns or PGY2 as it is a remote location and fairly isolated both socially and professionally. It would be able to cater for PGY3+ and preferably senior GP registrars doing their ARST.

Rotating an intern through the regional hospital in Dubbo is possible provided the GP supervisors are agreeable and there is funding for their supervision and teaching time. It would be possible at the Walgett hospital to take interns if there is a VMO stationed there full time.

v. Clinical attachments

<table>
<thead>
<tr>
<th>Training stage</th>
<th>Optimum placement period</th>
</tr>
</thead>
<tbody>
<tr>
<td>First or second-year undergraduate medical school</td>
<td>Not suitable for undergraduate year 1 or 2</td>
</tr>
<tr>
<td>Third-year or beyond in undergraduate medical school PGY1,2,3 year postgraduate medical school</td>
<td>4–6 weeks PGY1 – not suitable PGY2 – 1-2 months PGY3 – 3-6 months</td>
</tr>
</tbody>
</table>
3. Developing a regional training hub: building links between trainees and communities

vi. Interdisciplinary training hub

The Bila Muui AMS would form a great training network for registrars wanting to do ARST in Aboriginal health. Walgett itself would be ideal for training in small town rural general practice with a focus on chronic disease management and Aboriginal health.

We need funding for GP supervision time and university linkage/support for teaching appointments and access to teaching resources/library and journals. Housing for the doctors in training is a must, if we are to provide this rural training opportunity. It’s hard to find good housing for short periods in town. The AMS has units that it can hire to staff. This may be appropriate for short-stay students and registrars. For longer placements a house or purpose-built units are more appropriate.

A training coordinator is vital to organise everything for the trainees, rather than leaving the supervisors to organise, which will deter potential supervisors.

vii. Facilitating a training community

Those wanting to stay in the region could undertake PGY1 and PGY2 training in Dubbo and possibly Orange base hospitals. They can then rotate through to the smaller towns such as Walgett for training in primary care and specific skills from PGY3+ onwards. Procedural skills training can be done in Orange or Dubbo. Non-procedural skills training can be done in the small towns in the region.

Undergraduate medical students from University of Sydney are already seconded to Dubbo for their training. Undergraduate medical students from UWS are also attending AMS in the region including Walgett, Brewarrina and Bourke.

The only group needing development is the PGY1–2 trainee doctors as they require close supervision and the current structure of the practices do not cater for their skill and knowledge-acquisition stage.
### Case study 4: Nambucca Heads

**Project:** New approaches to integrated rural training for medical practitioners

**Capacity for a fully integrated rural training model**

- **Ready now for first pilot:** The training location is currently working across the full training continuum including a rural GP intern rotation.
- **Priority site for development:** Strong training capability, but requires infrastructure investment. Considered an ideal training hub given the right supports.
- **Site identified for skill-specific registrar pilot:** The location has training capacity to trial the skill-specific registrar concept.

**Key contact**  
**Dr Tim Francis.**

**Practice name**  
Peachtree Medical Centre.

#### 1. Training capacity: current teaching capability

**i. Current training capacity**

Coastal retirement town with high level of unemployment, socioeconomic and educational disadvantage and lifestyle related chronic illness. Currently no registrar training in the town, some GPs take short-stay (RAMUS or John Flynn) medical students. District Hospital in Macksville – VMO arrangement with CMO ED cover. Base Hospital in Coffs Harbour with half a dozen rural preferential recruitment (RPR) positions. One training practice in the Nambucca Valley at Macksville with one FTE registrar position. RTP node based in Coffs Harbour with significant growth over last 5 years. General practice training players include UNSW (Coffs Harbour Rural Clinical School), Wollongong Uni, HETI, PGPPP from Westmead, Coffs Harbour Health Campus, Royal North Shore, North Coast NSW GP Training.

Our regional centre for tertiary services is Dubbo Base Hospital. We have visiting specialists who come from Dubbo and Sydney.

**ii. Advanced Rural Skills Training**

Current ARST available in mental health (Headspace Coffs Harbour, based on relationship between RTP, medical educator and Medicare Local), emergency (reduced capacity due to defunding of GP procedural training program (GPPTP) and workforce changes in hospital, strong relationship between RTP and local health district, ED, anaesthetics (Coffs Harbour, strong support for GP-anaesthetist, involvement in biennial anaesthetic conference, quality training site and now rural generalist post), obstetrics (Coffs Harbour, variable departmental support for GP-obstetrician, relies heavily on particular individual and relationship between supervisors and RTP ME team. Surgery post previously available in Grafton not filled recently through lack of interest and clear guidelines on curriculum content/scope of practice.
1. Training capacity: current teaching capability (Cont.)

iii. Current constraints

Low socio-economic status of the region limits ability to provide quality medical care in fee-for-service system. Ageing GP population with new recruits not matching natural attrition. Ageing practices with outdated equipment, technology, systems, capital and infrastructure as a disincentive to joining one of these practices. Influx of corporate medical centres with a focus on shareholder income rather than patient care. Lack of capital and/or space for additional rooms to meet the need for team based primary care as well as training. Relatively inflexible VMO model of care at local hospital working as a disincentive to registrar involvement in VMO roster.

2. Implementation capability: national integrated rural training pathway

iv. Implementing an integrated approach

Inadequate capacity to implement training across the full training continuum at this stage, including rural GP intern.

v. Clinical attachments

<table>
<thead>
<tr>
<th>Training stage</th>
<th>Optimum placement period</th>
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<tr>
<td>First or Second-year undergraduate medical school</td>
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<tr>
<td>Third-year or beyond in undergraduate medical school</td>
<td>4 weeks</td>
</tr>
<tr>
<td>PGY1,2,3 year postgraduate medical school</td>
<td>nil</td>
</tr>
</tbody>
</table>

3. Developing a regional training hub: building links between trainees and communities

vi. Interdisciplinary training hub

Opportunities exist for shared rotation with other primary care providers. Other primary care providers are, however, just as overstretched in their ability to provide core services to the community. Significant investment in infrastructure, coordination and incentive would be required to make a meaningful impact on delivery of quality, coordinated multidisciplinary training in primary care.

vii. Facilitating a training community

Our first locally trained medical student, come intern, come GP registrar is about to sit exams for RACGP and has moved to Dorrigo to join a local practice. For those who are keen to remain in the region for the duration of their training, strong connections exist between the training providers to assist with facilitating a smooth progression from medical student through prevocational and into vocational general practice training. Training networks for other specialties may limit the capacity to
3.2.4. Case study 5: Shepparton

Case study 5: Project: New approaches to integrated rural training for medical practitioners
Shepparton RA 2
Victoria
Capacity for a fully integrated rural training model

- **Ready now for pilot:** The location is currently working across the full training continuum, excluding PGPPP.
- **Priority site for development:** Strong training capability, but requires infrastructure investment. Considered an ideal training hub given the right supports.
- **Site identified for skill-specific registrar pilot:** The location has training capacity to trial the skill-specific registrar concept.

**Key contact**  
*Dr Graeme Jones.*

**Practice name**  
*Lister House Medical Centre.*

1. Training capacity: current teaching capability
   i. **Current training capacity**

   Shepparton is a regional city with a population of approximately 50,000, including the sister town of Mooroopna. It has a GP population of approximately 80 and is not an area of workforce shortage.

   **Hospitals**

   The town has a regional hospital, Goulburn Valley Health, with approximately 150 acute beds. It provides general medical and surgical services, orthopaedics, urology, emergency medicine, paediatrics, women’s health, mental health, oncology, rehabilitation and aged care.

   Shepparton Private Hospital has 60 acute beds, providing services in mainly medicine and surgery.

   **University**

   The University of Melbourne Rural Clinical School is based in Shepparton. It has a dedicated teaching general practice attached on site, providing significant general practice exposure for medical students.

   General practice training is provided and co-ordinated through Bogong GP Training. Bogong’s footprint covers north-east Victoria, the Goulburn Valley and the southern Riverina adjacent to Albury.

   **General practices**

   There are five group practices in Shepparton/Mooroopna currently active in teaching, mainly at the vocational training and undergraduate levels. In addition there are six practices not involved in teaching. Most of the latter are staffed by overseas-trained doctors, or are corporate-owned practices with no interest in training.

   Lister House Medical Centre is a long established general practice, with 12 GPs and currently four GP registrars. In addition to mainstream general practice, its GPs provide a wide range of special skills including mental health, women’s health, aged care and sports medicine. Two of the GPs provide the only GP obstetrics service in the region. The practice has a long record of teaching at the undergraduate and vocational training levels.
ii. Advanced Rural Skills Training

ARST is available through Goulburn Valley Health in anaesthetics, mental health and, potentially, in obstetrics. The anaesthetics post is popular, well supported and produces competent graduates.

ARSTs are available at other sites in the Bogong region; obstetrics and anaesthetics at North-East Health, Wangaratta, and at Albury-Wodonga Health.

iii. Current constraints

There are a number of constraints.

1. Hospitals. Staff changes have impacted on training capacity, especially in the ARST in obstetrics at GV Health.

2. Practices. Constraints include:
   - Infrastructure – available consulting rooms.
   - Teaching capacity. Not all GPs have an interest in teaching and training. This is a major issue at Lister House MC where the senior teacher has recently retired. Teaching and supervising medical students is time consuming. Similarly, PGPPP interns are a significant burden on the supervisor, as they do not have registration and all patients must be seen by the GP.
   - Ageing of the GP teaching workforce, with probable further retirements in the intermediate future.
   - Patient numbers. The rise of corporate practices, and loss of DWS status, has led to a dilution of the patient resource, threatening capacity of practices to provide an adequate number of patients for the registrar to have a satisfactory experience.
   - Funding. Although financial support for GP registrar training is satisfactory, funding for undergraduate teaching is seen as inadequate.

3. Registrars. Ability to place registrars in the area or town of their choice. This relates to capacity. Regarding ARS training, some registrars find it difficult to gain ongoing experience in their chosen skill after completion of their training. An example is a registrar based in a small town who travels a significant distance each week to work a day in the regional hospital, so she can keep her skills. There is not enough work in her home town to support her skill, in addition to the resident GPs.
2. Implementation capability: national integrated rural training pathway

iv. Implementing an integrated approach

Shepparton, and indeed, the Bogong region, has a great opportunity to build on current assets in developing an integrated training process. The assets are:

- Bogong GP training. The region has capacity to provide excellent GP training in its hospitals, general practices (many of which have a very long record of quality training), and special skills/ARST opportunities. These include alpine medicine, small town practice, paediatrics, endoscopy, emergency medicine, and Indigenous health in addition to the procedural skills of obstetrics and anaesthetics.

- Bogong has excellent relationships with the health services in the region and the Rural Clinical Schools.

- The University of Melbourne Rural Health Academic Centre (including the Rural Clinical School). The Rural Clinical School commenced training medical students in 2002. It is now at the stage where a significant number of its graduates are entering and completing rural general practice training. An example is a married couple of graduates who did internships and PGY2 at GV health, entered GP training with Bogong and will commence their general practice terms in neighbouring practices in Shepparton in 2014.

- The Murray to Mountains program, which facilitates integrated training of graduates (ideally from the RCS) into small town internships, PGPPP placements, working in conjunction with Bogong GP Training.

There is an enormous opportunity to build on these structures to develop a coordinated, integrated training pathway into general practice for new graduates, especially those from the RCS.

v. Clinical attachments

<table>
<thead>
<tr>
<th>Training stage</th>
<th>Optimum placement period</th>
</tr>
</thead>
<tbody>
<tr>
<td>First or second-year undergraduate medical school</td>
<td>Lister House currently takes MD2 students from the RCS for a four day attachment. An attachment of a day a week x 2–3 months might be more attractive to both students and GPs</td>
</tr>
<tr>
<td>Third-year or beyond in undergraduate medical school</td>
<td>Lister House is part of the RCS’ Extended Rural Cohort. one or two MD3 students are attached to the practice for a full year.</td>
</tr>
<tr>
<td>PGY1,2,3 year postgraduate medical school</td>
<td>PGY 1, 2 = PGPPP. Current 10-week placements seem appropriate</td>
</tr>
<tr>
<td></td>
<td>PGY3 and beyond = GP training. Bogong places registrars in the practice for 12/12 attachments, which is highly popular from the practice and registrar perspectives and enhances effective training.</td>
</tr>
</tbody>
</table>
3. Developing a regional training hub: building links between trainees and communities

vi. Interdisciplinary training hub

There is a great opportunity to develop an integrated training program in the Bogong region. In terms of interdisciplinary training for general practice, nurses, midwives, practice nurses, allied health professionals, (e.g. physiotherapists, pharmacists, diabetic educators and psychologists) are an integral part of training for both students and registrars. There is capacity to extend training to involve specialists more, along with placements in private practice and private hospitals, particularly for students; possibly also interns and GP registrars with special interests. This will need a change in the mindset of some specialists, along with funding to recognise their supervisory and teaching time and roles.

There are other opportunities in the wider primary care field. Examples in Shepparton include Indigenous health at Rumbalara, aged care, child and family care, intellectual incapacity facilities, community health (which provides drug and alcohol services and a wide range of other allied health services), and community mental health services. Staff are often keen to showcase their facility and skills; provision of adequate funding is a major barrier. Significant thought needs to be given to addressing this barrier.

From a general practice perspective, there is a need for smarter teaching models, integrated teaching at student, PGPPP and registrar levels, teacher training, adequate coordinated funding, and provision of infrastructure where possible and where this will demonstrably enhance capacity to train at multiple levels.

vii. Facilitating a training community

Medical students at the RCS have the opportunity to experience a full year in general practice under the Extended Rural Cohort program. All these practices are integrated teaching practices who also take GP registrars, some participating in PGPPP as well.

The Murray to Mountains model is based on a continuum of training in the one region – the Bogong GP training footprint in North East Victoria and southern Riverina. It has demonstrated early success in placing interns in PGPPP in towns with small hospitals such as Yarrawonga and Numurkah for 20-week blocks. These interns locate to either North East Health, Wangaratta or Albury-Wodonga Health for their core hospital terms.

Goulburn Valley Health has 10 PGPPP rotations to regional small towns.

Bogong GP Training has a policy of placing registrars in the one location for their GPT1 and GPT2 terms, often leading to continuity into the GP3 and 4 terms. Registrars meet the RACGP requirement for variety of practice, often on a reciprocal arrangement with other practices in the town, for example Shepparton, or in neighboring towns. Many registrars complete their training in the one location, leading to Bogong’s success in retention of its Fellowed GPs in the local region.

Building on these local resources, there is a great opportunity for the development of an integrated GP training program in North East Victoria.
4.4. Policy surveys

Three policy surveys were undertaken throughout the project to support policy development as well as test and further filter the policy advice coming through in the consultations. Each survey had a different focus and target audience, summarised below:

Policy survey 1: Access and availability to professional development activities
Policy survey 2: Integrated rural training pathway
Policy survey 3: New approaches to skill investment and retention

The analysis against each survey is provided below. A copy of the survey questions is provided in Section 5 at 5.2.3.

Policy survey 1: Access and availability to professional development activities

<table>
<thead>
<tr>
<th>Survey objective</th>
<th>Key respondent demographics</th>
</tr>
</thead>
</table>
| To examine the training and support needs of rural GPs in order to maintain their skills. | • Membership type:  
- Fellow – 65%  
- Registrars and Associate members – 27.7%  
• Completed the Fellowship in Advanced Rural General Practice (FARGP) – 4.6%  
• Age of responders:  
- 31 to 50 years – 50.4%  
- 51 to 60 years – 29.6%  
• Location of responders:  
- NSW/ACT – 25.8%  
- QLD – 21.4%  
- VIC – 22.0%  
- WA – 11.3%  
- TAS – 6.7%  
- SA – 6.7%  
- NT – 3.5%  
• Remoteness of responders:  
- ASGC-RA-2 – 45.5%  
- ASGC-RA-3-to-5 – 30.6%  
- ASGC-RA-1 – 20.9% |

<table>
<thead>
<tr>
<th>Survey duration</th>
<th>29 August 2013 to 4 September 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey cohort</td>
<td>Policy survey 1 was distributed to the full RACGP National Rural Faculty membership.</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>345 RACGP National Rural Faculty members responded to this survey.</td>
</tr>
</tbody>
</table>
Introduction

In September 2013 the RACGP National Rural Faculty membership was sent QuickPoll#20. This was the latest in an ongoing series of periodic member surveys which inform faculty strategic direction. QuickPoll#20 invited NRF member feedback on issues related to professional development activities, in particular online learning and access to educational activities. Feedback was also requested from members relating to procedural and non-procedural skills training.

Summary of key findings

• Respondents indicated that the lack of funding for maintenance of non-procedural skills impacts their ability to keep these skills up-to-date (62.7%).
• A significant proportion expressed that non-procedural skills were essential in the delivery of healthcare within their community (63.7%).
• Mental health was highlighted as the non-procedural skill most needed by respondents’ communities (32.6%).
• Emergency medicine was nominated as the procedural skill most needed in respondents’ communities (50.6%).
• The majority of respondents believe that more needs to be done to re-engage GPs into procedural practice (90.1%).

Procedural and non-procedural skills

As procedural and non-procedural skills form an integral component of healthcare delivery in rural and remote areas, QuickPoll#20 invited feedback specific to these skills. Currently, Commonwealth Government grants are only available for skills maintenance of procedural skills disciplines (anaesthetics, obstetrics and surgery) and emergency medicine in rural and remote areas and do not support non-procedural skills maintenance.

GP members were asked if the lack of access to funding for maintenance of non-procedural skills impacted their ability to keep these skills up to date, and 62.7% indicated this was the situation. This response was consistent across the country except for South Australia (47.8%) and Western Australian (50%) where less than half agreed with the statement.

Using a four-point scale, GP members were asked how they would rate the level of importance of non-procedural skills in the delivery of healthcare within their community. Non-procedural skill delivery was seen as essential by 63.7% of respondents. An even higher proportion of respondents viewed non-procedural skills as essential in Tasmania (78.3%) and the Northern Territory (91.7%).

GP members identified the following non-procedural skill as most needed by their community:

• Mental health (36.2%)
• Small town rural general practice (19.6%)
• Internal medicine (18.9%)
• Aboriginal & Torres Strait Islander health (9.8%)
GPs indicated they would elect to undertake in the following non-procedural skills if more funding were available:

- Small town rural general practice (23.5%)
- Internal medicine (22.9%)
- Mental health (17.8%)
- Paediatrics (17.6%)
- Aboriginal & Torres Strait Islander health (9.2%)

The other non-procedural disciplines included dermatology, women’s health, palliative care, and public health. These results were consistent across all states and territories.

GPs were also asked which procedural skill was most needed in their community; just over half of responders (50.6%) stated emergency medicine, followed by obstetrics (22.3%), surgery (12.1%) and anaesthetics (5.0%). Queensland was the only state where this result was different; surgery replaced obstetrics as the second most needed procedural discipline in rural areas.

Finally, 90.1% expressed the view that more needed to be done to re-engage GPs into procedural practice.

### 3.3.2. Policy survey 2: Integrated rural training pathway

**Survey objective**

To further clarify the feedback obtained from GP members during consultation on the integration of training and test these ideas with medical student, intern, resident and registrar members of the National Rural Faculty.

**Survey duration**

4 November 2013 to 30 November 2013

**Survey cohort**

Policy survey 2 was distributed to RACGP National Rural Faculty students, interns, residents and registrars members.

**Number of respondents**

121 RACGP National Rural Faculty members responded to this survey.

**Key respondent demographics**

- Respondent stage in medical training pathway:
  - Registrars – 62%
  - Students – 27%
  - Residents – 6%
  - Interns – 5%

- Age of responders:
  - 20 - 39 years of age – 76%
  - 40 - 59 years of age - 24%

- Location of responders:
  - VIC – 29%
  - NSW/ACT – 28%
  - QLD – 24%
  - WA – 7%
  - TAS – 7%
  - SA – 4%
  - NT – 1%

- Remoteness of responders:
  - ASGC-RA-2 – 41%
  - ASGC-RA-1 – 32%
  - ASGC-RA-3-to-5 – 27%
Introduction

This survey was distributed to RACGP National Rural Faculty students, interns, residents and registrars in November 2013. This cohort was identified as a potential gap in the policy consultations and the survey aimed to ensure the policy recommendations represent a broad sample of National Rural Faculty members.

Of the 121 respondents to the survey, the majority had significant experience in rural medical placements with 61% having spent more than 1 year on rural medical placements, 18% between 12 weeks and 1 year, and only 14% having had less than 12 weeks experience in rural medical placements. The survey questions sought respondent feedback on their existing experiences of rural medical training and their views on the strategies likely to be most successful at improving the rural training pathway experience.

Summary of key findings

- Eighty-eight per cent of respondents reported that their rural medical placements have been a positive experience.
- Respondents indicated that the most important factor contributing to a positive rural placement is the quality of the clinical experience (85%).
- The survey results show that 79% of respondents agree or strongly agree that early exposure to rural general practice had, or is having, a significant impact on their career choice.
- Respondents viewed voluntary long term rural placements (>6 weeks) as the most successful strategy for early exposure (67%).
- There was strong support for rurally based internships (79% of respondents).
- Feedback about whether mandatory four week placements required under the Rural Clinical Training and Support (RCTS) program should be abolished was mixed (52% agreed, 48% disagreed).

Feedback on existing experience of rural medical training

The majority of respondents reported that their rural medical placements have been a positive experience; 88% agreed or strongly agreed with this statement. Most respondents (84%) also reported that they have had quality clinical and learning experiences on their rural medical placements and have had good social engagements and participated in local community activities (84%). A smaller proportion of respondents (61%) indicated that their placements have always been well coordinated, indicating that there is room for improvement in this area.

Respondents indicated that the most important factors contributing to a positive rural placement were:

- the quality of the clinical experience (85%);
- local mentoring (70%); and
- good organisation and coordination of placements (64%).

The strategies with the least support from respondents related to:

- compulsory long term rural placements (>6 weeks) (16%); and
- Bonded rural medical scholarships (22%).
Respondent views on strategies for improving the rural training pathway experience

The survey results show that 79% of respondents agree or strongly agree that early exposure to rural general practice had, or is having, a significant impact on their career choice. When asked which strategies for early exposure to the rural aspect of medicine were most successful in increasing the likelihood of a person working in a rural community, respondents expressed the most support for the following strategies:

- voluntary long term rural placements (>6 weeks) (67%);
- medical schools in rural areas (54%); and
- having rural GPs teach in universities (both in person and remotely) (51%).

There was strong support for rurally based internships; 79% of respondents agreed that these would provide a more seamless transition from undergraduate training into a rural medical career. Further, 57% of respondents indicated that if provided the choice, they would elect to take a rurally based internship.

The feedback from respondents about their existing experiences indicates that there is less support for compulsory and bonded strategies. However, when respondents were asked whether they agreed with the Mason Review recommendation to abolish the mandatory 4 week placements required under the RCTS in favour of increased support for longer-term high quality elective placements, the feedback was mixed; 52% agreed and 48% disagreed.

3.3.3. Policy survey 3: New approaches to skills investment and retention

<table>
<thead>
<tr>
<th>Survey objective</th>
<th>To further test feedback obtained from members during the consultations and ensure that all National Rural Faculty members who would like to provide input have been reached.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey duration</td>
<td>17 December 2013 to 8 January 2014</td>
</tr>
<tr>
<td>Survey cohort</td>
<td>Policy survey 3 was distributed to RACGP National Rural Faculty members in Western Australia, Victoria, ACT and Tasmania.</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>63 RACGP National Rural Faculty members responded to this survey.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key respondent demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership type</td>
</tr>
<tr>
<td>- Fellow – 65%</td>
</tr>
<tr>
<td>- Associate – 29%</td>
</tr>
<tr>
<td>- Member – 3%</td>
</tr>
<tr>
<td>- Student – 3%</td>
</tr>
<tr>
<td>Eleven per cent have completed the Fellowship in Advanced Rural General Practice (FARGP)</td>
</tr>
<tr>
<td>Age of responders:</td>
</tr>
<tr>
<td>- 20 – 39 years of age – 44%</td>
</tr>
<tr>
<td>- 40 – 59 years of age – 35%</td>
</tr>
<tr>
<td>- 60 plus years of age – 21%</td>
</tr>
<tr>
<td>Location of responders:</td>
</tr>
<tr>
<td>- QLD – 3%</td>
</tr>
<tr>
<td>- VIC – 59%</td>
</tr>
<tr>
<td>- WA – 32%</td>
</tr>
<tr>
<td>- TAS – 6%</td>
</tr>
<tr>
<td>Remoteness of responders:</td>
</tr>
<tr>
<td>- ASGC-RA-3-to-5 – 51%</td>
</tr>
<tr>
<td>- ASGC-RA-2 – 38%</td>
</tr>
<tr>
<td>- ASGC-RA-1 – 11%</td>
</tr>
</tbody>
</table>
Introduction
This survey was distributed to RACGP National Rural Faculty members in December 2013. It was specifically targeted to members located in states where face-to-face consultations were not held to ensure the policy recommendations represent a broad sample of National Rural Faculty members. The states included were: Western Australia, Victoria, ACT and Tasmania. The survey sought respondent feedback on the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter general practice in regional and rural communities. The questions aimed to clarify feedback obtained from members during member consultation. Four key areas were covered: recruitment, skill retention, specialist competition and teaching capacity.

Summary of Key Findings
• Sixty-seven per cent of respondents rated more flexibility to allow for a broad and varied training experience as an important or very important requirement.
• The development of a national system to provide navigational support for the learner within current training arrangements was supported by 67% of respondents.
• Eighty-one per cent of respondents believe creating family support strategies for doctors willing to relocate will make rural general practice more attractive.
• The overwhelming majority of respondents, 94%, agreed that policy should support a skill-acquisition pathway for practising GPs.
• Thirty-eight per cent of respondents reported that they have identified examples of specialist competition to the exclusion of GPs in their community.
• The policy approaches for engagement of more rural GPs to teach supported by most respondents included: significant increases to GP teacher/supervisor payments (76%) and flexible infrastructure grants (73%).

Recruitment
A key system weakness identified during member consultations was the rigidity and uncertainty caused by workforce-driven policy. Participants suggested more flexibility allowed for a broad and varied training experience to meet both the needs of the learner and community. It was argued the effort to address workforce driven pressures impacts on both training and role certainty. Sixty-seven per cent of survey respondents rated this requirement as either important or very important.

The need to ensure the adult learner is empowered to make their career decisions was also seen as important throughout the consultations. One strategy to address this is to develop a national system to provide navigational support for the learner within current training arrangements. Seventy-eight per cent of survey respondents agreed with this approach.

Making rural general practice attractive requires changes and more flexibility to current arrangements. Respondents expressed most support for the following policy elements to address this issue:
• Create family support strategies for doctors willing to relocate – 81%
• Incentivise (financial and structural) integrated training – 78%
• Provide choice for registrars seeking specific skill acquisition (e.g. ACCHS, mental health, palliative care) – 76%
• Provide rural exposure through rural community internships – 73%
• Enable RTPs and universities to work together to improve the quality and interconnectedness of the training – 68%
Skill retention

There is little recognition of GP lifelong learning and currently there is no mechanism to enable GPs to up-skill or retrain to address a specific community health need. The overwhelming majority of survey respondents, 94%, agreed that policy should support a skill-acquisition pathway for practising GPs in rural and remote areas. Seventy-eight per cent of respondents believe there is a bias toward the acquisition and maintenance of procedural skills and 87% of respondents believe there is a need to broaden the incentive to include non-procedural advanced skills.

Specialist competition

There is evidence of competition between specialities to the exclusion of GPs in regional Australia. A majority of the respondents, 62%, have not identified examples of specialist competition to the exclusion of GPs in their community. However, this was an issue experienced by 38% of respondents. These respondents explain that a reduction in access to lists, hospital theatre time and reduced involvement in cases related to their skill area have led them to have inadequate cases to maintain their skill base. Areas of practice cited include: surgical, anaesthetics, palliative care, obstetrics, gynaecology and adult internal medicine.

Teaching capacity

Policy to address the administrative burden placed on practices is seen as one way of encouraging more rural GPs to teach. Respondents provided most support for the following strategies to achieve this aim:

• Significant increases to GP teacher/supervisor payments – 76%
• Flexible infrastructure grants – 73%
• Allow for innovative and flexible models of supervision where appropriate – 69%
• Ensure incentives support integrated training – 63%
• Local coordinator of teaching and learning – 61%.
3.4. **Stakeholder consultation**

External stakeholder engagement was undertaken with 40 key training and education stakeholders as part of the consultation process. The organisations included Regional Training Providers (RTPs), University Departments of Rural Health (UDRH), as well as broader rural training networks. Stakeholders were invited to provide written comments against the six themes discussed during the face-to-face member consultations, with a copy of the consultation questions provided. Particular feedback was sought on the key barriers in establishing a more streamlined national approach and on ways to develop a culture of teaching in rural areas.

3.4.1 **Stakeholder contributions**

A total of six responses were received, these are listed below and presented in their received format from 3.4.1.1 to 3.4.1.6.

3.4.1.1. Southern GP Training
3.4.1.2. Mount Isa Centre for Rural and Remote Health
3.4.1.3. General Practice Education and Training Ltd
3.4.1.4. University of South Australia
3.4.1.5. Australian Rural Health Education Network
3.4.1.6. University of Melbourne

The full list of external stakeholders and engagement letter is provided at Section 5.2 Consultation activity material, in 5.2.6 External stakeholder consultation, in accordance with Section E of the Schedule.
3.4.1.1 Southern GP Training

Position Statement

| To:           | Dr Kathryn Kirkpatrick  
|               | Chair, National Rural Faculty  
|               | Royal Australian College of General Practitioners |
| From:         | Greg McMeel  
|               | Chief Executive Officer  
|               | Southern GP Training |
| Reference:    | New Approaches to Integrated Rural Training for Medical Practitioners Project |
| Date:         | 9 December 2013 |

Thank you for the opportunity to provide input into your project, I have consulted with my Directors of Training and Senior Medical Educators/Supervisors in the development of this response. The recommendations are not represented in order of importance; they have been cross reference to the relevant themes as presented in your letter.

**Recommendation 1: Development of a two year rural internship (Theme: 1, 2, 3 & 5)**

There is a critical lack of accessibility to regional intern training and PGY 2 and PGY 3 positions. This will worsen in the next couple of years as the increasing number of medical students graduate. Regional Clinical Schools have made a significant difference to the rural pipeline. Medical graduates report their frustrations that, while they are receiving excellent undergraduate rural clinical training, there are very limited opportunities to secure rural postgraduate training.

Similarly school entry medical students from rural areas who study at metropolitan universities cannot secure rural training as they are often allocated to graduate entry students of the regional clinical schools or as mandatory placements for urban-based students who have no intention of ever working in a rural area.

Consideration should be given to developing a two-year longitudinal rural internship which moves away from the tradition core and non-core placement model. It is acknowledged that work is being done to develop community-based intern models and this is encouraging, we recommend that such development is not driven by creating cost efficiencies but in the interest of developing rural pipelines and meeting local health needs and workforce requirements.

To enable the rural pipeline we are suggesting rural internships should be dedicated to students of rural origin and/or students of the Regional Clinical Schools. Funding should be directed to support community based internships and/or two year longitudinal internships.
There is an argument that the cost of community-based internships makes it prohibitive for governments but Southern GP Training argues that the current cost of training in PGY1 and 2 has not yet been calculated. An actual cost and comparison of each model should be undertaken.

The community-based models should utilise general practice, Aboriginal Community Controlled Health Services, smaller general hospitals, larger regional hospitals, community mental health, aged care, resident and visiting medical specialists which is augmented by simulated learning and telehealth. Models should investigate alternative training posts/opportunities which are customised to local areas are well supported and have been developed with appropriate stakeholder consultation and engagement.

At the end of the two-year internship, the junior doctors could be offered the option of a procedural year or they can start general practice training having completed two years that is recognised as equivalent to the mandatory hospital rotations/time required by RACGP and ACRRM.

To this end we must also ensure that rural prevocational training doesn’t inhibit opportunities for entry into specialist training jobs so we need to include at least junior registrar training jobs (general) for physicians, surgeons, paediatrics and emergency medicine.

**Recommendation 2: Establish Regional Training Networks (Theme: 1, 2, 3, 4, 5 & 6)**

Mason refers to “Networked Intern Training” this needs to be expanded to “Regional Training Networks” which covers the training continuum from the intern year through to vocational endpoint for medicine; over time this arrangement could be extended to other disciplines, such as nursing and allied health.

A Regional Training Network would have responsibility for:

- Clinical support and governance
- Development of Integrated Training Pathways
- Evidence-based medicine
- Accreditation
- Research
- Population health needs and outcomes
- Service utilisation, planning and development
- Continuity (vertically, horizontally and across time)
- Team-based and multi-disciplinary training
- Embedding primary care in the training

The Regional Training Networks will be established as partnerships between relevant regional medical education organisations; including Regional Training Providers (RTPs), Rural Clinical Schools, hospitals and other relevant bodies. They will oversee planning and implementation of training arrangements over the continuum from undergraduate through to vocational training for Fellowship.

The RTPs are well positioned to be the lead agency and hold the funds on behalf of the Regional Training Networks in that they are already part of a national network and they are unique in their independence from hospitals, the colleges and universities. RTPs are proven and capable of advancing this movement and they have good connections with general practice and regional health services.

A metropolitan tertiary hospital/network should partner with a specific Regional Training Network and offer opportunities for mentoring, secondments for additional clinical experience/training, education and remote supervision. At the moment we deal with a number of tertiary hospitals and it would be preferable if the one hospital network was allocated to a region.

The focus must shift from rotating junior doctors out from a metropolitan hospital to a rural placement, and instead rotate junior doctors from a rural community setting into a metropolitan hospital to supplement the training.
Recommendation 3: Focus on simplified funding, reorganisation and area based planning to meet community needs and workforce requirements (Theme: 1, 2, 3, 4, 5 & 6)

There are various ‘buckets’ of funding across the training continuum which makes it difficult to provide seamless transition from undergraduate training to vocational end-point. If the Regional Training Network was given a sum of funding they could apply a population-based planning approach to address rural workforce needs and service requirements, this would result in a more targeted training investment.

Now is the time for regional areas to review current training and education arrangements and to seriously investigate options for medical workforce reorganisation. There is no doubt that there is scope to create additional training posts and through the rearrangement of existing rotations to create coordinated training pathways.

The Rural Medical Generalist Draft National Framework introduces a concept of selecting for a region rather than a hospital or general practice or training post. This enables junior doctors to have the required variety of postings and work across the regional setting rather than having to re-locate.

Procedural training posts and any supplemental intern training positions should not be seen by individual hospitals as a solution to filling workforce shortages, but rather as training posts that will prepare a doctor for future independent generalist practice, increasing the capability of outlying hospitals and lessening workload of the training hospital.

Recommendation 4: Selection and recruitment must factor in rural aptitude and orientation (Theme: 1, 2, 3 & 4)

Rural training pipelines need to address specialist, generalists and general practitioners but we do not endorse splintering the profession in terms of general practice training and rural generalist training. Recruitment of generalists should be done as part of the Australian General Practice Training Program Application and National Assessment process, where doctors can select an option for generalism.

Rural background and training in a rural area should receive a preferential weighting which is considered in the score and allocation to specific RTPs. The allocation to RTPs would be general pathway, rural pathway and rural generalist.

Recommendation 5: Use existing definitions of Rural Generalist, do not create a new one (Theme: 4)

We support the definition of a rural generalist that was endorsed by the Queensland State Government in 2005. A Rural Generalist is defined as a rural medical practitioner who is credentialed to serve in:

- Hospital-based and community-based primary medical practice; and
- Hospital-based secondary medical practice:
  - in at least one specialist medical discipline (commonly but not limited to obstetrics, anaesthesics and surgery); and
  - without supervision by a specialist medical practitioner in the relevant disciplines
- Possibly, hospital and community-based public health practice - particularly in remote and indigenous communities.

We also support the four components of rural generalism that were presented by Professor Richard Murray at the recent World Summit on Rural Generalism:

- Comprehensive, coordinated, ambulatory care for individuals, families and communities;
- Hospital inpatient service and emergency care;
- Extended, specialised care in a discipline as required;
- The incorporation of a systems and population health approach.
Recommendation 6: Prepare a sound business case for being a training practice which factors in the true cost of supervision (Theme: 6)

General Practice Education and Training (GPET) have commissioned a study that investigates the costs of being a training practice and supervisor. The rural workforce pipeline operates primarily through the good will and commitment of doctors, who sacrifice consulting time for teaching commitments. The business case for supervision is weak: it is essential that costs associated with infrastructure, supervision, teaching and clinical governance is considered in funding formulas and thus determining training capacity.

Recommendation 7: Build on local examples, innovations and structures to meet rural health and workforce needs (Theme: 1, 2 & 3)

In terms of local innovations and examples, the Victorian Department of Health has recently funded Southern GP Training to conduct a scoping and feasibility study in South West Victoria with the aim of developing integrated rural pathways from internship through to general practice end-point with or without recognised procedural capabilities. This project will be finished in December 2014, we are happy to make the outcomes and recommendations available to the RACGP.

Another example is the Gippsland Rural Generalist Program which offers a clear, defined and integrated six-year pathway from internship through to vocational end-point with credentials in either obstetrics or anaesthetics. As a result of this program we have found that while there is merit in offering doctors a defined and quarantined pathway from intern year to vocational end-point, it does restrict flexibility (unless you have a critical mass) and it is not always appealing to medical graduates who have not decided what they want to do or where they want to go. We recommend that defined pathways are offered but so too are options for lateral entry.

One size does not fit all, models and arrangements of rural generalism, community-based internships and integrated rural training pathways need to be customised to local arrangements and jurisdictions with appropriate levels of funding. For example the Queensland rural generalist model is unlikely work in Victoria due to the devolved governance model and piecemeal funding approach.

Recommendation 8: Streamline the training accreditation process (Theme: 2, 5 & 6)

The accreditation of training practices should be streamlined and simplified. It is recommended that training of medical students, junior doctors and GP registrars is offered as an optional module during the general practice standards accreditation process. A streamlined process and associated paperwork should be developed by jurisdiction.

If you would like to discuss this submission in greater detail please feel free to email me on greg.mcmeel@sgpt.com.au or call me at the Warrnambool office on 5562 0051.

Sincerely

Greg McMeel
Chief Executive Officer
3.4.1.2 Mount Isa Centre for Rural and Remote Health

5/12/2013

DR Kathryn Kirkpatrick
Chair
National Rural Faculty
Royal Australian College of General Practitioners
100 Wellington Pde
East Melbourne Victoria 3002

Dear Dr Kirkpatrick

RE: New Approaches to Integrated Rural Training for Medical Practitioners Project

I write on behalf of my colleagues at the Mount Isa Centre of Rural and Remote Health (MICRRH) James Cook University located in northwest Queensland. There are several issues that on their own may not be troublesome but when the climate initiates convergence the wicked problems of maldistribution of training places and workforce results.

The current set geographical boundaries for rural general practice training providers as it relates to North West Queensland. The current situation is that Mount Isa has a severe shortage in general practice capacity – 7 full time equivalent GPs. This is not a new situation – Mount Isa has been under doctored for many years and should be experiencing impact from the workforce training reforms including advanced rural training and general practice training. The impact of one or two doctors leaving town after a period of two or more years is felt disproportionately and has raised considerable concern by the population, doctors, services, and educators with now solution in clear sight. The registrar numbers placed to date have been a trickle consequently not contributing to the overall growth in service capacity or translating into attractive recruitment options for trainee graduates. In fact the GPs have had to struggle to secure registrars – 2014 will see one more FTE registrar allocated to the town. Currently there are 2 Rural Generalist registrars who will continue. Cloncurry, an exemplar of GP training by international standards have had great difficulty securing registrars and they offer a fully integrated training experience – 4th & 6th year Medical students – long placements, PG1 and PG2s and registrar – with excellent supervision, variety of experience which has translated to 2 graduates choosing to stay and join the workforce – success by any measure.

Whilst clearly multifactorial, this is largely an unintended consequence of the regionalisation of general practice training, generally a good strategy which should be retained once remodelled. The flow of registrars to Mount Isa and the northwest region is insufficient to either create a critical mass of trainees for the period of their training or a graduate flow on. Where registrars are placed in vertically integrated environments such as exists in Cloncurry or Longreach, registrars seek out the training placement and graduates are more likely to seek employment in the practice or like environments.

Medical students who have undertaken significant placements in these practices are returning as post grads and registrars to Cloncurry and Longreach. One current GP supervisor in Longreach was one of the first medical student cohort placed by MICRRH, the registrar is a return long look 6th year JCU medical
student, and current students have indicated a desire to return to train. The pipeline once visible and accessible is working if the RTP is responsive and in fact proactive. They are seeking out these places themselves as the opportunities are clearly visible – registrars are in the practices they are placed in as students— a vote of confidence for the pipeline and an outcome of the full vertical integration – 4th and 6th year medical students, PGPPPs, registrars s well as the committed supervisors and practice staff.

The practices in both towns largely secure their own trainees and then match them with a training provider. This is increasingly difficult and should not be so. Mount Isa does not have a consistent flow of PGPPPs or registrars. Currently (2013) there are two registrars in the MI Hospital and none specifically attached to general practice. These practices now have 4th and the hospital 4th and 6th year students with no reliable, consistent or visible pathways for the students to return to. It would seem the numbers of registrars applying though the RTP are insufficient to feed the pipeline or are not encourage to consider a rural and remote training option.

Mount Isa’s population of more than 22,000 with an additional fly in fly out workforce who also use the health services is as described above under-doctored, resulting to bottleneck access issues. It is also a high health need population on several fronts, high levels of disadvantage, poor health literacy across the population, industry related issues, a young population and a significant Aboriginal population in town and the region. The current GPs across the practices are extremely hard working, endeavoring to maximize service provision. The hospital emergency has to pick up the overflow and no one manages to follow-up for those without a PHC home.

The three practices and one Aboriginal Medical Service are frequently or always without a GP registrar undermining the comprehensive workforce strategies in place and exposing the sustainability of general practice to high risk. This then potentially impacts on their ability to take medical students in sufficient numbers to build their confidence in rural practice and life. One practice has not had students for most of the year – a critical component of integrated rural training.

**Despite an established evidence base for remote supervision, practices are required to have on site fellowship supervision to meet RTP accreditation requirements, and so the circle goes round. This needs to be improved.**

The regional university – James Cook has a rural focused medical program with strong emphasis on recruitment for rural background and extensive high quality clinical experience in rural, regional and remote areas. This is producing graduates who are seeking positions in rural, regional and remote areas and the current system does not have a sophisticated system to match them to this – graduate are allocated places agnostic of background. Pipeline haemorrhage starts here.

PG1 and PG2 jobs for rural intended graduates need to be prioritized.

Procedural and non procedural training positions need to be created in sufficient numbers in regions such as Northwest Queensland to ensure critical mass to overcome long standing deprivation. Pipeline haemorrhage continues here

Where a region or town is supervision vulnerable – a mixed mode model utilizing best practice models including shared arrangements with a key supervisor in the university department of rural health should be instigated to ensure training capacity is optimized and underserved towns and communities become assets not deficits.

A practical example is a strategy MICRRH proposed in 2013. In an effort to overcome the current situation and build an innovative supervision model, MICRRH offered to fund pool with TMT and seek additional funds to employ a GP supervisor to bolster Mount Isa practices and the AMS and shore up a more robust training environment, at least for the next 4 years until we can reasonably expect to see some stabilisation.
This has not eventuated.

Across Australia, there seems to be a degree of disconnect between regional training and its place in building a future workforce in and for the regions. To get a different outcome to where we are now we need a different strategy.

I recommend you view the North West conundrum as one of advantage not deficit.

As most remote regions this could be quite different. There is within this region a rich training environment potential comprising an abundance of clinical opportunity, good collaboration between practitioners, services and settings; and an academic presence in the form of a University Department of Rural Health.

- We have a strong undergraduate pipeline with 2nd 4th 5th and 6th year students placed across the region. These are largely rural origin students, studying a rurally influenced curriculum at a regional university – James Cook University.
- Extended 6th year placements also occur in Mount Isa, Cloncurry and Longreach.
- Mount Isa Cloncurry and Longreach can support PGPPPs.
- Mount Isa and Longreach could support interns.
- Mount Isa, Cloncurry, Normanton and lower could support at least 12 registrars for general practice and advanced rural training.
- Longreach could support at least 3 with the potential of an additional 4 associated with Winton and Barcaldine.
- As a region we can offer a fill comprehensive training program for a variety of pathways - the hospital based advanced clinical terms (emergency, obstets, paediatrics, palliative care, mental health (tele oncology – not a current term but a wonderful opportunity to future proof), remote health, general practice terms, rural generalist terms, emergency retrieval RFDS terms, Aboriginal health terms – the whole box and dice for the full training period, well supported by the health and Medical community, General Practice Medicare Local, Hospitals and Health Services and the Mount Isa Centre for Rural and Remote Health.

After 4 years of training we could well expect a reasonable percentage to stay for several years and in turn contribute to the training of the upcoming growth in graduates, transforming North West Queensland into a beacon training region.

To achieve this, the following must occur:

- Relax the strict RTP boundaries so the region could recruit trainees from which ever training provider who undertook to support the direction set out above or individually.
- Post grad positions (PG1 & PG2) need to be increased in the region and linked to rural intention graduates
- Dedicated Training places need to be allocated to the region.
- Rural intention graduates need to be linked to the offering of training places
- Invest in collaborative, innovate models of supervision and training
- Accommodation for trainees needs to be secured.

It is important to not lock out RTPs who have been responsive where the allocated RTP has failed to provide trainees or discourage others who may be interested. Competition would encourage RTPs to be more responsive RTPs and attract those who have a rural or remote focus.

It may even be possible for Mount Isa to partner with other remote regions and a responsive RTP to form a remote northern Australian RTP. This may not be necessary, however it important to keep options necessary for success open.
NWQ has the people and practices in the region, who despite the many obstacles have been resilient in very trying times, demonstrating commitment to rural medicine and wish to build from that base. It is fair to say that there is a high level of frustration about the lack of GP registrars in the region and how that impacts on their ability to inspire and teach the students who will make up that base in the future. There is also strong commitment to local solutions.

Yours truly

Professor Sabina Knight
Director
Mount Isa Centre for Rural and Remote Health
3.4.1.3 General Practice Education and Training Ltd

**EVENT DETAILS**  
**PROJECT AIM:**  
Undertake consultations with the RACGP rural membership to identify the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter general practice in regional and rural communities. This includes the structural requirements and advanced skills training for new entrants and the existing general practice workforce. The input obtained will be guided by the key recommendations in the Mason Review relating to the coordination of training and the proposed National Rural Training Pathway (NRTP).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Policy Objective</th>
<th>GPET Comments</th>
</tr>
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</table>
| 1. Access to quality care for rural and remote communities | Secure equitable outcomes for rural communities through workforce strategies that provide more primary care in the community. Training responses ensure doctors have the skills to meet the health needs of the community. | Key reform is required in this area to ensure there are enough opportunities for trainees (particularly those in rural areas) to pursue all of their medical training in rural and remote communities.  
Reform around:  
- Early identification of potential trainees  
- Selection (all stages) to node or region (based on identified workforce need)  
- Ability for trainees to pursue a pathway of full medical training (undergraduate through to specialist registration),  
- Policy that supports minimal geographical dislocation |
| 2. Integrated rural training pathway | To provide a comprehensive rural medical training experience, with a seamless transition from undergraduate training to rural general practice by linking the difference stages of training in rural settings. | Integrated pathway is supported, but will require reforms including those outlined above.  
For this to occur, GPET would recommend that the pathway  
- Not necessarily be totally ‘procedurally’ focussed  
- Be cognisance of the need for rural and remote patients to be sent to acute care hospitals, i.e. not all can be managed locally.  
- Make use of current existing RTP infrastructure to manage and deliver training  
- Make use of strategically-aligned partnerships at regional level (RSC/UDRHs etc…)  
- Be responsive to the identified needs and interests of a community  
- Be mindful of regional/community differences |
| 3. The use of advanced skills in rural areas | Identify key policy requirements for improving rural GP access to advanced skills training, both procedural and non-procedural. | This requires a whole-of-government (State, Territory and Federal Health departments) along with input from Universities, PGMECs and colleges.  
Opportunity to pursue training need to increase across the health sector. |
| 4. GP-Rural Generalist: Defining the role and pathway | Clarify and identify the skill mix required for safe, high quality generalist practice by doctors in rural and remote practice. | Distinction to be made between training for ‘generalist’ practice and ‘proceduralist training’, which is the hallmark of QLD Rural-generalist program.  
- Key reforms should focus on integrating GPRG training with current training infrastructure to maximise the use and benefits of the Commonwealth’s existing investment in the areas of prevocational and vocational training in general practice.  
- There is a need to develop (and publish) clear criteria against which potential trainees will be selected into GPRG training.  
- Selection criteria should be linked to ‘job analysis’ (i.e. what is the job?) and focus on the ‘person specifics’ (i.e. who can do the job?).  
- Key reforms are likely to support early  
  - identification and selection of GPRGs who are suitable for and prepared to commit to rural training  
  - engagement with RTPs to manage ‘whole-of-program’ training and support  
  - planning of learning (and support), identifying and scoping opportunities for advanced skills training (including ongoing support), PGPPP and vocational training placements  
  - Reforms could address ongoing ‘employment’ arrangements to ensure an GPRG’s employer (usually State Health) remains a constant throughout GPRG training  
  - A policy of early and continuous RTP involvement will provide GPRGs with access to appropriate PGPPP placements and ensure GPRGs can successfully compete ‘on merit’ for a place in vocational training (AGPT). |
Early identification of suitable trainees remains paramount to the success of any GPRG program. Of those identified, only those who are able to demonstrate a clear commitment to train as a GPRG in rural or remote locations, should be selected for GPRG training.

Selection criteria should be developed to help identify likely GPRG doctors, both in terms of job/person fit and suitability for GPRG training.

RTPs are responsible for the delivery of training under the PGPPP and AGPT program. The RTP network is well established and is able to provide GPRGs with considerable access to a highly qualified primary health care medical education workforce as well as other education and training resources, infrastructure and support. These reforms (focusing on early identification and continuous support) would ensure RMGs can move smoothly through their training with the assistance of an RTP who could effectively manage and support their training from under/post graduate medicine, prevocational training (via PGPPP) through to vocational training (via the AGPT program) and specialist registration.

Employment stability is a key component of success and when present, is able to address a range of HR and IR issues which, under the current arrangements, can be a barrier to a streamlined training pathway. This is particularly evident where (under present arrangements) a trainee doctor needs to change their employer to pursue vocational training; non-hospital based advanced skills training (Aboriginal health) or other community-based training.

5. Embedding more primary care in the training
   Incorporating more primary care into the basic training to ensure there is an appreciation of the role of general practice early in the training.
   No comments specifically on this theme.

6. Training capacity
   Address factors limiting rural GP training capacity. Work through the additional requirements placed on the sector with a new national rural training pathway.
   No comments specifically on this theme.
3.4.1.4 University of South Australia

29 November 2013

Dr Kathryn Kirkpatrick  
Chair, National Rural Faculty  
RACGP  
100 Wellington Parade  
East Melbourne Vic 3002

Dear Dr Kirkpatrick

Re: New Approaches to Integrated Rural Training for Medical Practitioners

Thank you for your letter, dated 1st of November 2013, requesting input for the current RACGP project. To ensure brevity and clarity, I have provided comments in each of the six themes you have identified. These comments are centred on helping to build a culture of teaching in rural areas and how UDRHs can help facilitate this.

Access to quality care for rural and remote communities

I take a view that the person would need to have a presence in the community, rather than clinical experts, who may only spend a couple of days per month in the community. I also take the view that there are opportunities for the specialist registrar to supervise other disciplines outside medicine and to share their expertise and clinical skills.

Integrated Rural Pathway

A clinical rural placement provides opportunities to view different health care settings with additional complexity. To maximise the potential benefits of this, the specialist registrar and their dependents will need to be able to live within the community and be supported to contribute to the wider community infrastructure. There needs to be a clear focus as to what the benefits are of living and working in a rural community; particularly research opportunities for specialist registrars.

By providing clinical leadership and developing rural pathways, the role is a natural catalyst for research facilitation in wider national rural health projects. I feel that University Departments of Rural Health (UDRH), as academic centres in rural settings, are a natural home for specialist registrars to develop their research portfolio and cement long-term partnerships between academic partners and health care providers. UDRHs may be developed to provide academic support for specialist registrars, such as visiting academic posts and/or clinical chairs. Following on from this, specialist registrars should be provided with opportunities to switch specialist areas to maintain a flexible career.
The use of advanced skills in rural areas
Access to quality supervision in a rural setting can be challenging. We should consider how we can better use the technology available to provide access to supervision nationally and internationally. UDRHs, as academic leaders in rural settings, will have a key role to help facilitate this.

GP-Rural Generalist: Defining the role and pathway
The health care rural pathway can provide experience, training and supervision in building and sustaining therapeutic relationships within the community. The GP-Rural Generalist is a key member of rural community infrastructure; however, special preparation for GP-Rural Generalists in this area may be required. This area of community leadership provides opportunities for GP-Rural practitioners to provide a public health population and promote wide health services, for which UDRHs will have a number of resources and expertise to provide support in this area.

Embedding more primary care in the training
This can entail building into the curriculum the challenges of working with co-morbidity and developing models of medical education. This will enable primary care teams to integrate different care pathways, e.g. Cardiac Vascular Disease (CVD) and Depression. Clinical leaders in primary care have a stronger system-wide clinical leadership responsibility. This could be delivered by supervising and guiding other health care professions to acquire advanced clinical roles, such as prescribing of medicines or delivering psychological interventions for depression.

Training Capacity
The specialist registrar will have a number of advanced clinical, analytical and strategic skills which will be of enormous benefit to rural strategic health groups. Placements in these areas provide opportunities for both the rural community and the specialist registrar. Health care in rural communities, as in metropolitan areas, is much broader than providing care at the bedside. The health and wellbeing of the rural community is interwoven with a quality education system, various services and quality housing. I think that some of these areas could also provide placements.

Finally, I recommend that time is taken to explore opportunities to deliver joint training with non-medical care professionals to help develop an increased appreciation of other professional contributions within rural communities.

If you would like to discuss any of the above points further, please do not hesitate to contact me.

Yours sincerely

[Signature]

Professor Guy Robinson
Director, UDRH
Director, Centre for Regional Engagement
3.4.4.5 Australian Rural Health Education Network

Dr Kathryn Kirkpatrick
Chair, National Rural Faculty
Royal Australian College of General Practitioners
100 Wellington Parade,
East Melbourne, Vic 3002

Via rural@racgp.org.au

Dear Dr Kirkpatrick

Thank you for your letter of 1 November 2013 seeking input from the Australian Rural Health Education Network (ARHEN) on key issues, enablers and barriers to establishing streamlined education and training for medical students to enter rural practice. Please see the table attached for our response to the specific questions you have raised.

ARHEN strongly supports the concept of service learning and has implemented the model in several University Departments of Rural Health. This approach has been demonstrated to have the potential to:

- dramatically increase the capacity of a region to support students on clinical placement, and
- foster greater involvement of parent universities and their academic staff in the region as they partner with UDRHs to develop and deliver the service learning programs.

Key features of this model include:

- redesigning the UDRH student programs to accept groups of students from different disciplines for extended placements (eg. 6-8 students from a feeder university for periods between 6 -12 weeks and longer)
- consulting with local communities and regionally based service providers about their key health issues with a focus on access and equity, and working with them to develop service learning objectives, specific placement opportunities and relevant educational programs
- creating placement opportunities in both health and other sectors, including school education, aged care and disability services, and welfare agencies
- negotiating with parent universities to align their educational objectives with the service learning and placement opportunities identified locally
- integrating a learning program with the clinical training that focuses on areas of rural/remote practice, Indigenous health, and inter-professional learning
- securing adequate resources to provide students with a rewarding experience in rural and remote practice in appropriately supervised and supported environments,

The inclusion of service learning programs across rural and remote Australia will result in UDRHs influencing the clinical training, professional development and career choices of an increasingly large proportion of nursing, allied health and importantly medical students. These programs also align with Health Workforce Australia’s priorities for student training dealing with innovation in clinical training, increased training capacity, greater investment in inter-professional learning and new and improved methods of student supervision.

Please contact Janine Ramsay, National Director, ARHEN on 02 62822166 if you require any further information.

Yours Sincerely

Professor Sandra Thompson
Chair, ARHEN
3 December 2013
New approaches to integrated rural training for medical practitioners

Final report

2.1 What strategies can support a more streamlined rural training pathway.

Having registrars based in large regional hospitals so undergraduate students see career progression across the spectrum of specialty including GP rotation.

2.2 Ensuring training is coordinated in such a way to support both positive and quality training outcomes.

2.3 More early exposure to rural experiences.

The University Departments of Rural Health and long stay medical programs provide positive and quality training outcomes. These could be extended.

2.4 More rural doctors teaching at universities.

Rural doctors are employed to teach students who get rural exposure in their study program. Rural doctors provide a great role models for the students.

2.6 What adjustments are required to address the varied state based systems?

There is a need to work with the Colleges to get agreement so that regional training in General Practice or any speciality is accepted and valued.

2.10 Capacity to combine intern and registrar training positions

The provision of salaried GP services through Medicare would enable practices to offer intern positions.

ARHEN supports the Mason Review Recommendation 4.1 to develop a new, more integrated rural training pathway.

ARHEN strongly supports the need for rurally based internship positions combining acute care and primary care within a range of settings.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Policy Objective</th>
<th>Response</th>
</tr>
</thead>
</table>
| Access to quality care for rural and remote communities | Secure equitable outcomes for rural communities through workforce strategies that provide more primary care in the community. Training responses to ensure doctors have the skills to meet the health needs of the community. | 1.1 Innovative solutions to ensure equitable access. One of the biggest challenges in rural and remote health is an available and work-ready workforce. The education pipeline eventuates in a rural-ready workforce. Rural background and educational experience are two important predictors for taking up rural practice. This links to the concept of a rural training pipeline or ‘joined up’ approach which to date has referred mainly to doctors. The pipeline:

- commences in school, with careers promotion in primary and high school
- progresses to the tertiary level
- continues with undergraduate followed by postgraduate training with new graduate employment and specialty training for those with intent to practise rurally.

There is a link between longer rural placements/rotations and rural recruitment for internships. Rural curriculum and exposure help develop a ‘rural-ready’ workforce that is prepared for the challenges, isolation, variety – and satisfaction - of rural and remote practice.

One strategy used in UDRHs is the implementation of service learning which

- dramatically increases the capacity of a region to support students on clinical placement, and
- fosters greater involvement of parent universities and their academic staff in the region as they partner with UDRHs to develop and deliver the service learning programs.

Another important strategy is the employment of a salaried GP academic providing services to the people without a GP. |

One of the biggest challenges in rural and remote health is an available and work-ready workforce. The education pipeline eventuates in a rural-ready workforce. Rural background and educational experience are two important predictors for taking up rural practice. This links to the concept of a rural training pipeline or ‘joined up’ approach which to date has referred mainly to doctors. The pipeline:

- commences in school, with careers promotion in primary and high school
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- continues with undergraduate followed by postgraduate training with new graduate employment and specialty training for those with intent to practise rurally.

There is a link between longer rural placements/rotations and rural recruitment for internships. Rural curriculum and exposure help develop a ‘rural-ready’ workforce that is prepared for the challenges, isolation, variety – and satisfaction - of rural and remote practice.

One strategy used in UDRHs is the implementation of service learning which

- dramatically increases the capacity of a region to support students on clinical placement, and
- fosters greater involvement of parent universities and their academic staff in the region as they partner with UDRHs to develop and deliver the service learning programs.

Another important strategy is the employment of a salaried GP academic providing services to the people without a GP.
| Integrated rural training pathway | 2.1 What strategies can support a more streamlined rural training pathway.  
Having registrars based in large regional hospitals so undergraduate students see career progression across the spectrum of specialty including GP rotation.  
2.2 Ensuring training is coordinated in such a way to support both positive and quality training outcomes.  
2.3 More early exposure to rural experiences.  
The University Departments of Rural Health and long stay medical programs provide positive and quality training outcomes. These could be extended.  
2.4 More rural doctors teaching at universities.  
Rural doctors are employed to teach students who get rural exposure in their study program. Rural doctors provide a great role models for the students.  
2.6 What adjustments are required to address the varied state based systems?  
There is a need to work with the Colleges to get agreement so that regional training in General Practice or any speciality is accepted and valued.  
2.10 Capacity to combine intern and registrar training positions  
The provision of salaried GP services through Medicare would enable practices to offer intern positions.  
ARHEN supports the Mason Review Recommendation 4.1 to develop a new, more integrated rural training pathway.  
ARHEN strongly supports the need for rurally based internship positions combining acute care and primary care within a range of settings. |
| To provide a comprehensive rural medical training experience, with a seamless transition from undergraduate training to rural general practice by linking the different stages of training in rural settings. |
| The use of advance skills in rural areas | Identify key policy requirements for improving rural GP access to advanced skills training, both procedural and non-procedural. | 3.1 What advanced skills are being used and what are the barriers impacting on acquisition and retention of these skills

University Departments of Rural Health play a key role in addressing the acquisition and retention of skills for the rural, regional and remote workforce. |
| GP-Rural Generalist: Defining the role and pathway | Clarify and identify the skill mix required for safe, high quality generalist practice by doctors in rural and remote practice. | 4.2 Defining the term and role

The rural generalist role is very valuable to the profession and to patients. ARHEN supports the findings of the Mason Review around the need for rural clinical training and the mix of short and longer term placements and strongly supports the need for rurally based intern positions. |
| Embedding more primary care in the training | Incorporating more primary care into the basic training to ensure there is an appreciation of the role of general practice early in the training. | 5.1 How can more primary care be embedded into the training?

The University Departments of Health and our long term medical placements support the embedding of primary care into training. However, the availability of GPS to take on students is a limiting factor. |
| Training Capacity | Address factors limiting rural GP training capacity. Work through the additional requirements placed on the sector with a new national rural training pathway. | 6.1 What are the key constraints currently limiting supervision.

The number of GP practices able to take students is the key limiting factor. 6.6 That changes could be made to the funding framework to improve the interconnectedness and encourage more training across the full training continuum?

ARHEN believes that Practice Incentive Payments need to be less cumbersome and more realistic. |
2 January 2014

Dr Kathryn Kirkpatrick
Chair, National Rural Faculty
Royal Australian College of General Practitioners
rural@racgp.org.au

Dear Kathy

Re: New approaches to integrated rural training for medical practitioners

This letter relates to a specific component of rural training for medical practitioners that is poorly addressed in existing materials such as the Mason Review, namely further skilling for experienced general practitioners who wish to move their practice location from metropolitan to rural areas. Such a circumstance was one driver for the RACGP to develop a vertically integrated curriculum in the mid-2000’s, laying out the learning at the ‘Continuing Professional Development’ (CPD) level that an experienced, re-locating general practitioner would need to undertake in order to best serve their new practice population.

Even more specifically, this letter relates to the educational support of metropolitan-based general practitioners who are prepared to provide short-term locum relief for rural colleagues, or in areas where general practitioner vacancies exist perennially. It is a personal perspective, based on my own experiences undertaking locum placements in the vastly contrasting locations of Hamilton Island off the Queensland coast and Yirrkala in eastern Arnhem Land.

My motivation for writing stems from my enthusiastic support for the College’s Rural Procedural Grants Program, through which I have been able to maintain my emergency medicine skills at a level where I am competent to manage trauma, resuscitations and other emergency department presentations in isolated areas. In my view, this program needs to be expanded to encourage greater mobility amongst existing general practitioners. While an itinerant GP workforce is far from an ideal solution for isolated areas, it provides one piece of the puzzle both in the short term and also for longer-term sustainability of permanent placements.

Having recently completed my first placement in the Aboriginal Medical Service at Yirrkala (and considering myself a general practitioner of fairly average skills), I was pleased to discover that my basic FRACGP competencies provided an adequate

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foundation on which I was quickly able to build in order to function safely and
effectively, albeit for a short period of time. My anxieties about not being up to the
challenge were largely unfounded, thanks to a well-established interdisciplinary team
at Yirkala that was willing to offer support and encouragement. I am eager to return.

Reflecting on the experience, it struck me that many more metropolitan general
practitioners such as myself – reaching a point in their career where greater clinical
and personal challenges are welcomed – would be prepared to go to rural and
remote areas if given appropriate bridging training. Much of this would need to be
directed at building on existing primary care competencies, reassuring metropolitan-
based GPs that they are indeed able to do this work. One of the perverse outcomes
of attempting to segregate rural medicine has been to create an impression that it is
beyond the range of the ‘city’ GP, effectively closing the door to the majority of
Australia’s primary care doctors. Any ‘integrated rural training pathway’ envisioned
by policy-makers needs to consider how this vast human resource can be best
supported to enter a vertical training stream laterally. The benefits of minimal lead-
time and existing phronesis when compared to the novice GP are obvious.

I must return to my own example. While the Rural Procedural Grants Program
provided me with the necessary emergency medicine competencies to practise
safely in isolated environments, I keenly felt the need for more skills in remote
Aboriginal Health before heading to Yirkala but was unable to find suitable CPD,
despite a plethora of procedural courses. As is typical in general practice, my
needed curriculum declared itself by the patient needs I struggled to meet, from
intercultural communication and mindfulness, through to clinical content areas such
as renal disease, rheumatic heart disease, diabetes, and tropical infections and
infestations. I would have eagerly attended a targeted three-day CPD program that
built on the basic knowledge of these areas that all GPs have, as well as providing
tips and insights for successful practice from experienced colleagues.

Please don’t think that I believe such a brief program would create an expert
Aboriginal Health general practitioner – true mastery requires years of committed
practice, of course. What I believe such a program would achieve is to encourage
more mid-to-late-career GPs to consider expanding their scope of practice and
gaining the confidence to venture into previously impenetrable areas as their family
circumstances change. A series of short-term locum placements may well turn into a
longer-term commitment.

Yours faithfully

[Signature]

Professor Stephen Trumble
3.5. RACGP State Faculty consultation

The RACGP State Faculty Boards were asked to provide jurisdictional detail and to further test some key aspects emerging from the policy consultations. A policy discussion paper was provided for tabling at their final meetings for 2013. Specifically, each State Faculty Board was asked to comment on two key areas of the policy advice. The first, Item 1, related to the Integrated Rural Training Pathway with further clarification sought at the state level on the key jurisdictional barriers affecting the establishment of a more integrated pathway. Item 2 related to establishing teaching hubs in specific and targeted locations nationally to help build a culture of teaching in a chosen region, providing the critical mass of students required for sustained success, as well as the supportive structures to enable a positive rural training experience.

3.5.1. Queensland Faculty Board consultation

The RACGP Queensland Faculty Board consultation was held in Brisbane on Wednesday 20 November from 7pm – 7.45pm as part of the QLD Faculty Board meeting. The Board discussed two project themes – the integrated rural training pathway and learning hubs in rural towns. A total of 14 GPs participated in the discussion. The participants have been de-identified in the following transcript; all participants in the discussion were members of the QLD Faculty Board with the exception of one person (QLD Faculty Manager). The discussion was facilitated by a member of the NRF Board.

Theme 1: Integrated rural training pathway

Introduction

The Faculty Board discussed the requirements for the development of rural GP intern rotations, and capturing the jurisdictional differences and changes required to facilitate such an approach. Given the interconnected nature of the themes, GP intern rotations and rurally located learning hubs were discussed together.

The discussion

The discussion highlighted some of the models currently being implemented in Queensland and some of the structural barriers impacting on their success. Improved support for supervisors in rural and remote locations is considered a priority, including appropriate remuneration and recognition as well as programs and strategies to reduce burnout and minimise the burden of teaching on private general practice.
Clarity around funding arrangements for rural GP intern rotations is needed, particularly in relation to existing pathways and where current PGPPP funding has been redirected to support intern positions. This redirection of funding has occurred in some rural areas of QLD, with RTPs funding intern positions via PGPPP fund allocation.

Establishing critical masses of students across medical and allied health disciplines in rural communities is also seen as a positive and necessary step in achieving functioning and sustainable learning hubs. Creating such critical mass creates an early understanding of the importance of delivering primary care in multi-disciplinary teams, and provides multidisciplinary support for early-career health professionals. While this has already commenced in many areas, there remains a current a lack of infrastructure to adequately support their sustainable development.

Learning in rural communities

The group reported several existing arrangements involving rural GP intern rotations already occurring across Queensland through localised arrangements. For example, three interns have rotated through Emerald from Rockhampton Hospital in the last month (through QRME). The Gold Coast hospital reportedly rotates interns through St George as well. This is made possible because local partnerships have developed the infrastructure to support the arrangement, however this is not repeated uniformly across the state and arrangements are seen as ad hoc, often relying on the goodwill of individual relationships rather than formalised structural and systemic arrangements. The group supported a hybrid model, encompassing both hospital and community (private) general practice training experiences.

Rural GP intern rotations are a positive and welcomed development, however it was emphasised that this should not be to the detriment of the PGPPP program. There is concern about the funding arrangements and lack of clarity around the use of PGPPP funds, with perceptions that funding for PGPPP is being diverted and streamlined into intern placements. A key priority should be around the allocation of specific funding for interns to have rotation to rural hospitals or rural general practice (or both), distinct from and in addition to PGPPP funding.

Concerns were raised about the training continuum and the level of competency of doctors at various stages of training. For example, some PGY2 level doctors are not getting to make decisions unless they are in particular hospitals, resulting in a lack of confidence in decision-making when they begin GP training. General practice requires quick summations and decisions, and the ability to create and action plans. However, some of the junior doctors transitioning from PGY2 into vocational training aren’t ready for that level of autonomy. This becomes an issue of access equity for rural communities in which they will be located.

From a student and resident perspective, placements in hospitals have different levels of responsibility. While they do have to see patients on their own, they are required to discuss each patient with a registrar or consultant. Once taken out of this highly supportive, regimented network into rural general practice where they are on their own, it is difficult as a ‘green’ intern to assess people who are sick, and who potentially need to be admitted. In Brisbane, emergency departments have 20% rostered time out to do training with interns in emergency. It was suggested that a similar type of program could be implemented for interns or PGPPPs to build confidence in practising in a more autonomous environment.

Concerns were raised about the training continuum and the level of competency of doctors transitioning from PGY2 into vocational training. It was noted that some doctors were not ready for that level of autonomy. This becomes an issue of access equity for rural communities in which they will be located.

The preparedness of some junior doctors being sent to rural general practice placements was questioned, highlighting that placements can occur too early. Potential good GPs are frightened away because of the lack of support being received on some rural placements early in their journey. Supervision requirements can be extremely demanding, particularly for PGPPP and interns. Longer-term placements in rural communities are seen as ideal and less demanding, particularly longer placements with multiple levels of learning. This would add value to private practice, and enhance learning of junior doctors and registrars through peer teaching and mentoring.
**Theme 2: Learning hubs in rural towns**

**Learning hubs**

Establishing a critical mass of multidisciplinary learners and teachers in rural communities is strongly believed to enhance experience of living in community in terms of social and professional support. Anecdotally, the more supported and socially engaged students are (and the longer their placements), the more likely they are to take up an internship in that particular rural location. Two significant predictors of rural career choices are rural origin and the length of placements that junior doctors experience in rural areas, referred to as the ‘home-grown’ model and the ‘bloom where you are planted’ model, in which learners establish roots and networks in a rural community.

Training consortia already have hubs to build on, requiring further infrastructure support. Grants should be directed to rural communities and learning hubs consisting of multi-level, horizontally and vertically integrated learners. Essential components are adequate infrastructure and a solid business model. The group suggested targeting infrastructure grants to teaching hubs in rural communities that can demonstrate business plans incorporating teaching and supervision into service delivery.

**Teaching in rural communities**

With markedly low numbers of GP supervisors in rural general practices, the group expressed concern about how we are supporting and protecting our rural GP supervisors from burnout, which is seen as a significant issue. Short-term placements are seen as a contributor to this exhaustion. Students undertaking 4–8-week placements are taxing. Registrars also pass through for six months only, just gaining competence and learning referral networks before moving on. The need for longitudinal, vertical and horizontal integration of training in rural areas is highlighted as a partial solution – while some progress has been made it is reported as being ad hoc and not uniformly applied given jurisdictional barriers. Learning hubs described below offer an ideal model in addressing some of these placement issues and increasing the teaching capacity of rural communities to minimise the impact of burnout on rural GP supervisors.

The need for remuneration, recognition and respect for rural supervisors is a key factor in increasing the teaching capacity of rural general practice. Remuneration appropriate for the time involved in teaching will enable GPs to provide the supervision that is required while ensuring viable private practice. It is already extremely difficult to find practices to take on PGY2 placements, let alone PGY1 placements given their supervision requirements. PGY1 don’t get provider numbers, which is an issue for private rural general practice facilities. Legislation change enabling PGY1 to get provider numbers is required.

**QLD-specific issues**

Southern Queensland has two RTPs with differing approaches to training and different funding arrangements. Difficulties can arise when students travelling to another town for a placement can cross RTP jurisdictions, and across much of Southern Queensland these RTPs share a geographic footprint. Increased cooperation and collaboration between relevant stakeholders, including RTPs, will be required to ensure structural support is in place for rural GP intern placements.

Recent issues identified in Queensland associated with the approaching influx of graduating medical students could have potentially significant impacts on the primary healthcare system in coming years unless addressed with priority. In Queensland, the state health department has flagged using district of workforce shortage and ‘area of need’ policy as a mechanism for prevocational doctors to access provider numbers and move out of hospitals and into rural practice. However, this proposal is made outside of a training program and into an environment that is completely unsupported. This problem has some urgency – next year in Queensland alone nearly 200 PGY2, PGY3 and PGY4 doctors won’t have hospital placements and may be encouraged to go out to rural communities and obtain provider numbers through the DWS/AON provisions, working outside of training programs and completely unsupported.
Queensland State Faculty recommendations:

1. Allocation of specific funding for interns to have rotation to rural hospitals or rural general practice (or both), distinct from and in addition to PGPPP funding.

2. Creation of vertically and horizontally integrated rural learning hubs enabling longer and more effective rural placements, with particular emphasis placed on funding for infrastructure.

3. Increased recognition of rural GP supervisors through appropriate remuneration, enabling them to provide the supervision that is required.

4. Increased AGPT training positions in line with projected numbers of PGY3 and PGY4 doctors who will be displaced from the hospital system as SMO positions make way for increased registrar numbers in the hospital setting. This will address issues around potential access to provider numbers via current workforce levers (DWS/AON) that would see junior doctors being forced into rural general practice without appropriate support or access to training.

3.5.1.2. New South Wales and Australian Capital Territory Faculty Board consultation

The RACGP New South Wales and Australian Capital Territory Faculty Board was provided with an overview of the ‘New approaches to integrated rural training for medical practitioners’ project and asked to provide feedback on two project themes: an integrated rural training pathway and learning hubs in rural towns. The Faculty Board members provided written feedback in response to the two project themes.

Theme 1: Integrated rural training pathway

The concept of rural hubs is appropriate and fully supported, and already exists to some extent in certain areas. It would be important to ensure policy focus is on the areas already functioning well, to build capacity in the areas with established links and partnerships (link with local hospitals +/- teaching of students and registrars).

In terms of the overarching strategy in directing actual trainees (containment of numbers) to rural practice, it is important to note that most medical students will not identify rural general practice as a potential career pathway from the outset. However, general experience and exposure is very important for students and interns to be able to make an informed decision about the path for their professional lives. It would be important to ensure rural exposure strategies are not driven by workforce imperatives alone and that care is given to ensure a quality experience for individuals.

In delivery of the training, should a national rural pathway be pursued, there will be both federal and state funding implications and significant shifts required in terms of the coordination, including involvement from universities, RTPs and local clinical schools. Retaining practice viability in rural areas needs to remain the priority and any additional training load will have a significant impact. Therefore incentivised solutions must prioritise service continuity against a private business model to ensure rural doctors are able to teach as well as see patients.
The Faculty Board reported on a rural internship in Bega for 2015 which is currently in development. Bega currently has year-long students and GP registrars training, with the gap being an intern opportunity. In this location there is significant interest from third and fourth years who are keen to do a whole year in a rural term and recognise that they will get better experience there than in a big teaching hospital where there are not enough patients for learners. A PGPPP placement, a surgical intern and medical intern placement also already exist; however, there has been a gap in emergency. Following recent rule changes it is now possible to place an intern into an emergency without a FACEM, so long as there is clear senior supervision by a Fellow of ACCRM or RACGP. The rural internship in Bega is being developed in collaboration with Australian National University and Canberra Hospital.

In order to make the internship opportunity described above in Bega possible, an intern salary to cover the emergency medicine rotation is required. This funding is currently difficult to secure across jurisdictions as NSW Health is not able to fund it, and Canberra can’t fund a NSW place. The emergency department at Bega is full of patients that would be highly suitable for an intern and an ideal environment for them to develop rural emergency skills.

Theme 2: Learning hubs in rural towns

The Faculty Board expressed strong support for the proposal of learning hubs in rural towns. It was noted that while the Commonwealth currently funds Rural Clinical Schools, they are not specifically GP-focused and not all are interested in GP training. These schools are also limited in number. It was recommended that the relationship with Rural Clinical Schools would need to be negotiated, for learning hubs to function well.

3.5.1.3. Victorian Faculty Board consultation

The RACGP Victorian Faculty Board consultation was held on Tuesday 12 November as part of the Victorian Faculty Board meeting. The Board was provided with an overview of the ‘New approaches to integrated rural training for medical practitioners’ project and following the meeting board members provided written feedback on two project themes: an integrated rural training pathway and learning hubs in rural towns. Feedback was focused on key jurisdictional barriers that need to be taken into consideration in implementing an integrated rural training pathway.

Theme 1: Integrated rural training pathway

Victorian Faculty Board contributions provided suggestions for the structure of a rural GP intern rotation:

- Interns should be allocated to primary healthcare
- Internship training should be coordinated between the primary healthcare and the acute services / area health services
- Internship rotation could be between one area / regional health service
- One model could be a 3-month cycle of rotation between GP practice and specialty medical attachments, such as: surgery, medicine and gynaecology. Allowing two interns to be rotated on a 3-monthly basis between a GP practice and acute service.

The Victorian Faculty Board also highlighted a model previously adopted during the development of a rural super clinic in the Central Highlands. The super clinic had the aim of providing teaching and learning opportunities for medical, nursing and allied health in undergraduate, intern and postgraduate levels. It also included providing teaching and learning opportunities for police, fire, ambulance and rescue services. A key feature of the design of the super clinic was to map which groups had regular active engagement with rural GPs and to allow all of these groups to have some degree of combined or co-located teaching and learning. The purpose of this design was to ensure the training environment provided the opportunity for social interactions, which are vital to success as a rural GP. A lack of exposure to the social mixing of rural life in the rural medical education pathway is seen as a major barrier to rural practice, and as such it is recommended that learning hubs have a broad scope.
Theme 2: Learning hubs in rural towns

The Victorian Faculty Board members were asked to provide feedback on the proposal to create learning hubs in rural towns. Board members expressed support for this approach and agreed that there is a need for a coordination position; a director of medical training. This role was seen as important in identifying role models and motivated teachers/supervisors in general practice in the local community and developing local clusters of students with shared resources among practices. The Victorian Faculty Board also expressed support for a team-based approach that utilises team members other than GPs.

Further recommendations were also made around the benefit of using technology. It was identified that the efficient use of technology could help make the most of resources across regional and even state boundaries. It was recommended that rural general practice education include simulation-based training, and that the development of general practice-based simulation hubs in key regions would be of benefit.

The Victorian Faculty Board also highlighted a project currently underway at The University of Melbourne: Feasibility of Intern Training in Community Health (FITCH). The project headed by A/Professor Ruth McNair has conducted consultations on proposed models of community intern training, including a cluster model and teaching hub.

3.5.1.4. Tasmanian Faculty Board consultation

The RACGP Tasmanian Faculty Board was provided with an overview of the ‘New approaches to integrated rural training for medical practitioners’ project and asked to provide feedback on two project themes: an integrated rural training pathway and learning hubs in rural towns. Tasmanian Faculty Board members provided written feedback in response to the two project themes.

Theme 1: Integrated rural training pathway

There are a number of disconnects within the process that need to be addressed, particularly, although not exclusively, jurisdictional and financial:

- The distance from the primary care placement to the rural training hospital.
- The distance from the primary care placement to their home.
- Recouping the cost of travel in both cases.
- The number and quality of primary care supervisors required.
- The models of supervision, e.g. e-moderation, distance, face-to-face.
- The proposed candidate numbers.
- Addressing consumer requirements, delivery and continuity of service.

In all of these items there are logistic and cost questions that need to be clarified. There needs to be a clear understanding that the rotation fulfils the pressing needs of rural and remote centres better than the current system.

Some concern was also expressed about how a rural GP intern rotation would overlap with the PGPPP and that it may face similar hurdles, including: lack of space, significant supervisor workload, and the need for supervisors to attend to every patient due to the lack of an assigned Medicare number.

Positive feedback was received around the feasibility of incorporating a rural GP rotation into the existing Launceston General Hospital Intern Program. This program currently has four rotations, three being core (DEM, Medicine, Surgery) and one which varies (for example next year it will be surgery). It would be possible to incorporate an optional rural GP pathway stream which would be similar to the PGPPP program. For this to occur, it would be necessary to receive funding to employ more interns at the Launceston General Hospital.
Theme 2: Learning hubs in rural towns

Tasmanian Faculty Board members expressed support for the creation of learning hubs in rural towns. In current arrangements, small, teaching-focused practices, are carrying the weight of placements through universities. These practices accommodate third years, fourth years, John Flynn scholars and Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme students, and are under pressure from universities to take more students each year. This supervisory load is unsustainable. The establishment of a learning hub will help to reduce the supervisory burden on GPs as well as offer a better supervision experience for students. It is also thought that the attraction of registrars through a learning hub model would have a flow on benefit for universities, as registrars are often well equipped to teach students.

3.5.1.5. Western Australian Faculty Board Consultation

The RACGP Western Australian Faculty Board was provided with an overview of the ‘New approaches to integrated rural training for medical practitioners’ project and asked to provide feedback on two project themes: an integrated rural training pathway and learning hubs in rural towns. The Faculty Board members provided written feedback in response to the two project themes.

The WA State Faculty Board supports a more strategic approach to rural training than what has occurred in the past. Training locations must be goal-focused and directed to areas with existing capacity and with a need to ensure the training is responsive to local health needs. The key locations should be planned at a state level and a strong business case developed for the key areas to lead the training. In terms of selection, it is important to acknowledge that no size fits all. Personal issues play a role in rural inclination including choice, expectation, exposure through Rural Clinical Schools, defined scope of practice, increased numbers in future, and family commitments. System issues also play a role; these include little streamlining, inflexibility in the training, credentialing issues for local hospitals, numbers of places to train, infrastructure issues, turf wars and supervisor numbers and burnout.

Thought should be given to creating rural training hubs to address specific skills shortages. For example, GP procedural training units could be established in outer metropolitan or regional hospitals with existing accredited facilities. A GP procedural training unit would allow for supervised training in GP surgery and GP anaesthetics at the same time (and/or GP obstetrics). Programs could focus on emergency and elective procedures appropriate for services provided by GPs. Although a training facility, a procedural training unit would also offer state governments a potential cost savings and a reduction in elective list waiting times compared to similar procedures being performed by consultant surgeons in large metropolitan hospitals.

The ongoing success of this training hub model would allow GPs with the appropriate training to deliver surgical services as part of the comprehensive care in their rural and remote communities. This could reduce the need for patient travel and offer further reductions on the waiting times for surgery. In addition, patients can have specialised care delivered by a known and trusted medical practitioner.

This model could also facilitate a reduction in ‘turf wars’ as GP surgery procedural trainees would not be blocking theatre times otherwise needed by consultant surgeons to perform larger and more complex cases.
The learning hub will be effective in the eastern states where rural means much larger towns than it does in Western Australia. The challenge in WA is providing doctors to the least doctored parts of the state, primarily inlands towns, small towns, in Aboriginal Medical Services and remote towns needing GP proceduralists, which will render the model problematic and ineffectual in places. The issue lies in the current and significant mismatch between training capacity and the areas of need. Currently training capacity sits in all the large coastal towns which are already relatively well doctored. Experience shows that those who train in large coastal towns, tend to stay if they don’t return to the city. Therefore, the only areas large enough in WA to support such a model are Bundbury, Kalgoorlie, Mandurah and possibly Karratha, Broome and Albany. These are the towns with significant numbers of interns and junior doctors, including PGPPP placements, and therefore the capacity to support.

It should be noted that whilst the training hub could work in those towns (outlined above) their ability to take on community interns is quite separate and doubtful given areas such as Kalgoorlie are almost entirely serviced by limited-registration IMGs. Two major problems in increasing junior doctor placements in rural areas are the shortage of experienced, senior GPs to undertake supervision, and the financial model. It is unrealistic to expect to graft a major teaching hospital level of teaching and supervision on a fee for service model in general practice, especially in small towns with only one to three GPs. Should these barriers be addressed (lack of experienced supervisors and the financial model underpinning rural general practice), then the capacity to rotate community interns through these areas might be feasible.

But significant work also would be required in terms of bringing in the key stakeholders to support the community intern ideal. There is strong opposition in many quarters of WA, including the Postgraduate Medical Council (PMC), to establishing intern rotations in rural general practice. There are valid concerns about the capacity of rural general practice in WA to provide the supervision and teaching required. WA is close to saturation point for intern and junior doctor positions in rural hospitals, and any expansion will be into smaller towns where the PMC has concerns about supervision. The other challenge in WA is in the power of the major teaching hospitals, coupled with a teaching hospital-centric view of the world in the PMC and the Medical Board.

3.5.1.6. South Australian and Northern Territory Faculty Board consultation

The RACGP South Australian and Northern Territory Faculty Board were provided with an overview of the ‘New approaches to integrated rural training for medical practitioners’ project and asked to provide feedback on two project themes: an integrated rural training pathway and learning hubs in rural towns. The SA/NT Faculty Board members provided written feedback in response to the two project themes.

The SA/NT Faculty recognises the ongoing workforce issues for rural general practice. South Australia has a small population with only a few large country towns. This limits the attractiveness and sustainability of non GP medical services with only a few surgeons, paediatricians, obstetricians and physicians living and working in rural areas. Although this presents opportunities for procedural GPs, the number of training positions is limited and likely to get worse with the growing number of junior doctors. Rural generalism is being promoted as a solution; however, if it takes precedence over the current rural training offered by RTPs it will not increase capacity. We must recognise that two-thirds of the current rural GP workforce had origins in the city and many city GPs undertake locums in country areas. We should not create artificial barriers to urban doctors practising in rural areas; such divisions will inevitably lead to more problems.
Section 4: Research component

4.1. Introduction

The context of rural general practice and expanded role of the rural GP

General practice functions at the centre of an effective primary healthcare system, providing person-centred, continuing, comprehensive and coordinated holistic healthcare to individuals and families in their communities. The delivery of general practice in a rural or remote context offers its own diversity in terms of community demographics and infrastructure, disease distribution, geographic challenges and patient-access barriers, clinical variety, professional skill and responsibility and workforce requirements. Geographic isolation and access to services also contribute to poorer health outcomes for rural and remote communities. For many rural populations, access to specialist services in regional centres or cities comes at significant expense, including time away from work and family, transport costs and dependence upon transport availability. Each community is unique and presents a challenging setting for those providing healthcare and working to improve health outcomes.

The workforce shortage of doctors in all specialties outside of metropolitan areas is well documented. Social dislocation and professional isolation are cited as disincentives to recruitment and retention of doctors for rural and remote communities, and many communities do not have the population to sustain specialist services. While technology is being applied to break down barriers to specialist care through telehealth and e-health developments, rural and remote populations still require access to local procedural and non-procedural secondary care services (such as emergency care) within their community.

GPs manage undifferentiated presentations and may encounter almost any condition, acute or chronic, in their daily practice. However, for rural GPs this is likely to occur in an environment where specialist support is not immediately available. They are often engaged in work that requires a high level of confidence and competence across broad skill areas, such as emergency care and on call services, given they are the only available workforce. Therefore the crucial determinants of requisite skills rest in the context in which GPs are providing care, and the health needs of the community in which they work. Rural GPs require the skills, confidence and resilience to provide care for a broad range of illnesses in settings with varying levels of available resources, equipment and facilities and to work independently where less specialist support is available.

Skill requirements fluctuate throughout the career of a rural GP as they respond to the changing needs of their community (such as change in disease profile), upskill for remuneration imperative, ensure practice viability, adapt to changes in government policy and environment (such as rural hospital closures), or change in areas of interest. GPs may respond to the changes by acquisition of advanced skills. Advanced rural skills training (ARST) is the mechanism by which rural GPs may extend their expertise in a particular area and enhance their capacity to provide secondary-level care to their community. These skills encompass knowledge as well as physical and practical capabilities. ARST can be undertaken in both procedural and non-procedural skill areas; however, current policy and training approaches are predominantly focused toward procedural skill acquisition and maintenance. Clarification is needed of the skills required by the profession to service rural and remote communities to ensure the areas of the highest need for a particular community profile are prioritised, and accurately reflect the nature and the context of rural general practice.

The ability to acquire, practise and maintain advanced skills is crucial to securing a resilient, multi-skilled general practice workforce which is confident and competent to meet location specific service gaps and address the challenges presented by rural general practice. Insufficient opportunity to acquire these skills and the concerns around skill maintenance in rural areas are well documented. There needs to be a broader approach to training for both existing and future rural doctors in order to address the maldistribution of the rural health workforce. Key outcomes from this research will inform future policy concerning targeted supports for advanced skills in rural general practice.

Objectives

This research seeks to highlight the complexity of rural general practice and clarify the advanced skillsets sought by GPs to meet, safely and confidently, the needs of their rural communities. Section 4.2 explores the current definitions of advanced skill and the emphasis on procedural skills through a literature review. Section 4.3 reports on the research component which aims to identify the barriers and enablers to the acquisition and maintenance of advanced skills, and to clarify the skills required by the profession to meet the healthcare needs of their rural communities. Recommendations for future policies that will support and strengthen the advanced skill capacity of the rural GP workforce are outlined in the executive summary at Section 2 (2.2.4).

4.2. Defining advanced skills in rural general practice

Introduction

Smaller rural and remote communities do not have the population size or the accessibility to sustain specialist services, often leaving a service deficit in many areas. It is within this context that rural GPs often practise advanced skills as part of their comprehensive care to meet the needs of the patients in their community. However, there is no agreed or peer-recognised definition of an advanced skill and very little clarity around what accurately constitutes an advanced skill, and as a result funding and support priorities are inadequate and somewhat misdirected. This paper explores current definitions of advanced rural skills in the literature and highlights the lack of clarity and consistency in language, as well as the need to broaden current definitions to reflect the full range of advanced skills practised in rural general practice.

Method

A literature review of procedural and non-procedural advanced rural skills was conducted through the RACGP John Murtagh Library. Search terms included: advanced rural skill, general practice advanced skill, procedural GP, non-procedural advanced skill, rural general practice.

Articles included were relevant to Australian general practice, and offered some form of definition around the aforementioned search terms. Definitions were also identified through a Google search.

Results

Defining advanced skills

There is a distinct shortage of literature offering a definition for an advanced skill, with existing descriptions narrowly focused on procedural skills or the GP-proceduralist. The GP-proceduralist has historically embodied what it meant to have an advanced skill general practice. A study of the landscape of GP procedural practice, defines GP-Proceduralist as a ‘highly trained cohort of GPs that have historically provided anaesthetics, obstetric, surgical and other routine and emergency procedural interventions for patients in local communities’ (pg. 2). It also acknowledges and utilises the definition of GP-proceduralist offered by Dunbabin 2002, which distinguishes between GPs who perform minor procedures and those who perform more advanced procedural work, defining the clinical parameters by which each procedural advanced skill area is determined. Robinson et al. noted the useful but competing definitions of general practice and procedural medicine.

These definitions give no recognition to GPs with non-procedural or knowledge-based advanced skills extending beyond surgical, maternal and emergency care. These existing definitions are becoming increasingly inaccurate as the broader advanced skill areas relevant to rural general practice are being increasingly recognised. However, a broader skillset is somewhat recognised through advanced rural skills training (ARST), which facilitates the acquisition of both practical and knowledge based advanced skills relevant to rural general practice. Allan & Schaefer 2005 explain that topic choices for ARST are defined by the nature of rural general practice, which involves more emergency, procedural and community based care than an equivalent based practice in an urban setting. According to McKenzie et al ARST is a platform to broaden skills beyond the normal scope of general practice training, in areas both procedural and non-procedural. The availability of both procedural (anaesthetics, obstetrics, emergency and surgery) and non-procedural (Aboriginal and Torres Strait Islander Health, paediatrics, adult internal medicine, mental health, population health, palliative care) ARST is evidence of the professional recognition of the breadth of skills sought by GPs to meet the needs of rural and remote communities. However, this training is ad hoc, and those acquiring the skills needed in their community do so within a health system that does not recognise or value all of these advanced skills.

1. Robinson M, Slaney GM, Jones GI & Robinson JB. GP Proceduralists ‘the hidden heart’ of rural and regional health in Australia, Rural and Remote Health (online) 2010, 10:1402.
Advanced skills research

Advanced skill and general practice research agendas have also predominantly focused on procedural advanced skills, despite the need for research into the use of advanced skills in areas of growing global concern such as chronic disease and mental health. Glazebrook & Harrison (2006) identified obstacles to the maintenance of advanced procedural skills by rural GPs, many of which would undoubtedly be applicable to the maintenance of non-procedural skills as well, including lack of opportunity, expense, access to locum relief and funding, lack of flexible delivery options for education, access to training, time constraints, credentialing and recognition issues, family obstacles and medico-legal issues.1 The research survey, undertaken as part of this project (Section 4.3), identifies some of the barriers impacting on the maintenance and use of the full range of advanced skills in order to fill some of these information gaps.

Acknowledging the service deficits in rural areas encourages broader understanding around the need for advanced skills in rural general practice. Research by Pegram et al. 2005 describes the current patterns, problems and solutions to the provision of specialist services in rural and remote areas, strongly emphasising the importance of GPs gaining procedural advanced skills to address service deficits.2 Acknowledgement is also given to the service gaps left by non-procedural specialties (such as psychiatry and paediatrics).2 Issues around access equity arise from these service gaps, with rural GPs having little choice but to provide the best care they can with the skillset they have acquired, transferring responsibility of care out of the local community if service requirements cannot be met safely.

The narrow perception of advanced skills is also evident in recent research undertaken to measure advanced skill attainment. Datasets such as the NSW Rural Doctors Network research ‘Procedural Medicine in Rural and Remote NSW’ and the Rural Health Workforce Australia Minimum Data Set report in 2012 are heavily focused on procedural skills (the latter includes the provision of Aboriginal health services as well).3,4 There has been no equivalent research undertaken on the full range of advanced skills required by the general practice workforce in Australia. The research in Section 4.3 clarifies that the scope of skills has broadened, highlighting the need to guide stakeholders toward a more realistic view of general practice advanced skills that extend beyond hospital-based and procedural-skill services.

Structural constraints

Policies and criteria for remuneration and recognition of advanced skills are ad hoc, characterised by jurisdictional complications and competing interests. Some advanced skills carry a remunerative imperative, as well as agreed requirements for ongoing maintenance of professional standards. These operational requirements impose a responsive definition of advanced skills within the sector that is not consistent with that understood by the general practice profession.

The issue is deeply embedded in the value and recognition of some advanced skills over others. Recognition is needed for GPs addressing unmet patient needs in their local context, acknowledging a broader range of skills that is required to achieve this level of service delivery.

However, caution must be taken to ensure that this recognition is not tied to remuneration or imposed ongoing professional maintenance standards, given that the suitability of this model is not consistent across the skillset and could act as a deterrent rather than an enabler. A skill-acquisition pathway is required for practising rural GPs which provides flexible and ongoing support for the use and maintenance of advanced skills. This includes supports for those who wish to upskill to meet a need in their community.

Support for advanced skill acquisition and maintenance

Two programs are currently available to support GPs in the acquisition and maintenance of procedural advanced skills; however, this support does not extend to non-procedural skills. The Rural Procedural Grants Program (RPGP) supports rural GPs in maintaining procedural skills, and the General Practitioner Procedural Training Support Program (GPPTSP) supports GPs in attaining procedural skills in obstetrics or anaesthetics only.\(^1\)\(^2\) GPs require flexibility and support to adapt and acquire skills as the needs of their community change, and this limited support does not enable responsiveness. This is a significant policy gap and a much broader approach to training and support for rural GPs is required.

Conclusion

The review of current literature around advanced rural skills highlights that there is no accepted, consistent or comprehensive definition of an advanced skill, demonstrating the narrow focus toward procedural skills. Without a definition that reflects the context in which advanced skills are required and represents the full range of skills needed in rural communities, these narrow definitions facilitate the bias in research toward procedural skills and the ad hoc approach to skill recognition.

There is undeniable value in patient access to procedural advanced skills in their rural and remote communities, without which emergency and maternity services and various other essential services would not be available locally. The issue lies in the absence of recognition that these are not the only additional skills required to address patient need in rural communities. Recognition of the broader range of generalist skills required by rural GPs to provide continuing, comprehensive, patient-centred holistic care in a rural context is increasing, supported by the findings of the research in Section 4.3. Research and policies to support skill acquisition and maintenance must also expand to align more closely with the advanced skill areas acquired and practised in rural communities in response to patient need.

4.3. Research – advanced skills in rural general practice

Title

Acquisition, practise and maintenance of advanced skills: addressing patient need in rural general practice

Abstract

Objective: GPs acquire advanced skills in order to address patient demand or particular health needs in rural communities. Current training and support is targeted toward the acquisition and maintenance of procedural skills, with no equitable strategies supporting rural GPs looking to acquire or maintain non-procedural skills. The range of skills needed and currently practised in rural communities requires clarification to ensure that investment in advanced skill acquisition encompasses the broad range of skills needed to address the health needs of rural communities. Method: The qualitative and quantitative results from a survey of Australian rural GPs are reported. Free-response survey questions were analysed for major themes. Participants: RACGP National Rural Faculty members, excluding students and members living overseas (8277 total). Results: Twenty per cent (1722) of surveys were completed, with participants reporting a range of demographic characteristics. Survey responses identified and prioritised the range of advanced skills being practised and in demand in rural communities, and identified new skills they would acquire to meet a patient-driven need in their community. The data highlights the low rates of procedural skill practise and the prominence of non-procedural advanced skills in addressing the needs of rural communities. Barriers to and enablers for advanced skill acquisition, practise and maintenance were explored, confirming the need for increased training and support for rural GPs. Conclusion: This research has shown that the range of advanced skills needed to address patient-driven health needs in rural communities extends well beyond procedural, highlighting the prominence of non-procedural skills and the need to extend training and support approaches to reflect these findings. The lack of opportunity to acquire and maintain advanced skills, and concerns around skill maintenance for the existing workforce need to be addressed in any future workforce planning, with targeted strategies to support both skill acquisition and maintenance for the current and future workforce.

Aim

To identify barriers to and enablers for rural GPs to acquire and maintain advanced skills; and to clarify the range of advanced skills currently being acquired and practised by rural GPs in order to meet the needs of their community.

Method

A cross-sectional survey of Australian rural GPs was conducted, with a cohort of 8277 sourced through the RACGP National Rural Faculty membership database. The Dillman protocol was adapted and applied to this research survey in order to maximise the survey response rate. The multiple choice and free-response survey questions were emailed to the entire cohort, allowing 2 weeks for participants to respond.\(^1\) Data to assign the ASGC-RA (2006) based on a responder’s current postcode was sourced from the Australian Bureau of Statistics. Chi-squared tests were used to assess whether questionnaire responses varied by age group, state and ASGC-RA. Ethics approval for the research was granted by the RACGP National Research and Evaluation Ethics Committee, noting that this approval is not an endorsement of any product associated with the research.

Results

Demographics

Of the 8277 NRF members invited to participate in the survey, 1722 completed surveys were submitted within the 2 week period (response rate 20.8%). The age distribution of participants was found to be broadly similar when compared with that of the GP workforce nationally. Outer regional, remote and very remote locations were over-represented in the questionnaire responses, compared with the distribution of locations in the NRF membership (table 1). The distribution of states was generally similar between survey respondents and the NRF membership; however, members from the Northern Territory and Western Australia were slightly over represented in the survey responses.

Table 1: Demographics of survey respondents

<table>
<thead>
<tr>
<th>ASGC-RA (2006)</th>
<th>Survey respondents</th>
<th>NRF Membership</th>
<th>GP workforce data1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Major cities of Australia</td>
<td>287 (16.8)</td>
<td>3406 (33.3)</td>
<td>19420 (66.9)</td>
</tr>
<tr>
<td>Inner Regional Australia</td>
<td>594 (34.8)</td>
<td>3781 (37.0)</td>
<td>5747 (19.8)</td>
</tr>
<tr>
<td>Outer Regional Australia</td>
<td>579 (33.9)</td>
<td>2331 (22.8)</td>
<td>2642 (9.1)</td>
</tr>
<tr>
<td>Remote Australia</td>
<td>142 (8.3)</td>
<td>352 (3.4)</td>
<td>661 (2.3)</td>
</tr>
<tr>
<td>Very remote Australia</td>
<td>104 (6.1)</td>
<td>346 (3.4)</td>
<td>541 (1.9)</td>
</tr>
<tr>
<td>State</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>18 (1.0)</td>
<td>97 (1.0)</td>
<td>440 (1.5)</td>
</tr>
<tr>
<td>New South Wales</td>
<td>435 (25.3)</td>
<td>2691 (26.8)</td>
<td>8998 (31.0)</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>76 (4.4)</td>
<td>212 (2.1)</td>
<td>479 (1.7)</td>
</tr>
<tr>
<td>Queensland</td>
<td>426 (24.7)</td>
<td>2622 (26.1)</td>
<td>6199 (21.4)</td>
</tr>
<tr>
<td>South Australia</td>
<td>128 (7.4)</td>
<td>761 (7.5)</td>
<td>2348 (8.1)</td>
</tr>
<tr>
<td>Tasmania</td>
<td>82 (4.8)</td>
<td>457 (4.6)</td>
<td>770 (2.7)</td>
</tr>
<tr>
<td>Victoria</td>
<td>414 (24.0)</td>
<td>2243 (22.3)</td>
<td>7033 (24.2)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>223 (13.0)</td>
<td>956 (9.5)</td>
<td>2744 (9.5)</td>
</tr>
</tbody>
</table>

^ Respondents can record more than one state in order to capture GPs working in multiple locations.

The majority of participants (83.9%) graduated between 1980 and 2009, and when asked to identify the qualifications participants held, the most commonly reported was the FRACGP (64.1%) followed by registrars in training (18.5%). Approximately 10% held a FACRRM, 6.5% a FRACGP/FARGP and 16.4% of participants also held a DRANZCOG. One-third (30.7%) of participants provided additional qualifications in various areas, including obstetrics and gynaecology, anaesthetics, child health, public health, tropical medicine, musculoskeletal medicine and dermatology. Several respondents indicated they had passed AMC exams, but it is unclear as to whether this was an additional qualification, or their progression to date. More than half (51.7%) of the participants identified as international medical graduates.

Participants were asked to choose the best description of their current role in the workforce and were able to select only one answer. Forty-four percent identified themselves as a GP, and 27.4% as a rural GP. Less common responses included GP/VMO proceduralist (8.4%), GP rural generalist (5.9%), rural locum (2.9%), district medical officer (2.1%), GP registrar (2.0%), educator (1.2%) and academic (0.9%).

Participants worked in a variety of practice settings (see Table 2). Although 69.0% had been in that role less than 5 years, more than half (50.9%) of the cohort indicated that they intend to remain in rural general practice for 5 or more years (29.0% of these for more than 10 years). One-quarter of participants indicated that they did not have an advanced skill.

Table 2: Practice setting

<table>
<thead>
<tr>
<th>Practice setting</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural general practice</td>
<td>791</td>
<td>(46.0)</td>
</tr>
<tr>
<td>Regional general practice</td>
<td>457</td>
<td>(26.6)</td>
</tr>
<tr>
<td>District hospital</td>
<td>281</td>
<td>(16.4)</td>
</tr>
<tr>
<td>Urban general practice</td>
<td>199</td>
<td>(11.6)</td>
</tr>
<tr>
<td>Aboriginal community controlled health service</td>
<td>138</td>
<td>(8.0)</td>
</tr>
<tr>
<td>Remote general practice</td>
<td>125</td>
<td>(7.3)</td>
</tr>
<tr>
<td>District health service</td>
<td>47</td>
<td>(2.7)</td>
</tr>
<tr>
<td>Private hospital</td>
<td>38</td>
<td>(2.2)</td>
</tr>
<tr>
<td>Royal Flying Doctors Service</td>
<td>31</td>
<td>(1.8)</td>
</tr>
<tr>
<td>Rural Clinical School</td>
<td>29</td>
<td>(1.7)</td>
</tr>
<tr>
<td>Tertiary education sector</td>
<td>26</td>
<td>(1.5)</td>
</tr>
<tr>
<td>Government health department</td>
<td>22</td>
<td>(1.3)</td>
</tr>
</tbody>
</table>

* Respondents can select more than one answer

Skills acquisition and use

Participants were asked to provide each of the advanced skills they had acquired and those currently being used in their practice (Table 3). In terms of skill attainment, emergency medicine (38.7%) was the most commonly acquired skill, followed closely by mental health (31.1%), chronic disease management (27.6%), obstetrics (26.2%), paediatrics (24.0%), small town rural general practice (23.8%), Aboriginal and Torres Strait Islander health (23.0%), palliative care (20.1%) and aged care (19.3%). Common responses in the ‘other’ field for skill acquired and currently in use include dermatology/skin cancer medicine, drug and alcohol management and sexual/women’s health. The most commonly practised skills followed a similar pattern, though the non-procedural skill areas were more prominent (Table 3).

Practice rates can be derived from the data presented in Table 3. Obstetrics and anaesthetics have the highest rates of non-practice (40.1% and 41% respectively). Most non-procedural skills (excluding tropical disease medicine) had low non-practice rates, or practice rates that exceed that of skill acquisition.
Skill acquisition and current practice data was stratified by state (Appendix 1.1 & Appendix 1.2). Most notably, South Australia had more GP-proceduralists in comparison with other states, also reporting higher rates of current procedural skill use. Table 3 shows the advanced skills with current usage percentages >20%, stratified by state. In five states (ACT, NSW, QLD, TAS and VIC) mental health is the leading skill used in rural general practice, and its most prevalent use is in the NT (42.9%). Aboriginal and Torres Strait Islander health (55.6%) and chronic disease management (44.4%) are the most commonly used skills overall in the NT. Emergency medicine is most commonly used in SA (58.5%) and WA (40.3%) followed by paediatrics (33.1% and 32.3% respectively) and mental health (33.1% and 29.9% respectively).

Table 3: Skill acquisition and current skill use

<table>
<thead>
<tr>
<th>Advanced skill</th>
<th>Acquired n (%)</th>
<th>Current use n (%)</th>
<th>States in which usage is &gt;20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>535 (31.1)</td>
<td>591 (34.5)</td>
<td>All</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>666 (38.7)</td>
<td>557 (33.6)</td>
<td>All, except ACT</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>474 (27.6)</td>
<td>516 (30.1)</td>
<td>All, except ACT</td>
</tr>
<tr>
<td>management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>412 (24.0)</td>
<td>468 (27.3)</td>
<td>All</td>
</tr>
<tr>
<td>Aged care</td>
<td>332 (19.3)</td>
<td>382 (22.3)</td>
<td>NSW, VIC, SA &amp; WA</td>
</tr>
<tr>
<td>Small town rural</td>
<td>409 (23.8)</td>
<td>365 (21.3)</td>
<td>NSW, VIC, WA &amp; SA</td>
</tr>
<tr>
<td>general practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal &amp; Torres</td>
<td>396 (23.0)</td>
<td>354 (20.6)</td>
<td>NSW, NT, QLD, WA</td>
</tr>
<tr>
<td>Strait Islander health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative care</td>
<td>345 (20.1)</td>
<td>352 (20.5)</td>
<td>NSW, NT, VIC, SA &amp; WA</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>278 (16.2)</td>
<td>344 (20.1)</td>
<td>NSW, NT, QLD, SA, TAS, WA</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>451 (26.2)</td>
<td>270 (15.7)</td>
<td>SA &amp; NT</td>
</tr>
<tr>
<td>Public health</td>
<td>174 (10.1)</td>
<td>175 (10.2)</td>
<td>NT</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>261 (15.2)</td>
<td>154 (9.0)</td>
<td>None</td>
</tr>
<tr>
<td>Surgery</td>
<td>164 (9.5)</td>
<td>154 (9.0)</td>
<td>None</td>
</tr>
<tr>
<td>Defence health</td>
<td>39 (2.3)</td>
<td>27 (6.1)</td>
<td>None</td>
</tr>
<tr>
<td>Tropical diseases</td>
<td>132 (7.7)</td>
<td>93 (5.4)</td>
<td>None</td>
</tr>
<tr>
<td>Refugee health</td>
<td>62 (3.6)</td>
<td>51 (3.0)</td>
<td>None</td>
</tr>
<tr>
<td>N/A (don’t have advanced skill)</td>
<td>458 (26.6)</td>
<td>437 (25.0)</td>
<td></td>
</tr>
</tbody>
</table>

^ Respondents can select more than one answer
Skill acquisition and current practice data was stratified by ASGC-RA classification system and age. Procedural skill areas showed an increase in prevalence associated with remoteness, though remote participants (RA-4) were least likely to be practising their *acquired* surgical skills. Overall those in more remote areas reported they had acquired more skills ($P<0.05$), particularly skills in Aboriginal and Torres Strait Islander health, emergency medicine, tropical diseases, chronic disease management, public health and obstetrics skills. All areas (with the exception of defence and refugee health) showed a significant increase in *acquisition* associated with the age of the doctor, indicating that older GPs had generally *acquired* more skills. Younger respondents were more likely to indicate a desire to acquire a new skill.

**New skills acquisition to meet a community need**

Participants were asked to select skills they would acquire in order to meet a need in their rural community, with the ability to make multiple selections and enter free text (table 4). Emergency medicine was the most prevalent response (28.3%), followed by palliative care (24.2%), pediatrics (22.4%) mental health (22.3%), aged care (19.1%) and chronic disease management (18.5%). Twenty-one percent of respondents indicated they would not acquire a new skill, though 42.1% of these were aged 60 and over. Stratified by ASGC-RA, data (Appendix 1.3) indicated that very remote areas (RA-5) had most demand for emergency, anaesthetics and obstetric skills. Demand increased with rurality for many of the non-procedural skills, with the exception of palliative care, which was more relevant to inner and outer regional areas (RA2 and RA3).

State-based analysis showed few statistically significant differences between states, with the exception of tropical disease medicine, which was reported most commonly by Queensland participants. Further skill-specific analysis is presented on p 147.
Table 4: New skill acquisition

<table>
<thead>
<tr>
<th>Skill acquisition to meet a need in respondents’ community</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medicine</td>
<td>484</td>
<td>(28.3)</td>
</tr>
<tr>
<td>Palliative care</td>
<td>414</td>
<td>(24.2)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>384</td>
<td>(22.4)</td>
</tr>
<tr>
<td>Mental health</td>
<td>382</td>
<td>(22.3)</td>
</tr>
<tr>
<td>Aged care</td>
<td>326</td>
<td>(19.1)</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>317</td>
<td>(18.5)</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>285</td>
<td>(16.7)</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>269</td>
<td>(15.7)</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander health</td>
<td>249</td>
<td>(14.6)</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>232</td>
<td>(13.6)</td>
</tr>
<tr>
<td>Surgery</td>
<td>215</td>
<td>(12.6)</td>
</tr>
<tr>
<td>Public health</td>
<td>173</td>
<td>(10.1)</td>
</tr>
<tr>
<td>Small town rural general practice</td>
<td>158</td>
<td>(9.2 )</td>
</tr>
<tr>
<td>Refugee health</td>
<td>128</td>
<td>(7.5 )</td>
</tr>
<tr>
<td>Tropical diseases</td>
<td>117</td>
<td>(6.8 )</td>
</tr>
<tr>
<td>Defence health</td>
<td>37</td>
<td>(2.2 )</td>
</tr>
<tr>
<td>Dermatology</td>
<td>24</td>
<td>(1.4 )</td>
</tr>
<tr>
<td>None</td>
<td>350</td>
<td>(20.5)</td>
</tr>
</tbody>
</table>

* Respondents can select more than one answer

Training and support requirements – practising, maintaining and regaining competence in advanced skills

Ninety-three percent of participants with an advanced skill indicated they intend to continue to apply their skills in a rural community. In order to undertake new skill acquisition, participants indicated they would require a range of supports including training opportunity (76.6%) and financial incentives (60.2%). The need for study leave increased with rurality though this was not statistically significant (P<0.07); study leave was required most commonly by the 30-39 year age group (45.0%, P=0.0002). Free text responses included time, financial support and locum relief.

The survey asked participants to identify the supports they require to maintain and regain competence (for those no longer practising) in their advanced skills (Table 5) The most commonly reported supports required across both groups were training opportunity (62.1% for skill maintenance; 21.1% for regaining competence) and financial incentive (46.4% and 14.2% respectively); skill competence training also commonly required for regaining competence (17.0%). Data stratified by age indicated that financial incentive and certification are required least commonly in the oldest (60+) and youngest (18–29) age groups.
Table 5: Acquiring, maintaining and regaining competence in advanced skills

<table>
<thead>
<tr>
<th>Support needed to acquire a new rural skill ^</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training opportunity</td>
<td>1293</td>
<td>(76.6)</td>
</tr>
<tr>
<td>Financial incentive</td>
<td>1017</td>
<td>(60.2)</td>
</tr>
<tr>
<td>Professional support</td>
<td>768</td>
<td>(45.5)</td>
</tr>
<tr>
<td>Study leave</td>
<td>657</td>
<td>(38.9)</td>
</tr>
<tr>
<td>Supervisor</td>
<td>469</td>
<td>(27.8)</td>
</tr>
<tr>
<td>Other</td>
<td>207</td>
<td>(12.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supports required to maintain skill ^</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training opportunity</td>
<td>1065</td>
<td>(62.1)</td>
</tr>
<tr>
<td>Financial incentive</td>
<td>795</td>
<td>(46.4)</td>
</tr>
<tr>
<td>Professional support</td>
<td>732</td>
<td>(42.7)</td>
</tr>
<tr>
<td>Study leave</td>
<td>619</td>
<td>(36.1)</td>
</tr>
<tr>
<td>Supervision</td>
<td>277</td>
<td>(16.2)</td>
</tr>
<tr>
<td>Locum support</td>
<td>272</td>
<td>(15.9)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>436</td>
<td>(25.4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support required to regain competence in advanced rural skill ^</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A (I am using my skill, or I haven’t acquired an advanced rural skill)</td>
<td>1050</td>
<td>(61.6)</td>
</tr>
<tr>
<td>Training opportunity</td>
<td>360</td>
<td>(21.1)</td>
</tr>
<tr>
<td>Skill competence training</td>
<td>290</td>
<td>(17.0)</td>
</tr>
<tr>
<td>Financial incentive</td>
<td>242</td>
<td>(14.2)</td>
</tr>
<tr>
<td>Certification</td>
<td>163</td>
<td>(9.6 )</td>
</tr>
<tr>
<td>Position in hospital</td>
<td>156</td>
<td>(9.2 )</td>
</tr>
<tr>
<td>Opportunity in clinic</td>
<td>151</td>
<td>(8.9 )</td>
</tr>
<tr>
<td>Sub-specialty training</td>
<td>138</td>
<td>(8.1 )</td>
</tr>
<tr>
<td>Study leave</td>
<td>133</td>
<td>(7.8 )</td>
</tr>
<tr>
<td>Correct skill mix in the community</td>
<td>104</td>
<td>(6.1 )</td>
</tr>
</tbody>
</table>

^ Respondents can select more than one answer

Support requirements for skill maintenance generally increased with rurality, however this pattern was not present in all regaining competence data (see Appendix 1.4). The need for training opportunity to regain competence increased with rurality, and the need for positions in hospitals and opportunities in clinics decreased with rurality. Study leave was most commonly required for skill maintenance by those in remote areas, RA-4 (10.6%) and RA-5 (10.7%).
In examining skill maintenance data by state, few differences are observed in support requirements. However, South Australian and Northern Territory participants indicate a strong need for several support areas including training opportunity (72%; 71.4%), financial incentive (55.1%; 46.0%), professional support (56.8%; 41.3%) and study leave (44.1%; 55.6%). Support requirements for regaining skill competence were similar between the states. Those in the Northern Territory were most likely to require study leave to regain competence, whereas those in Tasmania were most likely to require opportunity in clinic to regain competence. Both Tasmania and the Northern Territory had significantly higher study leave requirements than other states (15.4% and 17.5% respectively; P=0.04).

Competing factors were identified for the ability of participants to practise advanced skills (Table 6). Skill maintenance (41.3%), service demand (25.1%) and lack of remuneration (21.0%) were the most common factors impacting on skill utilization. Those in more rural areas were generally more likely to report competing factors for their ability to practise skills. Lack of career pathway, credentialing arrangements, lack of inter-professional team and skill-maintenance issues were significant competing factors for RA-5 participants when compared with other ASGC-RA classification regions. Hospital infrastructure is most problematic in remote Australia (RA-4). Older persons were more likely to report skill maintenance, lack of remuneration and credentialing arrangements as competing factors for their ability to practise skills. Lack of career pathway was more of an issue for younger respondents (18–39 years).

Table 6: Competing factors

<table>
<thead>
<tr>
<th>Competing factors impact on ability to practise skills ^</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skill maintenance</td>
<td>707</td>
<td>(41.3)</td>
</tr>
<tr>
<td>Service demand</td>
<td>430</td>
<td>(25.1)</td>
</tr>
<tr>
<td>Lack of remuneration</td>
<td>360</td>
<td>(21.0)</td>
</tr>
<tr>
<td>Hospital infrastructure</td>
<td>300</td>
<td>(17.5)</td>
</tr>
<tr>
<td>Credentialing arrangements</td>
<td>275</td>
<td>(16.1)</td>
</tr>
<tr>
<td>Lack of professional recognition</td>
<td>274</td>
<td>(16.0)</td>
</tr>
<tr>
<td>Lack of inter-professional team</td>
<td>219</td>
<td>(12.8)</td>
</tr>
<tr>
<td>Clinic infrastructure</td>
<td>201</td>
<td>(11.7)</td>
</tr>
<tr>
<td>Specialist completion</td>
<td>176</td>
<td>(10.3)</td>
</tr>
<tr>
<td>Lack of career pathway</td>
<td>176</td>
<td>(10.3)</td>
</tr>
<tr>
<td>Other (eg. family commitments, time constraints, insurance, bureaucracy and government policy, Medicare)</td>
<td>120</td>
<td>(7.0)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>571</td>
<td>(33.4)</td>
</tr>
</tbody>
</table>

^ Respondents can select more than one answer.

There were few clear differences in competing factors for the ability to practise skills between states. Exceptions were skill maintenance, which was reported highest in the Northern Territory (54.8%) and South Australia (50.9%), and credentialing arrangements, which were least likely to be reported in Victoria (11.6%) and Tasmania (6.9%) and most problematic in Western Australia (21.0%) and ACT (23.1%). The Northern Territory was least likely to report lack of remuneration as a barrier (11.3%). Lack of career pathway was more commonly reported as an issue in the ACT (15.4%) and the Northern Territory (16.1%).
Skills in focus

Mental health

Mental health is the leading advanced skill currently used in rural general practice in five states (ACT, NSW, QLD, TAS and VIC), the second highest in South Australia and third highest in Western Australia and the Northern Territory. It had the highest rates of current use overall (34.5% of respondents), and has been acquired by 31.1% of respondents. There is little difference in the prevalence of skill use between ASGC-RA, and all states demonstrated significant skill use with the Northern Territory having the highest prevalence (42.9%). Mental health advanced skills would be acquired by 22.3% of respondents as a new skill to meet community needs. Though prominent in all geographic areas and states, it was reported highest by remote participants (RA-4: 27%) and those in the Northern Territory (27%).

Emergency medicine

Approximately 60% of respondents indicated that emergency medicine is relevant in rural general practice. However, only 38.7% have acquired it and 33.6% currently using it. More than 16% of those with the skill are not currently using it. It is the most acquired skill and second highest current use prevalence, with usage rates above 20% in all states with the exception of the ACT. It is the leading advanced skill in South Australia (58%) and Western Australia (40.3%), second highest skill in New South Wales and Victoria, and third highest in Queensland and Tasmania. Current use of emergency medicine advanced skills increased significantly with remoteness, from 32.7% in inner regional (RA-2) to 51.9% in very remote (RA-5).

More than 28% indicated they would acquire that skill to meet a community need, most commonly in remote Australia (RA-4) and in ACT, NT & WA.

Chronic disease management

Advanced skills in the management of chronic disease are currently used by 30% of survey respondents, though 27.6% indicated that they have acquired the advanced skill. As the third highest utilised skill, it is reportedly used by more than 20% of respondents across all states with the exception of the ACT. Remote and very remote GPs (RA-4 & RA-5) demonstrated significantly higher usage of this skill (33.8 and 46.2%; P=0.004). Current skill usage is above 20% in all states with the exception of the ACT. The Northern Territory, Tasmania, New South Wales and Queensland have the most prevalent use of chronic disease management advanced skills.

Nineteen per cent of respondents indicated they would acquire chronic disease management advanced skills to address a need in their community, and this response was consistent across ASGC-RA and all states (except ACT). The Northern Territory had the highest desire for new skill acquisition in this area (23.8%).

Paediatrics

Paediatric advanced skills are the fourth highest used skill overall, increasing steadily with remoteness, most notably in very remote areas (40.4%; P=0.03). Twenty-four per cent of respondents indicated they have acquired the skill, however current usage rates exceed this number (27.3%). Rates of current use are well above 20% across all states, significantly higher in the Northern Territory, South Australia, Western Australia and New South Wales (P=0.02). It is the second most prevalent skill currently used in South Australia and Western Australia. Survey respondents identified paediatrics as the third highest ranking skill they would acquire to meet a need in their community (22.4%). There were no statistically significant differences across ASGC-RA. When compared with other age groups, the 30–39 year old age group indicated paediatrics more commonly (P<0.0001). Respondents from the ACT, Northern Territory, South Australia and Victoria were most likely to acquire paediatrics as a new skill.
Aged care

More that one-fifth (22.3%) of participants are currently using advanced skills in aged care, which is slightly more than the reported skill acquisition (19.3%). It is currently used by more than 20% of respondents in New South Wales, Victoria, Western Australia and South Australia. Approximately 19% of respondents indicated they would acquire aged care as an advanced skill to address a community need, with no notable differences in this data between ASGC-RA. Tasmania and Victoria showed statistically significant rates of responses for acquiring aged care as a new skill (31.9% and 23.2% respectively).

Small town rural general practice

Small town rural general practice is an entirely knowledge-based advanced skill, acquired by 23.8% of respondents and currently used by 21.3%. Expectedly, use and acquisition of this skill is significantly more prevalent in the more remote areas of Australia (RA-4 and RA-5). Participants from New South Wales, South Australia, Victoria and Western Australia indicated current usage rates above 20%, highest in South Australia (28.0%). No statistically significant difference in acquisition is evident between states. This particular skill was less favourable in new skill acquisition, with 9.2% of respondents indicating they would acquire it to meet a community need. This response rate was steady across ASGC-RA and states.

Aboriginal and Torres Strait Islander Health

More than one fifth (20.6%) of respondents indicated they are currently using advanced skills in Aboriginal and Torres Strait Islander health, with 23.0% having acquired the skill. Current usage increased significantly with remoteness, from 13.7% in inner regional areas (RA-2) to 56.7% in very remote areas (RA-5). Skill acquisition patterns were similar, although there was a higher proportion of respondents from major cities (RA-1) who had acquired the skill than are currently using. The skill was most commonly acquired and used in the Northern Territory, Queensland, Western Australia and New South Wales (all usage rates >20%). It was reported as the most commonly used skill in the Northern Territory, and the third most commonly used skill in Western Australia.

In order to meet the needs of their community, 14.6% of respondents indicated they would acquire this as a new skill. The likelihood of this increased with rurality, though not significantly. Across the states there was no significant difference noted, however Tasmania had the lowest new skill acquisition response (6.9%) for this particular advanced skill.

Palliative care

Palliative care advanced skills have been acquired by 21.0% of survey respondents, and are currently used by 20.5% of respondents; almost all who have acquired the skill are currently using it in practice. Notably, current use and acquisition by participants in major cities (RA-1) are reported less commonly, but rates are similar across the rural areas. No statistically significant differences were visible across the states in skill use or acquisition.

Despite its relatively lower acquisition and usage, palliative care advanced skills were the second highest reported new skill-acquisition with 24.2% of respondents indicating they would acquire this new skill to meet a community need. This was reported most commonly by participants located in inner and outer regional areas (RA-2 25.1% and RA-3 25.7%). It was the highest skill acquisition area for inner regional participants (RA-2). Current usage rates of >20% were reported by participants in New South Wales, the Northern Territory, Victoria, South Australia and Western Australia. The ACT (38.5%), Tasmania (33.3%) and Victoria (27.1%) were most likely to report a desire to acquire this new skill to address a community need. The Northern Territory was least likely (17.5%).
Internal medicine

Advanced skills in internal medicine had been acquired by 16.2% of respondents, but were reported by 20.1% of respondents as being used currently. More than 20% of respondents from New South Wales, the Northern Territory, Queensland, South Australia, Tasmania and Western Australia all reported that they are using the skill currently. The likelihood of internal medicine skill use increased with remoteness (P=0.01), and this trend was also evident for skill acquisition, though not statistically significant. There was no statistically significant difference in usage between states, though New South Wales (23.4%) and the Northern Territory (22.2%) had the highest reported rates of use. New South Wales (17.5%), South Australia (17.0%) and Western Australia (17.8%) had the highest number of participants who had acquired the skill.

Approximately 14% of survey respondents indicated they would acquire new internal medicine advanced skills in order to meet a need in their community, and this response was similar across ASGC-RA, though slightly more prominent in remote Australia (RA-4 17%). The ACT had the highest response in this area, with 23.1% of respondents from this Territory indicating they would acquire the skill. South Australia (17.1%) and the Northern Territory were the next highest response rates (15.9%).

Obstetrics

Although acquisition of obstetric advanced skills is relatively high (26.2% overall), there is a significant disparity in rates of current use with only 15.7% of respondents indicating current use, meaning that approximately 40% of those with the skill are not currently practising it. The use and acquisition of obstetric skills increases significantly with remoteness (P=0.0002; P=0.04 respectively). South Australia and the Northern Territory are the only states demonstrating current skill use above 20%. South Australia has a significantly higher number of GP-obstetricians than other states (37.3%).

In acquiring a new skill to meet a community need, 16.7% of respondents indicated they would seek obstetrics as an advanced skill. There was no obvious trend associated with remoteness here, though inner regional participants (RA-2) had the lowest response (12.5%). It was the third highest-ranking skill in very remote areas (RA-5), equal with chronic disease management for new skill acquisition. The ACT had the highest interest in acquiring this skill (23.1%).

Public health

Ten per cent of respondents indicated they had acquired and were using advanced skills in public health. The Northern Territory respondents (30.2%) were most likely to have acquired this skill, with Western Australian respondents (7.5%) least likely. Ten per cent of respondents also indicated they would acquire public health advanced skills to address a need in their community, and this response was similar across ASGC-RA and states (though most prevalent in the Northern Territory at 14.3%).

Anaesthetics

Advanced skills in anaesthetics were reportedly acquired by 15.2% of respondents; however only 9.0% of respondents indicated that they were using the skill, meaning that approximately 40% of those who had acquired the skill were not currently practising anaesthetics. The acquisition and use of anaesthetic skills was highest in very remote areas (RA-5). South Australia had the highest reported skill use (17.0%) and skill acquisition (26.3%), with the smaller state and Territory, Tasmania and ACT, reporting no use of anaesthetics advanced skills. Eight per cent of GPs in Tasmania had reportedly acquired the skill. Of the respondents from Western Australia, 20.8% had acquired advanced skills in anaesthetics, but only 11.9% were reported to be currently using that skill.
In order to address the need of a rural community, 15.7% of respondents indicated they would acquire the anaesthetic advanced skillset. This response was most prevalent in very remote (RA-5 25%) and remote (RA-4 22.0%), and significantly lower in inner regional areas (12.4%). Anaesthetic advanced skills were reported as the second highest skill to acquire for respondents from very remote areas (RA-5) to meet a community need. There were no statistically significant differences across states, though Tasmania had a notably lower response rate than other states.

**Surgery**

Although the proportion of those still practising surgical advanced skills is among the highest of all skills, the rate of acquisition and current use are relatively low. Respondents from remote areas (RA-4) had lower practice rates than other ASGC-RA. Skill use increased steadily with remoteness, however this pattern was not visible in the skill acquisition data. Surgical skills were more likely to be currently in use by respondents from South Australia (13.6%), New South Wales (10.4%) and Victoria (9.1%). Skill acquisition numbers varied more significantly (P=0.05) between states than those for current skill usage.

Thirteen per cent of respondents indicated that they would acquire surgical skills to meet a community need, with no significant variance between ASGC-RA or states. The Northern Territory respondents were most likely to report acquiring surgery as a new advanced skill.

**Defence health**

Approximately 2% of respondents had acquired advanced skills in defence health; however the skill is currently being used by 6.1% of respondents. There were no statistically significant differences in current use between ASGC-RA or states, though the Northern Territory had a notably higher rate of use than other states (6.4%). Two per cent of respondents indicated they would acquire a new advanced skill in defence health.

**Tropical diseases**

Tropical disease medicine advanced skills were being used currently by 5.4% of survey respondents, having been acquired by 7.7%. Expectedly the most remote areas of Australia (RA-5 and RA-4) had significantly higher rates of acquisition (22.1% and 9.9% respectively; P<0.0001) and use (18.3% and 9.2% respectively; P<0.0001) than other areas. The Northern Territory had a significantly higher number of respondents with this advanced skill (20.6%) and currently practising (19.1%).

In order to meet the needs of rural communities, 6.8% of respondents indicated they would acquire this skill. This was most commonly reported from participants in remote areas (RA-4 and RA-5), and significantly more commonly reported from Queensland respondents (11.9%; P<0.0001).

**Refugee health**

Refugee health was reported as the least commonly acquired and currently used advanced skill area. These advanced skills have been acquired by 3.6% of survey respondents, and are used currently by 3.0%. There were no statistically significant differences in skill acquisition between ASGC-RA; however the skill is used significantly more by respondents working in major cities (RA-1) and very remote areas (RA-5). Tasmanian and Western Australian respondents reported significantly higher skill acquisition rates (8.2% and 6.4% respectively) than other states; though this pattern was not evident in data around the current use of the advanced skill.

Eight per cent of respondents indicated they would acquire refugee health advanced skills to meet a need in their community. This trend steadily declined with remoteness, and was consistently reported across states.
Discussion

Acquisition, practice and maintenance of advanced skills

The research provides insight into the current extent of advanced skills in rural general practice, demonstrating the relatively low acquisition and application of procedural skills and the strong demand for non-procedural skills in rural and remote communities. The broad range of skills identified and prioritised by the profession extend well beyond procedural skills, confirming the prominent role of non-procedural skills in addressing the health needs of rural and remote communities.

Mental health and chronic disease management were among the top three advanced skills acquired and practised currently in rural general practice, reflecting the significant demand for both of these skill areas in rural and remote Australia. Emergency medicine skills are often a core requirement for GPs providing care in rural communities, and the importance of skill competence in this area is reflected in the results. There are many respondents not currently practising their emergency medicine skill (16.4%); a result not surprising given the strong reliance on health budgets to retain hospital infrastructure, and the reality of budget decisions which result in rural hospital closures and/or downgrade in services. However, the most significant loss of skillset is for the GP-anaesthetist and GP-obstetrician groups, and while it is beyond the scope of this research to understand why this loss has occurred, the findings are consistent with other literature noting the decline of procedural services in rural Australia.

The ability to acquire and maintain advanced skills is vital to ensure a resilient, multi-skilled general practice workforce capable of responding to the changing healthcare needs of rural communities. Rural GPs must be supported to upskill via access to training opportunities and professional support. However, the results of this research indicate that the lifelong learning and changing learning needs of rural GPs are not adequately recognised or supported. The need for certain skill-acquisition and maintenance supports were stronger in particular geographic areas of states, however, overall the results indicate that the broad range of supports identified are strongly needed by all rural GPs. Upskilling opportunities are effective workforce drivers and it is clear, from this research, that upskilling opportunities must extend beyond the current procedural focus and reflect the health needs of rural communities. Also specific, targeted strategies are required to re-engage GPs not currently practising their acquired skills, particularly those with the procedural skillset.

Despite current structural barriers and inadequate support, respondents have demonstrated a strong commitment to address rural community needs with 93% of respondents intending to continue to apply their advanced skills rurally. Intentions of participants to remain in rural general practice for substantial lengths of time (more than half intending to stay 5 or more years) highlight that along with pre-vocational and early vocational training opportunities, the existing rural GP workforce should be supported to access training. The lack of opportunity to acquire and maintain advanced skills, and concerns around skill maintenance for the existing workforce, are reinforced by this research.

Plans for future rural general practice workforce should consider the implications of imposing workforce adages on the profession. Whether it is to gain support for a specific workforce approach or skill intervention to address workforce maldistribution, pushing workforce descriptors in order to fit within certain policy goals is not a realistic strategy. Our study demonstrates a strong preference for the terms general practitioner and rural general practitioner. The possible reluctance of research participants to identify as a GP-rural generalist may be reflective of the low number of program graduates coming through the system and the fact it is a relatively new workforce policy intervention. However, it is clear the majority does not embrace the term.
Defining advanced skills

Proposed definition of advanced skills:

Advanced skills are the additional practice and knowledge-based skills sought by GPs to enable them to address patient needs in their community. Advanced skills training facilitates the lifelong learning requirements of a GP as they seek to acquire new skills. There is an imperative for GPs to develop and acquire new skills throughout their careers in rural Australia. The unequal distribution of health outcomes, health services and medical workforce has great impact in these areas and the GP must be able to respond to frequently changing community needs.

The research presented in Section 4.2 provides evidence of the lack of clear or agreed parameters for the definition of an advanced skill, highlighting that current definitions fail to reflect the scope of practice expanding far beyond procedural skills. The skills identified by the profession as most needed by rural communities showed the prominence of non-procedural areas. The lack of a clear definition of advanced skills in the literature and the current procedural bias embedded in policy result in an inequitable distribution of available funding for non-procedural training. Thus, the development of an advanced skill definition must acknowledge the full range of skills needed by rural communities. The proposed definition (above) reflects the nature of health needs in rural communities and the strong imperative for rural GPs to advance their skills by virtue of the context in which they work, characterised by substantial medical need, access barriers and support deficits.

Limitations

Varied interpretations of what constitutes an advanced skill were evident from the free-response answers, and parameters for advanced skills were not defined for the purposes of this survey. However, this reinforces the need for an agreed understanding and is not believed to have skewed results significantly. More remote GPs may have less internet connectivity and therefore less access to the online survey, however, this cohort (RA-5) was well represented in the research. The accuracy of the RAGCP National Rural Faculty membership database is not known, however the survey appears to be representative.

Conclusion

In terms of future policy setting, the research provides clarity of the key policy factors that impact advanced skill acquisition, which will assist governments in program design. In prioritising spending, the research again provides direction in terms of the most needed skills as identified and prioritised by the profession. Further focus is required to develop and support GPs to acquire and maintain the leading skill areas which will address community need. To harness the full advanced skillset held by rural GPs, the underutilisation of some skill areas must be addressed.

As reflected in the definition, rural GPs who are practising advanced skills are already responding to perceived needs in their local community, driven by patient demand for particular services. However, additional work is required to define community need, and to measure that need. Through this research, policy-makers can now more accurately and effectively target strategies to address advanced skills for the rural health workforce and consequently improve health outcomes for rural and remote communities.

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4.4. Skills in Focus

The Rural GP in Focus stories have been collected to give real accounts of advanced skill practice in rural and remote communities, and provide further insight into the profession’s definition of advanced skills. Several GPs practising advanced skills in rural and remote communities were asked to provide information about their community, their advanced skill and how it is used to enhance rural healthcare, why their advanced skill is required by the community and how they are currently supported to maintain advanced skills. The value of advanced skills for their community and practice is also described.

Rural GP in Focus

“These advanced skills enable me to be involved in the cradle-to-the-grave ‘generalist GP’ care I set out to practice when a starry-eyed youth (with normal hair colour and no grey in the beard)”.  

Dr Ross Wilson, Bathurst NSW  

Obstetrics, anaesthetics and emergency advanced skills

I am a GP in a town 200 km from Sydney with a population of around 35,000 people. Our community has a base hospital with 100 beds, including nine maternity beds. I have advanced skills in obstetrics, anaesthetics (obtained in UK) and emergency medicine, and I engage in regular ongoing medical education.

In my community there is an absolute deficiency of consultant obstetricians, and I am therefore needed to provide both obstetric and anaesthetic services. I also use both skills on the 1 month a year I do remote locum work. The total lack of consultants for adequate cover means that if this service is to continue in this region, it needs procedural GPs.

Procedural grants are essential in maintaining these skills, and local seminars (which are usually peer organised and in-kind) are also an advantage.

“My advanced skills allow me to provide an enhanced service to these patients and assist colleagues with both the complicated patients and the procedural work.”

Anonymous

Surgery and internal advanced skills

Working in a small remote rural town (ASGC-RA-5) for 5 years, I provide GP surgical services and also, nowadays, medical VMP services and assistance to some colleagues, especially palliative care and inpatient management. I am no longer in town long enough to provide longer-term medical management, but I assist colleagues and nursing staff with occasional phone or email advice and see some of the geriatric patients in residential care on a regular basis on my clinics. I do a lot of rheumatology.

There is no resident GP proceduralist in the region, most of the theatres are closed and the health department is busily trying to close as many more as possible by making it difficult for the visiting specialists to get theatre time, thereby reducing nursing skills so they are no longer considered current and competent by their employer. It’s a self-fulfilling prophecy and difficult to fight. The specialists spend a lot of time doing procedures that could easily be done by a skilled GP, but I have found it just as difficult to get theatre time. It’s being worked on – this should allow the specialists to do consultant procedures and me to back-fill the simpler procedures (vasectomy, carpal tunnel, Baker’s cyst, plastics etc.). Nevertheless, my surgical results have been pretty good, and the patients really appreciate not
having to travel. It’s 250 km in one direction to a regional hospital and 200–300 km in the other direction, depending on which edge of the region you live.

We have no gynaecologist in the region at all, so I have had to pick up quite a few gynae procedures. I am also the regional colposcopist. We have no equipment for LLETZ available, so I still have to share care with a specialist in the nearest capital city, which is 250 km away, but I can at least provide diagnosis and follow-up.

The internal medicine advanced skill means that I can provide additional palliative care and complex medical care support, though there are not so many colleagues who ask for this as for surgical services. Teaching and support is a bit ad hoc, but does happen, not as often as it needs to.

Most of the patients put off seeing specialists due to the travel and time off requirements. There is no anaesthetist in the region so anything I do at present has to be done under sedation, entonox or local/regional block. Our local health department has been hammered by me for the past 11 years to provide me with a GA list. The visiting specialists also find GA list access difficult and tend to recommend patients travel to the nearest capital city for their procedures, which compounds the local issues.

Procedural grants have made the difference for me – I would not have maintained the range of procedures nor the persistence in trying to provide services for my local communities if these had not been available. There is, of course, nothing financial to assist me with the internal medicine skill maintenance, and these patients are more challenging for most of us.

Our region is short of about seven doctors across five very small towns. Patients really appreciate being able to be treated close to home, able to be cared for in their terminal illness with family and friends around, able to take just 1 rather than 2–3 days off work for their procedure. My advanced skills allow me to provide an enhanced service to these patients and assist colleagues with both the complicated patients and the procedural work. And they allow my consultant colleagues to concentrate on the work for which they are consultants.
Rural GP in Focus

"For my community, advanced rural skills mean being able to have appropriate surgical procedures performed closer to home, overcoming transport and financial disadvantage."

Dr Tim Francis, Nambucca Valley (Mid-north coast) NSW

Advanced skill in anaesthesics

I live in the Nambucca Valley on the mid-north coast of NSW, with a population of about 25,000 consisting of the towns of Valla, Nambucca Heads, Macksville, Bowraville, Scotts Health and Stuart's Point. The area is ASGC-RA 3 and is serviced by the Macksville Hospital, 50 km to Coffs Harbour and 100 km to Port Macquarie. The population is ageing and overrepresented in most socio-economic measures of disadvantage. My anaesthetic practice occurs in Coffs Harbour and Kempsey due to shortages in those areas and a lack of surgical activity at Macksville Hospital. I have undertaken advanced skills training in emergency and anaesthetics, completing 6 months of emergency training in Coffs Harbour and 12 months of JCCA accredited training in anaesthesia at the Tweed Hospital and Murwillumbah.

There is a shortage of anaesthetists in general in the region from Kempsey to Coffs Harbour, with a moderate number of GP and specialist anaesthetists approaching retirement age. The main problem, however, is maldistribution. We have four GP-anaesthetists in the Nambucca Valley, but only enough work for three at Macksville Hospital. Due to a lack of public transport, socioeconomic disadvantage and ageing population in our area, there is high demand for procedures to be undertaken locally.

The area health service provides monthly specialist attendance at Macksville. Rural Procedural Grants also enable attendance at workshops and conferences to maintain skills. There are also regular hospital morbidity and mortality meetings as well as skills update sessions.

For my community, advanced rural skills mean being able to have appropriate surgical procedures performed closer to home, overcoming transport and financial disadvantage. For my practice, I found that immediately after my anaesthetic training, I was unable to maintain my anaesthetic skills in the local hospital and sought work elsewhere to consolidate those skills. The limitations of a rigid model of care at my local hospital meant that I eventually discontinued procedural work in Macksville and continued work outside of my local area due to service imbalances. Given the limited volume of available work and the case that I am no longer focused on my local community with my anaesthetic practice, I am currently questioning the ongoing viability of maintaining a practice in anaesthesia.

“It is great to be able to confidently perform full-body skin checks and treat people with skin cancers, pre-cancerous lesions and other dermatological issues locally.”

Dr Tara Parsons, Canungra QLD

Advanced skill in dermatology

I currently work on a military base in Canungra, QLD. It is a base that caters for 500–600 permanent staff and has multiple courses of varying number at any one time, plus groups here on ‘exercise’. Canungra is a small town in the Hinterland near the Gold Coast. Canungra itself has a population of 1148 at the last census. I also do additional rural locums supporting rural hospital EDs a couple of times a year and occasionally weekends. The hospitals I cover include Ballina Hospital Northern NSW, and Tomaree Hospital in Port Stephens in the Hunter Valley.

My advanced skill is in dermatology – particularly skin cancer management, but does cover dermatology in general. My training entailed a Masters of Medicine specialising in skin cancer through UQ and 12 months working in a skin cancer clinic in a capital city (large number of patients of varying ages and histories). Skin cancer is a growing issue here in Australia, and in particular with the rural population who have often spent countless hours with sun exposure through their work.
Also, they tend to have chemical and other allergen exposure and present with rashes and other skin lesions from various sources. My increased procedural work with skin cancers has enabled me not only to be able to detect and diagnose more readily, but also to be able to treat with more complicated local procedures (such as various flaps), that would normally have had to be referred to a specialist to be done. It has also improved my suturing skills for wound closures (for traumatic wounds/ED presentations).

Specialist treatment in my area necessitates a long wait time for a plastic surgeon or dermatologist on the Gold Coast itself. It is great to be able to confidently perform full-body skin checks and treat people with skin cancers, pre-cancerous lesions and other dermatological issues locally. I still do refer more complicated excisions or more extensive disease, and also those dermatological issues that are beyond my scope or are resistant to the management already undertaken. There are no reliance factors on other specialties for this particular area, although large excisions and MOHS type procedures would require an anaesthetist – hence I refer these. It does rely on a good dermatoscope and, preferably, imaging capabilities such as a Molemax machine with appropriate software for saving images, as well as hyfrecator/diathermy and cryotherapy. A dedicated treatment area equipped for excisions (suture kits etc) is also very useful.

For the particular speciality area that I did my advanced rural skills training in, there is no current funding or support arrangements for maintaining my skill. I am, however, registered for the rural grants via Medicare for provision of emergency medicine to rural areas. Advanced rural skills in dermatology/skin cancer (and also emergency medicine) are very useful in rural areas in order to accurately diagnose and treat dermatological conditions and skin cancers as well as precancerous lesions. Procedural skills in suturing and advancement flaps and other forms of skin repair are also extremely useful in providing a skilled physician to treat lacerations (sometimes very complicated lacerations) in the rural setting without having to refer to specialists or send people to larger centres with a regional hospital. I can treat people at my ‘point of care’ in the community.

“I believe general practice is an important component of mental health delivery ... augmented by the fact that GPs can also deal with clients with other medical needs.”

Dr Annette Newson, Bamera SA  
Advanced skill in mental health

Bamera has a population of 4500 and is one of five towns in a larger regional centre of 36,000 called the Riverland, or the River Murray. It is classified under ASGC-RA 3, and located 250 km north-east of Adelaide. This is primarily an agricultural area that has been severely affected by drought, water restrictions and poor prices for produce. We have substantial Aboriginal and migrant populations.

A regional hospital is being developed 16 km away, which will have a mental health inpatient unit. This will have the capability to look after patients who would have previously been placed under an involuntary order. I also have a small local hospital where we will continue to look after patients with emotional issues that do not require a mental health inpatient unit. I have access to both hospitals. I have level 1 mental health skills training, and I attend as many mental health training seminars as I can fit into my schedule as well as undertaking limited training with Headspace. I am a generalist so also need to undertake training in other fields.

As stated previously, my population has been affected by a severe drought and water restrictions. We have been targeted in the past for a number of government initiatives to assist with mental health. We were one of the first rural areas in Australia to be allocated a Headspace. At present we have outpatient access to mental health services through Headspace, the Division of General Practice (which is still operational in our area) and the mental health team based in the hospital system. However there is several weeks wait to get access to most of these services. There are no psychologists in my town, and only a few psychologists in the region. There is no resident psychiatrist. We have a mental health team that can support GPs acutely, but the service is limited by staff numbers.
There is no resident staff for inpatients in our regional or local hospital, and all inpatient work at present is done by GPs and mental health workers. There is a visiting psychiatric service but we experience long waits of several months for appointments. There is access to psychiatric service by telehealth, but this can also be difficult to access. The telehealth service does seem to be increasing its capacity. We find it very difficult to access any specialist psychiatric services for adolescents between 14 and 18 years of age.

I would like training in three areas of mental health:

1. The various skills that mental health workers are using to assist mainly my outpatients. As a rural GP I have limited time to undertake counselling myself of patients, but would like to develop how I can work as an interface between general practice and the various mental health agencies. I would then like to teach GPs how various mental health practitioners use their skills.

2. Acute mental health emergencies. Particularly how we could make it easier for rural accident and emergency departments to access mental health services, especially after hours, and how they can organise timely support from mental health practitioners or GPs with an interest in mental health.

3. How to attend to patients in a mental health inpatient in a regional centre. Specifically I would like training in what sort of patients can be managed in a rural centre and what support can be expected from specialist psychiatric units.

At present all training I have undertaken has been self-funded. I believe general practice is an important component of mental health delivery. This is augmented by the fact that GPs can also deal with clients with other medical needs. I would like to improve the interface between general practice and other mental health services.

My various advanced rural skills mean increased choices for my community, with improved quality of life and less need to travel away for medical services and specialised skills, particularly in pain management, nutritional medicine and active disease prevention and education."

Dr Karin Jodlowksi-Tan, Brewarrina NSW

Advanced skills in small town rural general practice and Aboriginal and Torres Strait Islander Health

Brewarrina is placed on the banks of the Barwon River, about 800 km north-west of Sydney. It was the traditional meeting place of several thousands, being on the lands of the Ngerinba, Muwarrari and Yualwari peoples. It has a large percentage of Aboriginal people with a total population of 1254 in 2011. Brewarrina is classified a ASGC-RA4 and previously RRMA7. The closest regional hospital in Dubbo is about 400 km away. We have a disproportionately high burden of chronic disease, with five fully occupied dialysis chairs located in the local hospital.

I chose small town rural general practice ARST when I started my FARGP, whilst working in a fishing village on the mid-north coast of NSW. In that term, I identified a need for me to study acupuncture and nutritional medicine, to service a town populated by retirees. In the process I gained my Fellowship in medical acupuncture. Since 2007, I moved to Aboriginal communities in the NT and NSW and have gained a lot of practical experience in Aboriginal health through immersion.

In my current community, there is a high prevalence of chronic kidney disease, diabetes and chronic pain. There are also a lot of unemployed people who are prone to poor diet and lifestyle. Even in the non-Aboriginal population there is a high burden of lifestyle related issues, as a result of the reduced access to exercise choices and the lack of access to good quality fresh foods one might enjoy in the metropolis. Growing one’s own vegetables might be the best option out here.

I also found the skills I gained in my personal development courses came in handy in the delivery of the nutritional and motivational workshops I gave to people in Bourke and Brewarrina. It is important for people to find meaning in their lives in order to be motivated and make changes. Without that motivation, nothing we do will make much difference. Having greater insight into lifestyle and nutrition helped me to understand the importance of prevention using lifestyle measures, and greater flexibility to
fit in with the cultural context that may favour other things besides taking medication. It is not easy to teach about eating the right foods when fresh produce is not always there, and when there, they may not be affordable. Knowing what the local people can and cannot implement is very important. Knowing what may be lacking in their diet and lifestyle helps us to help them tailor suitable supplementation and exercise programs. I also find physical therapies a very useful skill, particularly for pain management, with reduced need for narcotic medications and fewer people being sent away on long trips to have therapy.

Distance is the greatest barrier to accessing everything in Brewarrina. We do have regular psychiatric services, an exercise physiologist, a visiting eye team, a cardiology team, a renal physician and a dermatologist.

I found many people were reliant on narcotic analgesics for a multitude of pain conditions. Most of there are musculoskeletal in origin and the use of narcotics is not always judicious. As in many small towns, we have issues with abuse of narcotics by some, and our AMS discourages the prescribing of narcotics. Achieving an understanding with Aboriginal people, and cultivating good relationships, is vital to help them overcome the need for these. When they trust the doctor, they are willing to try alternatives, including physical therapies, as many of them are keen to be off medications with their incumbent side effects. And they appreciate that the doctor is not treating them as a drug seeker.

This skill in living and working with Aboriginal people harmoniously is a very important one, although it may seem a bit nebulous. The same skill can be applied in other cultural contexts with success once it is mastered.

There is no current funding to support the maintenance of my advanced skills in small town rural general practice or Aboriginal health. Since our AMS does not have admitting rights to the local hospital I am not even eligible for the emergency medicine procedural skill grant, although I maintain my emergency training updates to continue working out there.

My various advanced rural skills mean increased choices for my community, with improved quality of life and less need to travel away for medical services and specialised skills, particularly in pain management, nutritional medicine and active disease prevention and education.

“I am working in a primary care team, and I therefore have daily support and learning from my allied health peers, which is invaluable.”

Dr Mary Emeleus, Cairns QLD
Advanced skill in mental health

I currently live in Cairns, population 150,000 (RA-3). There is a regional hospital with an inpatient mental health unit, and several community mental health teams. There is also a private psychiatric hospital. Most of the general practices are looking for extra staff and are very busy. There are both privately billing and bulk-billing practices. Cairns has a large transient population of tourists, and many people have moved here from other parts of Australia. People tend to realise fairly quickly whether they like it here or not. They often leave after one hot/wet season, or stay forever. The main industries are tourism and services, and Cairns is also the regional centre for a number of surrounding rural communities.

My advanced skill is mental health. I completed a 12-month term as an unaccredited psych registrar during my GP training, working mostly in acute care and community-based teams. I had inspirational mentors, and immediately began using my skills through shared care with the local mental health team once I returned to general practice. I subsequently completed a 3-year Masters of Mental Health with a major in psychotherapy and have increasingly developed my psychological medicine special interest in that time.

I was invited to work at Headspace when it opened in Townsville in 2008, and since that time I have worked almost exclusively in youth mental health. I moved back to Cairns and began working at Headspace Cairns when it opened in 2012. My clients are 12–25 years old, and are often disenfranchised for various reasons and have difficulty accessing ‘mainstream’ services.
We are able to offer longer appointment times and a team approach including youth work. We provide trauma-informed care, which requires a good understanding of current research in mental health. We also have close links with other youth organisations, and the collaborative care we can offer is often highly effective. Making a difference to people at this stage of their life can change the trajectory of their entire adulthood. We see young people from all walks of life and can see them mostly within a non-pathologising framework. Our primary care team can help them with all aspects of their health, and if their sleep, nutrition, physical activity, social activities, work/study lives and family relationships are addressed, very often their ‘mental health’ improves and we don’t need to make a ‘diagnosis’ at all!

In my view, the biggest gap in our system is psychotherapy. Brain science confirms that relationships change the brain, and psychotherapy can contribute to healing and complete recovery, not just symptom palliation as most medications do. Many GPs don’t realise that they offer potentially transformative therapeutic relationships, just by being good GPs, and have been told for years that people need diagnosis and medication. I think good quality primary care mental health is very different to psychiatry, and it is what most people need. Unfortunately Medicare does not reward quality mental health care, which takes time, and many GPs are so busy they don’t have that time to provide the supportive counselling and good listening they are so well positioned to provide. Many people don’t require a diagnosis; if they are offered holistic care, empathy, attunement and unconditional positive regard, they will get better! Many psychiatrists would agree; they would then be freed up to manage the most unwell people for whom they are the best providers.

Psychology and other allied health (under Medicare) is limited to 10 sessions and is reliant on the GP ‘believing’ in psychotherapy and making the referral. In addition the allied health private practitioners may have prohibitive fees and long waiting lists. Being a GP with special skills in mental health, and in particular psychotherapy, is therefore very useful. I am often referred young people for second opinions from their own GPs, or by their families, and sometimes I am the only accessible option for young people with complex needs to access psychotherapy.

I attend trainings regularly to develop my skills at my own expense and I pay for professional supervision. I have actively sought out psychological medicine professional groups and am a member of the Australian Society for Psychological Medicine, The RACGP NFSI Psych Med Network, the Balint Society of Australia and the International Society for Psychological and Social approaches to Psychosis (ISPS). I strongly recommend that any registrar undertaking an ARS in mental health join either the ASPM or the NFSI network.

I am working in a primary care team, and I therefore have daily support and learning from my allied health peers, which is invaluable. I earn about 40% less than I would in mainstream general practice, but I love my work and am able to have a good work-life balance so I have no complaints about money!
### 4.5. Appendices

#### 1.1. Advanced skills acquisition by state

<table>
<thead>
<tr>
<th>Advanced rural skills competencies:</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
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#### 1.2. Advanced skills currently used by state

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<th>TAS</th>
<th>VIC</th>
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#### 1.3. New skill acquisition to meet a need in community, by ASGC-RA Classification System
1.3. New skill acquisition to meet a need in community, by ASGC-RA classification system

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<th>Major Cities of Australia</th>
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<th>Outer Regional Australia</th>
<th>Remote Australia</th>
<th>Very Remote Australia</th>
<th>P-values</th>
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<td>Which skill would you acquire to meet a need in your community</td>
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<td>n (%)</td>
<td>n (%)</td>
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1.4. Support requirements for skill maintenance and regaining competency, by ASGC-RA classification system

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<th>Major Cities of Australia</th>
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<th>Outer Regional Australia</th>
<th>Remote Australia</th>
<th>Very Remote Australia</th>
<th>P-values</th>
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<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
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### Section 5: Project activity materials

#### 5.1. Project management activity materials

##### 5.1.1. Project deliverables: Activity record

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<th>PAG Lead</th>
<th>Priority Task</th>
<th>Details</th>
<th>Status</th>
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<td>BD + KD</td>
<td>Dr KK</td>
<td>Final Report</td>
<td>The Grant Agreement stipulates that the Final Report will comprise: Detailed statement of all activities outlined in Section B of the Commonwealth Grant Agreement and Detail Project Plan; An Assessment of the challenges and opportunities, foreseen or otherwise, that arose during the project, the impact on the project, how these were addressed by the Grantee and the resulting outcomes; Three copies of all Activity Material used in undertaking this project; Findings and outcomes of the consultation process; An independent audited financial acquittal. Completed. Submitted 31 January 2014</td>
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### 5.1.2. Key project tasks: Activity record

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<th>Priority Task</th>
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<td>Brisbane write-up.</td>
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<td>BD</td>
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<td>BD</td>
<td>Dr KJ-T</td>
<td>Consultation Summary 5</td>
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<td>KD</td>
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<td>Research Survey</td>
<td>Survey finalised. Released on 11 Nov 13, closed 25 Nov 13.</td>
<td>Section 5 (5.3, 5.3.4)</td>
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<td>KD</td>
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<td>GP Narratives</td>
<td>Rural GP skills in focus.</td>
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<tr>
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<td>Research</td>
<td>KD</td>
<td>Drs CL, KK</td>
<td>Research Report</td>
<td>Research results + discussion.</td>
<td>Section 4 (4.3)</td>
<td>Completed</td>
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<td>Mid Dec 13</td>
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<td>Survey Policy 1</td>
<td>Quick poll 20 finalised. Released on 29 Aug 13 to 4 Sept 13.</td>
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<td>BD</td>
<td>Drs RO, CL</td>
<td>Survey Policy 2</td>
<td>Integrated Rural Training Pathway survey finalised. Released on 4 Nov 13 to 30 Nov 13.</td>
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<td>Lead</td>
<td>PAG Lead</td>
<td>Priority Task</td>
<td>Details</td>
<td>Final Report</td>
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<td>BD</td>
<td>Dr KK</td>
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<td>Section 3 (3.3, 3.3.3)</td>
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<td>Policy</td>
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<td>Section 3 (3.4)</td>
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<td>State Faculty Board Consultation</td>
<td>Survey distributed through State Faculty Managers. Closed 10 Dec 13.</td>
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<td>Drs KK, CL</td>
<td>Brisbane Event</td>
<td>Event held 2 Oct 13. Presentation + Questionnaire Hand out</td>
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<td>Early Oct 13</td>
<td>Consultations</td>
<td>HM</td>
<td>Drs RO, CL</td>
<td>GP13 Darwin Events</td>
<td>Events held 16 + 18 Oct 13. 2 Presentations + Questionnaire (NRF Board) Hand out (Member consult)</td>
<td>Section 3+5 (3.2 + 3.3), (5.2.1, 5.2.2 + 5.2.4)</td>
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<td>Drs MR, RO</td>
<td>Adelaide Event</td>
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<td>Section 3+5 (3.4), (5.2.1 + 5.2.2)</td>
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<td>HM</td>
<td>Dr KJ-T</td>
<td>Sydney Event</td>
<td>Event held 10 Dec 13.</td>
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<td>LC+</td>
<td>Dr KK</td>
<td>NRF Board Brief</td>
<td>Approval Brief (Executive Summary)</td>
<td>Section 2 (2.1+2.2)</td>
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<td>Approval</td>
<td>LC+</td>
<td>Dr KK</td>
<td>Council Brief</td>
<td>Approval Brief (Executive Summary)</td>
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<td>Financial Acquittal</td>
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<td>Post project report deliverable</td>
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5.2. Consultation Activity Materials

5.2.1. Question sheet

The following Question sheet template was used at each of the five member consultations to help guide discussion. The consultation questions were formed against the project’s six key themes and structured against the key recommendations in the Mason Review relating to the coordination of training and the proposed national rural training pathway (Chapters 3 and 4).

EVENT DETAILS
11.00 am – 3.30 pm
Wednesday 2
October 2013
Queensland State Faculty Office
Level 1, 201 Logan Road
BURANDA 4102

PROJECT AIM:
Undertake consultations with the RACGP rural membership to identify the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter general practice in regional and rural communities. This includes the structural requirements and advanced skills training for new entrants and the existing general practice workforce. The input obtained will be guided by the key recommendations in the Mason Review relating to the coordination of training and the proposed National Rural Training Pathway (NRTP).

CONSULTATION QUESTIONS

<table>
<thead>
<tr>
<th>Theme</th>
<th>Policy Objective</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access to quality care for rural and remote communities</td>
<td>Secure equitable outcomes for rural communities through workforce strategies that provide more primary care in the community. Training responses ensure doctors have the skills to meet the health needs of the community.</td>
<td>1. Ensuring the delivery of education and training matches the nature of demand and reflects the way health services are delivered in rural and remote areas. What are some of the more innovative solutions being used in your town to ensure equitable access outcomes for rural patients and what supports would help facilitate and sustain these? 1.2. To ensure a more targeted training investment against demand, would it help your community to have skill specific registrars placed through your service? Mason Review Reference(s): The Commonwealth’s role in planning and investing in health education has an increasing focus on delivery of education and training that matches the nature of demand and reflects the way health services are delivered in both clinical and community settings. (Ch. 3 p.73 + Rec. 3.4)</td>
</tr>
<tr>
<td>2. Integrated rural training pathway</td>
<td>To provide a comprehensive rural medical training experience, with a seamless transition from undergraduate training to rural general practice by linking the different stages of training in rural settings.</td>
<td></td>
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<td>------------------------------------</td>
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</tr>
</tbody>
</table>

2 (a) Providing a comprehensive rural training experience and seamless transition from undergraduate training into rural practice.

2.1. What strategies could be undertaken to support a more streamlined rural training pathway linking investment across the full training continuum?

2 (b) In influencing the career choice, ensuring quality experiences during rural clinical attachments in general practice is vital.

2.2. How can we ensure the training is coordinated in such a way to support both positive and quality training outcomes for students and build the required links between trainees and communities?

2.3. How can more early exposure or undergraduate(*) rural experiences be built into the training pathway to accommodate specific learning needs? (*): prevocational + university based training

2.4. Should more rural doctors be teaching at universities to expose students to the rural aspect of medicine?

2 (c) Building a rural GP intern rotation capability.

2.5. What strategies could be developed to encourage the early linkage (PGY1,2) of intern positions to a specific region at the national/state level?

2.6. What adjustments are required in terms of addressing the varied state based systems (intern allocation) in each state or territory?

2.7. Would your regional hospital and community have the capacity to support such an internship model? 2.7.1 If not, what needs to happen to make this possible?

2 (d) Capacity to combine intern and registrar training positions.

2.8. What coordination and structural changes would this approach impose including in regard to the accreditation process?

2.9. How can we retain flexibility in the training process?

2.10 Would your practice / service be ready for an intern? 2.10.1 If not, what is needed to make it possible?
<table>
<thead>
<tr>
<th>3. The use of advanced skills in rural areas</th>
<th>Mason Review Reference(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify key policy requirements for improving rural GP access to advanced skills training, both procedural and non-procedural.</td>
<td>The full Chapter (4) which outlines a National Rural Training Pathway, particularly:</td>
</tr>
<tr>
<td></td>
<td>Rec 4.1: The Commonwealth should take leadership in developing a new, more integrated rural training pathway, linking its investment in rural undergraduate medical training with new support for rural intern places and continued growth in specialist training positions.</td>
</tr>
<tr>
<td></td>
<td>Also refer to the discussions in the Mason paper again at Chapter 4 around:</td>
</tr>
<tr>
<td></td>
<td>• Rural clinical training medical students and need for mix of short term, longer placements, learning specific placements and non-compulsory options (relevant to Q.2.2+2.3) (p 123).</td>
</tr>
<tr>
<td></td>
<td>• The missing link – rurally-based internship positions combination of acute care + primary care within a range of settings in a particular region. In program design, building in the key attributes of the STP (relevant to 2c (p. 133-134) + Figure 4.1 (p. 136).</td>
</tr>
<tr>
<td></td>
<td>• Combined intern and registrar training (relevant to 2d,p. 135-138) + Figure 4.3 (p139).</td>
</tr>
</tbody>
</table>

3. Investing in the full range of rural advanced skills required to meet the complex needs of rural and remote communities

3.1 What advanced skills are being used in your area? Are there any barriers currently impacting on the acquisition, use and retention of these skills?

3.1.1 Firstly in regard to skill acquisition, use and maintenance of procedural skills?

3.1.2 How would you overcome these barriers?

3.1.3 The key barriers currently impacting acquisition, use and maintenance of non-procedural skills?

3.1.4 How would you overcome these barriers?

3.2 What supports are needed to ensure advanced skills training is widely accessible for rural GPs seeking to meet a skill need for their community?
6. Training capacity

<table>
<thead>
<tr>
<th>Address factors limiting rural GP training capacity. Work through the additional requirements placed on the sector with a new national rural training pathway.</th>
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</table>

6 (a) Current constraints: Supervision constraint is a key contributing factor affecting the lack of clinical training placements in rural and remote areas.

6.1 What do you see as the key constraints currently limiting supervision?

6.2 Are you or your practice currently involved in general practice teaching?

6.2.1 If not, what is currently restricting you from taking on a training load?

6.3 Is your service/practice able to take on medical students or interns, or both, at this point in time?

6 (b) An expanded sector: Examining some of the locational specific barriers and requirements for sustainable teaching practice environments

6.4 What are the key teaching requirements needed to support an expanded rural training pathway and in developing sustainable teaching practices?

6.5 Would a regional approach be possible where you are allowed to form local structures to facilitate increased training capacity? This would involve collaboration between a number of health providers to provide training.

6.5.1 Does this occur at all currently in your area?

6 (c) Remuneration: Stronger incentivised integration across the training continuum

6.6 What changes could be made to the funding framework to improve the interconnectedness and encourage more training across the full training continuum?

6 (d) Case studies

6.7 In identifying the locations which may have the capacity to implement an integrated training model more rapidly, are there areas in your state which might be more ready to pilot the approach now?
### Mason Review Reference(s):

There is limited discussion in the Mason Review around addressing clinical teaching capacity other than against the Specialist Training Program discussion. It is touched on in the discussions on the benefits of vertical integration in building capacity and creating an environment to help shift the burden of teaching (p. 92 +139-141) and briefly against an example of a new service learning model (Broken Hill) aimed at strengthening clinical training (p.13).

A related discussion around capacity is on p. 145 (Ch. 4). The model will need to build on existing programs and maintain access to primary care and private sector training though the development of a more networked approach to delivering quality education. This may need to involve some re-profiling of existing investments. It will need to be delivered through a highly collaborative approach involving consortia of key training/accreditation bodies and health service providers. All available policy levers, including contracting and reporting mechanisms, should be directed at incentivising collaboration by local and regional agencies and supporting a local network approach.
5.2.2. Consultation Presentation

The following presentation template was used at each of the five member consultations to help guide discussion. The consultation questions were formed against the project’s six key themes and structured against the key recommendations in the Mason Review relating to the coordination of training and the proposed National Rural Training Pathway (Chapters 3 and 4).

**New approaches to integrated rural training for medical practitioners**

**Member Consultations: Brisbane Forum**

11:00am-3:30pm

Wednesday 2 October 2013

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**Investing in rural skills series**

Securing the next generation of GPs for rural and remote areas relies on the integration of training towards rural practice.

- Identifying the key issues, enablers and barriers to establishing streamlined education and training towards rural practice.
- Examine the advanced skills training needs both for the existing workforce and new entrants.

---

**Theme 1**

Consultation theme

Access to quality care for rural and remote communities

**Policy objective**

Secure equitable outcomes for rural communities through workforce strategies that provide more primary care in the community. Training responses ensure doctors have the skills to meet the health needs of the community.

---

**Theme 1 Questions: addressing demand**

Ensuring the delivery of education and training matches the nature of demand and reflects the way health services are delivered in rural and remote areas.

1.1 What are some innovative solutions being used in your town to ensure equitable access outcomes for rural patients and what supports would help facilitate and sustain these?

1.2 To ensure a more targeted training investment against demand, would it help your community to have skill-specific registrars placed through your service?

---

**Theme 2**

Consultation theme

Integrated rural training pathway

**Policy objective**

To provide a comprehensive rural medical training experience, with a seamless transition from undergraduate training to rural general practice by linking the different stages of training in rural settings.

---

**Theme 2 (a) Questions: Streamlined training**

Providing a comprehensive rural training experience and seamless transition from undergraduate training into rural practice.

2.1 What strategies could be undertaken to support a more streamlined rural training pathway/targeting investment across the full training continuum?
### Theme 2 (b) Questions: Early exposure

Influencing the career choice, ensuring quality experiences during rural clinical attachments in general practice is vital.

2.2 How can we ensure the training is coordinated in such a way to support both positive and quality training outcomes for students and build the required links between trainees and communities?

2.3 How can more early exposure or undergraduate rural experiences be built into the training pathway to accommodate specific learning needs?

2.4 Should more rural doctors be teaching at universities to expose students to the rural aspect of medicine?

### Theme 2 (c) Questions: GP intern

Building a rural GP intern rotation capability.

2.5 What strategies could be developed to encourage the early linkage (PGY1,2) of intern positions to a specific region at the national/state level?

2.6 What adjustments are required in terms of addressing the varied state based systems (intern allocation) in each state or territory?

2.7 Would your regional hospital and community have the capacity to support such an internship model?

2.7.1 If not, what needs to happen to make this possible?

### Theme 2 (d) Questions: Intern + registrar training

Capacity to combine intern and registrar training positions.

2.8 What coordination and structural changes would this approach impose including in regard to the accreditation process?

2.9 How can we retain flexibility in the training process?

2.10 Would your practice/service be ready for an intern?

2.10.1 If not, what is needed to make it possible?

### Theme 3 Questions: Advanced Skills

Investing in the full range of rural advanced skills required to meet the complex needs of rural and remote communities.

3.1 What advanced skills are being used in your area? Are there any barriers currently impacting on the acquisition, use and retention of these skills?

3.1.1 Firstly in regard to skill acquisition, use and maintenance of procedural skills? How would you overcome these barriers?

3.1.2 Barriers currently impacting acquisition, use and maintenance of non-procedural skills? How would you overcome these barriers?

3.2 What supports are needed to ensure advanced skills training is widely accessible for rural GPs seeking to meet a skill need for their community?

### Theme 4 Questions: GP-Rural Generalist

Defining the term and clarifying the role

4.1 What does the term mean to you and what skills does it encompass?

4.2 What does it mean for the profession as a whole?

4.3 What does it mean for your community in terms of securing equitable outcomes leading to more primary care?
New approaches to integrated rural training for medical practitioners

Final report

Theme 5
Consultation theme
Embedding more primary care in the training

Policy objective
Incorporating more primary care into the basic training to ensure there is an appreciation of the role of general practice early in the training.

Theme 5 Questions: Embedding more primary care
The development of a more networked approach to delivering quality education toward primary care

5.1 How can primary care be embedded into the training?
5.2 What supports are needed to build training resilience in communities most in need of primary care services including in your own community?
5.3 What multi-disciplinary, team-based care (*) or area of specific interest training opportunities could be incorporated into the training pathway?

(*) refers to primary health care as opposed to primary care

Theme 6
Consultation theme
Training capacity

Policy objective
Address factors limiting rural GP training capacity. Work through the additional requirements placed on the sector with a new national rural training pathway.

Theme 6(a) Questions: Current constraints
Supervision constraint is a key contributing factor affecting the lack of clinical training placements in rural and remote areas.

6.1 What do you see as the key constraints currently limiting supervision?
6.2 Are you or your practice currently involved in general practice teaching?
   6.2.1 If not, what is currently restricting you from taking on a training load?
6.3 Is your service/practice able to take on medical students or interns, or both, at this point in time?

Theme 6(b) Questions: An expanded sector
Examining some of the locational specific barriers and requirements for sustainable teaching practice environments

6.4 What are the key teaching requirements needed to support an expanded rural training pathway and in developing sustainable teaching practice environments?
6.5 Would a regional approach be possible where you are allowed to form local structures to facilitate increased capacity? This would involve collaboration between a number of health providers to provide training.
   6.5.1 Does this occur at all currently in your area?

Theme 6(c) Questions: Remuneration
Stronger incentivised integration across the training continuum

6.6 What changes could be made to the funding framework to improve the interconnectedness and encourage more training across the full training continuum?

Theme 6(d) Questions: Case Studies
Identifying the locations with existing capacity to implement an integrated training model more rapidly.

6.7 Are there areas in your state which might be more ready to pilot the approach now?

Thank you
Please ensure Faculty staff have your contact details
5.2.3. Policy Surveys

Three Policy Surveys were undertaken as part of the project to help inform the policy advice. The email advice together with the survey questions is provided from 5.2.3.1 to 5.2.3.3.

Policy Survey 1: (QuickPoll #20) Professional Development Activities (Advanced Skills)
Policy Survey 2: Integrated Rural Training Pathway
Policy Survey 3: New approaches to skill investment and retention
5.2.3.1 Policy Survey 1: (QuickPoll #20) Professional Development Activities (Advanced Skills component)
New approaches to integrated rural training for medical practitioners

Final report

Advanced skills

Non-procedural skills form an important component of healthcare delivery in rural areas. Currently, grants are only available for rural and remote procedural and emergency medicine (GPs) to support skills maintenance. Eligibility for skills maintenance support is not extended to those non-procedural advanced skills which are also integral to rural practice.

09 (a) Does the lack of access to grant funding impact on your ability to keep these skills up to date?
- Yes
- No

09 (b) How important are non-procedural skills in the delivery of healthcare within your rural community?
- Essential
- Very important
- Somewhat important
- Not important

09 (c) Which of the following non-procedural skills would you elect to undertake if more grant funding were available to support you to continue to maintain those skills?
- Aboriginal and Torres Strait Islander health
- Internal medicine
- Mental health
- Paediatrics
- Small town rural general practice
- Other: ______________________

010 (a) Do you agree that further efforts are needed to re-engage doctors into procedural practice?
- Yes
- No

010 (b) Which of the following procedural skills are most needed in your community?
New approaches to integrated rural training for medical practitioners

Final report

$219/3$

Q: Which of the following non-procedural skills are most needed in your community?

- Anaesthetics
- Emergency medicine
- Obstetrics
- Surgery

010 (c) Which of the following non-procedural skills are most needed in your community?

- Aboriginal and Torres Strait Islander health
- General practice
- Mental health
- Obstetrics
- Paediatrics
- Rural general practice
- Other:

As these questions relate to your practice location, please notify the National Rural Faculty if your details have recently changed.

1 Unsupervised anaesthesiology, obstetrics and/or surgery in AGC-RA 1-5 locations (1 dependent on additional approval); and unsupervised emergency medicine in 24 hour triage Accident and Emergency facilities located in AGC-RA 2-5 locations.

Submit
5.2.3.2 Policy Survey 2: Integrated Rural Training Pathway

Dear [insert name],

The RACGP National Rural Faculty (NRF) is collecting information on the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter general practice in rural and remote communities. This is part of the Department of Health Workforce Fund project grant, underpinned by a need to develop policy solutions to address rural workforce maldistribution. The NRF values your contribution, and welcomes you to complete the following survey.

Launch the survey

www.racgp.org.au

Healthy Profession, Healthy Australia.
New approaches to integrated rural training for medical practitioners

Final report

RACGP

NRF integrated training pathway survey

*Q1: What is your current stage of training?
- 1st or 2nd year undergraduate medical school
- 3rd year or beyond in undergraduate medical school
- 1st or 2nd year postgraduate medical school
- 3rd year or beyond in postgraduate medical school
- Intern
- Resident
- GP registrar
- Other: 

*Q2: How much time in total have you spent on rural medical placements?
- None
- 1-4 weeks
- 4-12 weeks
- 12 weeks-22 weeks
- 23-44 weeks
- 1 year

*Q3: What are the most important factors that contribute to positive rural placements for you? (Please select all that apply)
- Being amongst a critical mass of students
- Local mentoring
- Engagement in local community activities
- Quality of clinical experiences
- Accommodation
- Ease of travel to metropolitan centre
- Willingness to go rural (voluntary, rather than forced)
- Good organisation and coordination of placement
- Other: 

The survey should take approximately 6 minutes to complete and your responses will be anonymous.
New approaches to integrated rural training for medical practitioners

Final report

**Q6: Early exposure to rural general practice has been shown to increase the likelihood of a person working in a rural community. In your opinion, which strategies for early exposure to the rural aspect of medicine are the most successful? (Please tick all that apply)**

- Compulsory short term rural placements (6 weeks or less)
- Voluntary short term rural placements (6 weeks or less)
- Compulsory long term rural placements (> 6 weeks)
- Voluntary long term rural placements (> 6 weeks)
- Having rural GPs teach in universities (both in person and remotely)
- Medical schools in rural areas
- John Flynn Placement Program
- Scholarships
- Other:

**Q7: Rural placements**

The recent Mason review of the health workforce initiatives comments that the mandatory four week rural placements required for all medical students under the RCTP program should be abolished, in favour of increased support for longer-term high quality elective placements.

Do you agree with this recommendation?

- Yes
- No

**Q8: Please state your reasons for agreeing / disagreeing.**

**Q9: Would rural based placements, combining acute care and primary care training in a range of settings (e.g., Primary, Community or Aboriginal Medical Service), provide a more seamless transition from undergraduate training into a rural medical career?**

- Yes
- No

**Q10: Please tick the appropriate box**


- Overall my rural medical placements have been a positive experience

- Early exposure to rural general practice had (or is having) a significant impact on my career choice

- During my rural medical placements I have had good social engagements and participated in local community activities

- During my rural medical placements I have had a quality clinical and learning experience

- My rural placements have always been well coordinated
New approaches to integrated rural training for medical practitioners

Final report

**NRF Integrated rural training pathways**

Blended rural placements (eg. Half time in hospital and half time in general practice) would help to develop the broad skills needed in rural areas.

If provided the choice, I would elect for a rural-based internship.
5.2.3.3 Policy Survey 3: New approaches to skill investment and retention

Dear [Insert name],

The RACGP National Rural Faculty is collecting information on the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter general practice in regional and rural communities. This includes identifying the structural requirements and advanced skills training for new entrants and the existing general practice workforce. This is part of a Department of Health, Health Workforce Fund project grant, underpinned by a need to develop policy solutions to address rural workforce maldistribution.

The purpose of this survey is to gather feedback obtained from members during the member consultations and ensure that all National Rural Faculty members who would like to provide input have been reached. As such, this survey is being targeted to the four remaining states and territories where face-to-face consultations have not occurred.

Launch survey

The RACGP National Rural Faculty values your contribution, and invites you to complete the following survey.

Yours sincerely,

[Signature]

Dr Kathryn Kekavatch
Chair, National Rural Faculty

Forward survey to a friend

www.racgp.org.au

Healthy Profession. 
Healthy Australia.
Recruitment focus (Q1 to Q3)

1. Flexible training enabling choice

A key system weakness identified during member consultation is the rigidity and uncertainty caused by workforce retirements. Participants suggested more flexibility allowed for a broad and varied training experience to meet both the needs of the learners and community. It was argued the effort to address workforce driven pressures impacts on both training and rate certainty (including imposing time constraints on acquiring skills and an emphasis on securing positions early).

Definition of “valued contact”: the recognising the employment by an individual in remote training or the acquisition of key skills will contribute to a valued position upon completion.

How important do you rate this policy requirement?


1 2 3 4 5

2. Learner empowerment

The need to ensure the adult learner is empowered to make their career decisions is seen by consultation participants as important, though deficient, in the current training arrangements. The first step must be to develop a national system to promote navigational support for the learner within the current training arrangements.

Do you agree?


1 2 3 4 5

3. Making rural general practice attractive

To encourage junior doctors to undertake GP training and attract more GP registrars to rural practice will require changes and more flexibility to the current arrangements.

Which of the following policy elements (incentivised or structural) do you consider important?

[ ] Provide rural exposure through rural community internship
[ ] Provide choice for registrars seeking specific skill acquisition (e.g., ACC10, mental health, palliative care)
[ ] Allocate general practice training places to areas of health need
[ ] Tailor varied and flexible training to meet community and health need
Advanced rural skills survey

- Enable ITDs and universities to work together to improve the quality and interconnectedness of the training.
- Create family support strategies for doctors willing to relocate.
- Incentive (financial and structural) integrated training.
- No disadvantage clauses for those who change their mind.
- Establish and maintain a goal training network for those areas with existing capacity.

Other: [Blank Space]

Skill retention focus (Q4 - Q6)

4. Support for upskilling

There is little recognition of GP lifelong learning. Currently, there is no mechanism to enable GPs to upskill or retrain to address a specific community health need.

Should policy support a skill acquisition pathway for practising GPs in rural and remote areas?

- Yes  ☑ No

5. Valuing the role of rural and remote general practitioners

Current policy tends to focus on procedural skills over non-procedural skills.

Do you believe there is a bias towards the acquisition and maintenance of procedural skills?

- Yes  ☑ No

5.2 Do you believe there is a need to broaden the incentive to include non-procedural advanced skills?

- Yes  ☑ No

6. Specialist competition

There is evidence of competition between specialities to the exclusion of general practitioners in regional Australia.

Have you identified in your community examples of specialist competition to the exclusion of the GP?

- Yes  ☑ No

If yes, what has been the impact upon the GP?

[Blank Space]

Teaching capacity (Q7)

7. Building a culture of teaching

Policy to address the administrative burden placed on practices is seen as one way of encouraging more rural GPs to teach.
Which of the following do you consider important to achieve this aim?

- Flexible infrastructure grants
- Significant increases to GP teacher/supervisor payments
- Incentives to develop inter-disciplinary local training networks
- Local co-ordinator of teaching and learning
- Simplify accreditation processes
- Build a key role for the RACGP in credentialing of Advanced Rural Skills Training (ARST) posts
- Regional collaboration
- Provide flexible training tailored to meet community or health need
- Ensure incentives support integrated training
- Allow for innovative and flexible models of supervision where appropriate

8. Demographics

Age

- [ ] <30

Gender

- [ ] Male

Are you a

- [ ] Rural GP
- [ ] Rural locum
- [ ] GP registrar
- [ ] Med. super
- [ ] GP teacher/supervisor

Principal practice location

- [ ] ARCHA I

Practice type

- [ ] Solo
- [ ] Group
- [ ] RCCHS
- [ ] Associate
- [ ] Partnership
- [ ] Shared
5.2.4 Handout (Darwin GP13 Consultation)

EVENT DETAILS
Wednesday 16 October 2013
2.15pm to 3.30pm
Meeting Room 3
Darwin Convention Centre

Project: New approaches to integrated rural training for medical practitioners
GP13 National Rural Faculty: Member
Consultation Session

THE SESSION
Today’s session will be facilitated by National Rural Faculty Board members Dr Cameron Loy and Dr Rodney Omond and will focus on the advanced skills used by general practitioners in rural and remote areas and training capacity in establishing an integrated national rural training pathway. The policy input obtained from the session will be used to form the main policy advice to government to support the shaping and implementation of a national rural training pathway and in informing broader workforce related strategy.

<table>
<thead>
<tr>
<th>Theme 1</th>
<th>Project objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>The use of advanced skills in rural areas</td>
<td>Identify key policy requirements for improving rural GP access to advanced skills training, both procedural and non-procedural.</td>
</tr>
</tbody>
</table>

1.1 Clarifying the skills used: Examining the advanced skills used and the barriers impacting on acquisition, use and retention.

1.2 Investing in these skills: The policy requirements in ensuring advanced skills training is widely accessible for rural GPs seeking to meet a skill need for their community.

<table>
<thead>
<tr>
<th>Theme 2</th>
<th>Project objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Capacity</td>
<td>Address factors limiting rural GP training capacity. Work through the additional requirements placed on the sector with a new national rural training pathway.</td>
</tr>
</tbody>
</table>

2.1 Current constraints: Examining the key constraints currently limiting GPs in teaching.

2.2 An expanded sector: Examining some of the locational barriers and requirements for sustainable teaching practice environments.

2.3 Remuneration: Developing stronger incentivised integration across the training continuum.

2.4 Case Studies: Identifying the locations with existing capacity to implement an integrated training model.

ALL FEEDBACK IS WELCOME
5.2.5 Case study template

Case Study 1

[insert town], RA [insert]
[insert state/territory]

<table>
<thead>
<tr>
<th>Project: New approaches to integrated rural training for medical practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity for a fully integrated rural training model</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>√</th>
<th>Ready now for pilot</th>
<th>The location is currently working across the full training continuum including a rural GP intern rotation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority site for development</td>
<td>Strong training capability but requires infrastructure investment. Considered an ideal training hub given the right supports.</td>
<td></td>
</tr>
<tr>
<td>Site identified for skill specific registrar pilot</td>
<td>The location has training capacity to trial the skill specific registrar concept.</td>
<td></td>
</tr>
</tbody>
</table>

Key contact [please provide]
Practice name [please provide]
Contact details [please provide]

1. TRAINING CAPACITY: CURRENT TEACHING CAPABILITY

(i) Current training capacity

[Please provide a description of the town and current training capacity at a practice, town and regional level. Please provide the key stakeholder currently involved in training in your region.]

(ii) Advanced Rural Skills Training

[Please provide details on the ARST provided and a brief description against each procedural or non-procedural advanced skill training offered and how this is achieved (consider reliant relationships).]

(iii) Current constraints

[Please list any constraints including in the local (at the practice level) state/territory arrangements (including in the accreditation arrangements) or national policy areas currently impacting on expansion or your ability to take on or take on additional students, interns or registrars.]
2. IMPLEMENTATION CAPABILITY: NATIONAL INTEGRATED RURAL TRAINING PATHWAY

(iv) Implementing an integrated approach
[Please provide a summary on your current capacity to implement an integrated approach now including existing local infrastructure and supports to implement training across the full training continuum – medical students, interns + registrars. This would also include your capacity to rotate a rural GP intern with a supportive regional hospital.]

(v) Clinical attachments
[Please indicate the minimum rural placement period against training stage which would be within your practice capabilities and appropriate to your rurality]

<table>
<thead>
<tr>
<th>Training stage (consider rurality and learning stage for early exposure)</th>
<th>Optimum placement period (for your practice)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st or 2nd year undergraduate medical school</td>
<td>[xx weeks, xx months]</td>
</tr>
<tr>
<td>3rd year or beyond in undergraduate medical school</td>
<td></td>
</tr>
<tr>
<td>PGY1, 2, 3 year postgraduate medical school</td>
<td></td>
</tr>
</tbody>
</table>

3. DEVELOPING A REGIONAL TRAINING HUB: BUILDING LINKS BETWEEN TRAINEES AND COMMUNITIES

(vi) Interdisciplinary training hub
[Please comment on regional capacity in terms of shared rotation with primary care and primary health care providers to enable varied and interdisciplinary experience during the community placement. Please include detail on the added supports required (incentives, seed funding, infrastructure funding, local coordination)].

(vii) Facilitating a training community
[Please comment on regional capacity in terms of retaining the individual for their full training years for those wanting to undertake training in the one location].
5.2.6 External stakeholder consultation

5.2.6.1 Stakeholder list

<table>
<thead>
<tr>
<th>Stakeholder List</th>
<th>Project: New approaches to integrated rural training for medical practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REGIONAL TRAINING PROVIDERS</strong></td>
<td></td>
</tr>
<tr>
<td>Adelaide to Cutback GP Training (SA)</td>
<td>Sturt Flavours GP Education and Training (SA)</td>
</tr>
<tr>
<td>Northern Territory GP Education (NT)</td>
<td>General Practice Training Tasmania (TAS)</td>
</tr>
<tr>
<td>Coast City Country General Practice Training (ACT &amp; NSW)</td>
<td>General Practice Training Valley to Coast (NSW)</td>
</tr>
<tr>
<td>Beyond medical education (NSW &amp; VIC)</td>
<td>Bogong Regional Training Network (VIC)</td>
</tr>
<tr>
<td>GP Synergy (NSW)</td>
<td>Victoria Metropolitan Alliance (VIC)</td>
</tr>
<tr>
<td>North Coast GP Training (NSW)</td>
<td>Southern GP Training (VIC and SA)</td>
</tr>
<tr>
<td>General Practice Training Queensland (QLD)</td>
<td>Western Australia GP Education and Training (WA)</td>
</tr>
<tr>
<td>Queensland Rural Medical Education (QLD)</td>
<td>WentWest (NSW)</td>
</tr>
<tr>
<td>Tropical Medical Training (QLD)</td>
<td></td>
</tr>
<tr>
<td><strong>UNIVERSITIES</strong></td>
<td></td>
</tr>
<tr>
<td>Broken Hill University Department of Rural Health (NSW)</td>
<td>University of Newcastle Department of Rural Health (NSW)</td>
</tr>
<tr>
<td>University Centre for Rural Health North Coast (NSW)</td>
<td>The University of Melbourne Rural Health Academic Centre (VIC)</td>
</tr>
<tr>
<td>Monash University School of Rural Health (VIC)</td>
<td>Greater Green Triangle University Department of Rural Health (VIC)</td>
</tr>
<tr>
<td>Mount Isa Centre for Rural and Remote Health (QLD)</td>
<td>Combined Universities Centre for Rural Health (WA)</td>
</tr>
<tr>
<td>Centre for Remote Health (NT)</td>
<td>University Department of Rural Health (TAS)</td>
</tr>
<tr>
<td>Centre for Regional Engagement (SA)</td>
<td></td>
</tr>
<tr>
<td><strong>TRAINING NETWORKS</strong></td>
<td></td>
</tr>
<tr>
<td>National Rural Health Students Network</td>
<td>National Rural Health Alliance</td>
</tr>
<tr>
<td>General Practice Students Network</td>
<td>Health Consumers of Rural and Remote Australia Inc.</td>
</tr>
<tr>
<td>Consumer Health Forum of Australia</td>
<td>General Practice Registrars Australia</td>
</tr>
<tr>
<td>Australian Medical Council Limited</td>
<td>Australian Rural Health Education Network</td>
</tr>
<tr>
<td>Remote Vocational Training Scheme</td>
<td>General Practice Education and Training Ltd</td>
</tr>
<tr>
<td>National Aboriginal Community Controlled Health Organisation</td>
<td></td>
</tr>
</tbody>
</table>
5.2.6.2 Stakeholder letter

19 December 2013

Dr Brett Dale  
Northern Territory GP Education  
Po Box 4829  
ALICE SPRINGS NT 0871

Dear Dr Dale

PROJECT: NEW APPROACHES TO INTEGRATED RURAL TRAINING FOR MEDICAL PRACTITIONERS

The RACGP has recently received a Health Workforce Fund project grant from the Department of Health to undertake national consultations with the rural membership to form strategic policy advice over a six month period, to 1 February 2013. The project is underpinned by a need to develop policy solutions to address rural workforce maldistribution, with particular reference to the rural training and workforce strategies that were outlined in the Mason Review.

A key project aim is to identify the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter rural practice, including the structural requirements and advanced skills training for new entrants and the existing GP workforce. A separate research undertaking around the training and support needs of rural GPs in relation to the acquisition, maintenance and retention of advanced skills, both procedural and non-procedural, forms an important project component.

The grant has enabled the RACGP to facilitate policy discussion with the profession to test some of the Mason Review recommendations relating to a national rural training pathway and to provide broader input to other areas of rural workforce policy relating to general practice. We have held two member consultations to date, in Brisbane and Darwin during October, with a further two consultations to be held in Adelaide and Sydney before the end of the year. The research component will commence in mid November through a member survey process.

The policy discussion generated from these consultations has provided many innovative and practical solutions to the current capacity constraints. We feel that it is important to share with our key training stakeholders the direction of these discussions and provide an opportunity for comment. Please find attached the consultation questions which have been structured against six themes all aligned toward ensuring a more integrated rural training pathway. It would be appreciated if you would provide any relevant comments particularly the key barriers from your organisation’s perspective in establishing a more streamlined national approach and any other ways to develop a culture of teaching in rural areas.
A policy paper will be prepared for the Department for submission by 1 February 2013. It would be appreciated if you could provide your formal input by Monday 9 December 2013. Please forward your comments online to the RACGP National Rural Faculty mailbox at rural@racgp.org.au. If you require any further information, please contact Ms Hildegard Mostmans on (03) 03 8699 0418. I look forward to your valued input which will support our collective efforts in securing a strong and sustainable future rural GP workforce.

Yours sincerely

Kathryn Kirkpatrick
Chair, National Rural Faculty

Attachment
5.2.7 RACGP State Faculty Board consultation

RACGP State Faculty Board Consultation

Project: New approaches to integrated rural training for medical practitioners

BACKGROUND

The Department of Health has funded the RACGP to undertake consultations with the rural membership to identify the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter general practice in regional and rural communities. This includes the structural requirements and advanced skills training for new entrants and the existing general practice workforce. The policy input obtained from the consultations will be used to inform the main policy advice to government to support the shaping and implementation of a national rural training pathway and inform broader workforce related strategy. The policy input has been guided by the key recommendations in the Mason Review relating to the coordination of training and the proposed rural pathway.

STATE FACULTY BOARD INPUT

An identified requirement in the project brief is to obtain further input from each RACGP State Faculty Board as the project nears its final drafting stage. It would therefore be appreciated if you would table the following two items for discussion at your final Board Meeting for 2013. Please provide your written feedback to the National Rural Faculty project team [bronwyn.darmanin@racgp.org.au] by Monday 9 December 2013.

The first, Item 1 below, relates to an area that requires further clarification at the state level. Further detail is required at the state level on the key jurisdictional barriers in establishing an integrated training pathway but particularly in building a rural GP intern rotation capability. The second, Item 2 over page, relates to a policy solution which has emerged during the consultations and which may benefit from further discussion at the State Faculty Board level. Building the culture of teaching through the establishment of a teaching hub in a specific town is considered a key requirement to supporting an expanded sector brought about by a new national rural training pathway. This idea is explained further in Item 2, below.

Item 1

<table>
<thead>
<tr>
<th>Project theme</th>
<th>Policy objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated rural training pathway</td>
<td>To provide a comprehensive rural medical training experience, with a seamless transition from undergraduate training to rural general practice by linking the different stages of training in rural settings.</td>
</tr>
</tbody>
</table>

Building a rural GP intern rotation capability

The development of rurally-based internship positions, a combination of acute care and primary care within a range of settings in a particular region, is a key focus in the Mason Report. The consultations have explored the key structural shifts and capacity issues in building a rural GP intern rotation capability. Further input is required from each State Faculty Board to capture the jurisdictional differences and changes required to facilitate such an approach.
Item 1 (continued) …

Please address the following question

1.1 In facilitating new rurally-based internship positions which provide a combination of acute care and primary care, what adjustments are required to the structural arrangements (intern allocation) in your state or territory?

Mason Review Reference

[Chapter 4, page 133-134] The missing link: rurally-based internship positions combination of acute care + primary care within a range of setting in a particular region.

Item 2

<table>
<thead>
<tr>
<th>Policy proposal</th>
<th>Policy outline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning Hubs in rural towns</strong></td>
<td>Provide the funding environment for large scale commissioning at the community level to provide the community interdisciplinary training and learning hub required for rural training which would facilitate more primary care experience across the full training continuum.</td>
</tr>
</tbody>
</table>

Building a teaching culture

Building the connectedness and leadership in a town to support a learning hub or integrated teaching model for the broader region to attract a cohort of students and registrars is certainly seen as valid policy approach. This would ensure towns are funded sufficiently and GPs have time to see their patients as well as time to teach.

Please provide your State Faculty Board view on the policy proposal, learning hubs in rural towns, outlined below.

2.1 The creation of learning hubs in rural towns would provide the critical mass of students and the supportive structures required to ensure positive early experience. This model is dependent on a coordination position, a director of clinical training. The coordinator could manage what are currently the key barriers to facilitating training in these communities including sorting through accreditation and making sure the curriculum is achieved. It would need to be a clear and delineated role and doesn’t need to be a doctor but someone who knows the local medical workforce. Provide the linkages, facilitate different training arrangements and ensure flexibility can be retained, rotations managed, so not to over burden supervisors. It provides the required support structure both for supervisors and students. Such an approach would help to draw out the vast untapped general practice teaching workforce. It could encourage a team approach within the community and varied and quality experiences for placements. It will help to engage GPs in teaching and passing on skills. It brings the university to the rural doctor and not the other way around.
5.2.8 Marketing and promotion

5.2.8.1 Extract from Fridayfacts newsletter: 30 August 2013

**News and media**

Fridayfacts newsletter: 30 August 2013
New approaches to integrated rural training for medical practitioners

The RACGP has recently received a Health Workforce Fund project grant from the Department of Health and Ageing (DoHA) to undertake national consultations with the rural membership to form strategic policy advice over a 6 month period, commencing 1 August 2013. The project is underpinned by a need to develop policy solutions to address rural workforce maldistribution, with particular reference to the rural training and workforce strategies that were outlined in the latest Review of Australian Government Health Workforce Programs (Mason Review). The College’s National Rural Faculty (NRF) will be managing this project on behalf of the RACGP Council.

The grant will enable the RACGP to facilitate policy discussion with the profession to test the Mason Review recommendations relating to a national rural training pathway and to provide broader input to other areas of rural workforce policy relating to general practice. Specifically, the College has been asked to identify the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter rural practice, including the structural requirements and advanced skills training for new entrants and the existing GP workforce.

This project provides a unique opportunity for members to help shape future policy to enhance and support the rural general practice workforce and improve the health of rural and remote communities through provision of quality primary care. I encourage you to become involved and contribute throughout the consultation phase which will be occurring over the coming months. There will be various ways to provide your input including through consultation sessions, member surveys or direct involvement in policy groups and contributing to small area studies. For more information and to register your interest contact the National Rural Faculty [email protected].
5.2.8.2 Extract from National Rural Faculty newsletter: October 2013

National Rural Faculty newsletter

15 October 2013

Chair report

Letter from the Chair

The NRF general meeting will be held, as is usual, at the RACGP conference for general practice – GP13, in Darwin. At the meeting the activity and achievements of the National Rural Faculty will be outlined and available for scrutiny by the members of our faculty. Over the last 12 months, the NRF has held membership engagement forums in Newcastle, Broken Hill, Port Hedland and Mackay and while it is important to seek and collect our member views, it is what we do with the information shared with us so generously that will count. In order to progress some of the recommendations formulated from the forums, the National Rural Faculty will work with the state faculties. The state faculties are well placed to use their regional knowledge to enact local solutions or programs. The National Rural Faculty will facilitate issues that require national action ensuring notification of the membership.

In August, the Department of Health and Ageing (now Commonwealth Department of Health) made a grant available for the RACGP to investigate, over 6 months, some of the recommendations from the Review of Australian Government Health Workforce Programs (the 'Mason Review'). The National Rural Faculty, on behalf of the RACGP, is undertaking the project – New approaches to integrated rural training for medical practitioners. The member forum, held each year following the NRF annual meeting, will this year take the form of one of the five consultations to feed into this project. The National Rural Faculty policy team is working with the Project Advisory Group to facilitate the consultations and synthesize the material that will form the basis for the report. The consultations will be complete by mid-December with the report due to be delivered to the Department in February.
5.2.8.3 Extract from National Rural Faculty newsletter: December 2013

National Rural Faculty Faculty newsletter

16 December 2013

Chair report

Letter from the Chair

The dedication and passion for rural health by our members has enabled the foundations of a new integrated rural training pathway to be developed, and we proudly congratulate our members on their strong engagement and enthusiasm in informing this process. The project aims to identify key issues, enablers for and barriers to establishing streamlined education and training for medical students, pre-registration and post-qualification trained GPs to enter and stay in rural practice, including the structural requirements and advanced skills training.

The policy discussion generated from these consultations has provided many innovative and practical solutions to the current training capacity constraints. Our task now is to see that the structural changes and policy shifts required to implement this pathway become a priority for our new government, including the emphasis on general practitioner-led primary care to support the next generation of GPs.

The strength of the NRF lies in its membership base. The Commonwealth project has enabled our members to have a voice in shaping future policy, ensuring we are part of the policy solution and I thank members for their commitment and generosity during the consultations. We hope this project provides an enduring legacy for rural communities and we look forward to working with the Abbott Government in developing an integrated rural training pathway for general practice.

Wishing you all a safe and joyful Christmas and New Year.

Dr Kathryn Kinchpatrick
Chair, National Rural Faculty

New approaches to skill investment and retention

In late December the RACGP National Rural Faculty will be sending out a survey to members in WA, Victoria, ACT and Tasmania as a final component of the New approaches to integrated rural training for medical practitioners project. The faculty is collecting information on the key issues, enablers and barriers to establishing streamlined education and training for medical students to enter general practice in regional and rural communities. This includes identifying the structural requirements and advanced skills training for new entrants and the existing general practice workforce. This is part of a Department of Health, Health Workforce Fund project grant, undertaken by a need to develop policy solutions to address rural workforce maldistribution.

The purpose of the survey is to clarify the feedback obtained from members during the member consultations and ensure that all National Rural Faculty members who would like to provide input have been reached. As such, this survey is being targeted to the four remaining alpine and teritoria where face to face consultations have not occurred.

The RACGP National Rural Faculty values your contribution and encourages you to participate in this survey.
5.2.8.3 Extract from State Faculty newsletters: December 2013 (appeared in Victoria, Western Australia, and Tasmania December Newsletters)

RACGP - Victoria Faculty newsletter December 2013

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychodynamic practice workshop: focused psychology strategies for GPs and mental health practitioners (part 2)</td>
<td>Saturday 10 May 2014</td>
</tr>
<tr>
<td>Victoria faculty drug and alcohol committee conference</td>
<td>Saturday 24 and Sunday 25 May 2014</td>
</tr>
<tr>
<td>Victoria faculty women in general practice committee conference</td>
<td>Saturday 16 and Sunday 17 August 2014</td>
</tr>
</tbody>
</table>

Express your interest

Please email vic.events@racgp.org.au or call on 03 8888 0400 to register your interest for any of the above events.

Further information on Victoria faculty events.

National news and opportunities

New approaches to skill investment and retention

Targeted Survey: ACT, Tasmania, Victoria and Western Australia.

The RACGP National Rural Faculty will shortly be sending out a survey to members in Victoria as a final component of its new approaches to integrated rural training for medical practitioners project.

The faculty is collecting information on key issues, models and barriers to establishing streamlined education and training for medical students to enter general practice in regional and rural communities. This includes identifying the structural requirements and advanced skills training for new entrants and the existing general practice workforce. This is part of a Department of Health, Health Workforce Fund project grant, underpinned by a need to develop policy solutions to address rural workforce redistribution.

The purpose of the survey is to clarify the feedback obtained from members during the member consultations and ensure that all National Rural Faculty members who would like to provide input have been reached. As such, this survey is being targeted to the four remaining states and territories where face-to-face consultations have not occurred.

The RACGP National Rural Faculty values your contribution and encourages you to participate in this survey.

RACGP Christmas closure

The RACGP Victoria Faculty will be closed from 5.00 pm on Friday 20 December 2013 and will re-open on Monday 6 January 2014. Please contact the faculty on 03 8888 0408 if we can assist you with any enquiries before Christmas.

The staff and board of the Victoria faculty would like to wish you and your families a safe and happy festive season, and a happy new year.

Department of Health updates

Immunisation newsletter – December issue

5.3. Research Activity Materials

5.3.1. Ethics Approval

NATIONAL RESEARCH AND EVALUATION ETHICS COMMITTEE

4 November 2013
Miss Kelly Dargan
RACGP National Rural Faculty
PO Box 1616
Coorparoo QLD 4151

Dear Kelly

Re: NREEC 13 – 013 Exploring the Broad Range of Advanced Rural Skills, Procedural and Non-Procedural, Practised in Rural Communities including the Retention and Supportive Factors in Skill Acquisition and Maintenance

Thank you for your response to ethical concerns with the above named study, raised by the RACGP National Research and Evaluation Ethics Committee (NREEC) from its meeting held on 14 October 2013.

The following documents were reviewed by the RACGP NREEC:

<table>
<thead>
<tr>
<th>Document</th>
<th>Dated</th>
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<tbody>
<tr>
<td>Cover Letter</td>
<td>Dated 22 October 2013</td>
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<tr>
<td>NEAF Application V2</td>
<td>Dated 22 October 2013</td>
</tr>
<tr>
<td>Survey Questionnaire V1.2</td>
<td>Dated 22 October 2013</td>
</tr>
<tr>
<td>Calculation of Minimum Nos.</td>
<td>Dated 22 October 2013</td>
</tr>
<tr>
<td>Draft Emails to Participants V1.1</td>
<td>Dated 22 October 2013</td>
</tr>
</tbody>
</table>

The Committee has reviewed the response out of session and noted that the interview process has been withdrawn from the study and that it will now be confined to a literature review and online survey analysis. Accordingly, I am pleased to advise that the study has been granted full ethics approval.

It should be noted that approval of ethical issues relating to this project are conducted in accordance with the NH&MRC’s National Statement on Ethical Conduct in Human Research. Accordingly, ethical approval should not be seen as an endorsement of any product associated with the research. This caveat should be included in any documentation relating to the study which refers to NREEC endorsement.

Please include the reference number NREEC 13 - 013 in all future correspondence with the Committee.

Yours sincerely,

Professor Siaw-Teng Liaw
Chair, RACGP National Research & Evaluation Ethics Committee
5.3.2. Marketing and promotion

Dear Ms Dargan,

The RACGP National Rural Faculty (NRF) is undertaking formal research into advanced rural skills to examine the broad range of skills practised in rural communities as well as the retention and supportive factors in skill acquisition and maintenance. This is part of a Health Workforce Fund project grant from the Department of Health to undertake national consultations with our membership to develop strategic policy advice.

Each survey participant has the chance to win a free one year membership to the RACGP. It would be appreciated if you could complete this short online survey requesting information about the types of advanced skills you currently hold and use, including your intention to continue to apply these skills or undertake further training. The information that you provide is important to the accuracy of our report. It is our hope to develop quality data that will help inform future rural training and workforce strategies.

The survey should take about 4 minutes.

Launch survey

If you do not wish to participate in this survey, click on the opt out link below. Non-participation or withdrawal from the study at any time will not jeopardise any future or ongoing relationship with either the National Rural Faculty or the RACGP more broadly.

If you have any questions please contact Lauren Cordwell, Manager, National Rural Faculty of the RACGP, phone 1800 636 764 or email lauren.cordwell@racgp.org.au.

The survey will remain open for 2 weeks, closing COB Wednesday 27 November.

Thank you in anticipation of your willingness to participate in our research.

Yours sincerely,

[Signature]

Dr Kathryn Kirkpatrick
Chair, National Rural Faculty
5.3.3. GP Narrative Template

**Research Project:**
Explore the broad range of advanced rural skills, procedural and non-procedural, practised in rural communities including the retention and supportive factors in skill acquisition and maintenance.

**General Practitioner:**

**RESEARCH AIM:**
To explore which advanced skills (both procedural and non-procedural) are being used in rural general practice and where; and to identify the barriers and enablers impacting the acquisition, use and retention of these skills. To clarify and identify the skill mix required for safe, high quality generalist practice by doctors in rural and remote communities to help target and prioritise future training and planning.

**NARRATIVE TEMPLATE**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of words (approx.)</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short description of your community (Location, size, ASGC-RA, distance to nearest regional hospital, general population characteristics)</td>
<td>120 words</td>
<td></td>
</tr>
<tr>
<td>Your Advanced Rural Skill area, and what training you have undertaken in this area</td>
<td>30 words</td>
<td></td>
</tr>
<tr>
<td>Describe the need for this skill in your area (in terms of the population it benefits, and how it is used to enhance healthcare for this population)</td>
<td>200 words</td>
<td></td>
</tr>
<tr>
<td>Describe the service gap in this skill area in your community (eg. barriers to accessing specialists). Identify any reliance factors for this service (eg. Obstetrics relies on an anaesthetist)</td>
<td>150 words</td>
<td></td>
</tr>
<tr>
<td>Current funding and support arrangements for maintaining advanced rural skill</td>
<td>50 words</td>
<td></td>
</tr>
<tr>
<td>Concluding statement about what advanced rural skills mean for your community and practice</td>
<td>50 words</td>
<td></td>
</tr>
</tbody>
</table>
5.3.4. Research survey questions

The RACGP National Rural Faculty is collecting information for a report on the range and scope of advanced skills practised in rural areas. This is part of a Department of Health Workforce Fund project grant to identify the training and support needs of rural GPs in order to maintain their skills and encourage their retention.

It would be appreciated if you would complete this short online survey requesting information about the types of advanced skills you currently hold and use including your intention to continue to apply these skills or undertake further training. The information that you provide will be important to the accuracy of our report. It is our hope to develop quality data that will help inform future training and workforce strategies.

The survey should take about 4 minutes to complete. Participants will have the option to enter a prize draw for free RACGP membership for 1 year upon completing the survey.

Personal information

*Age

18–29

*Town/s you currently work in (this information will be used to determine ASCG-RA Classification). Please enter both town and post code.

Please enter both town and post code for your second town if applicable.

*State (for each indicated town)
Choose more than one if required

- New South Wales
- Australian Capital Territory
- Queensland
- South Australia
- Northern Territory
- Tasmania
New approaches to integrated rural training for medical practitioners

Final report

*1. Practice setting

Choose the type of practice setting which best describes your facility or clinic.
Choose more than one if required

- [ ] Regional general practice
- [ ] Rural general practice
- [ ] Remote general practice
- [ ] Urban general practice
- [ ] Aboriginal Community Controlled Health Service
- [ ] District health service
- [ ] District hospital
- [ ] Private hospital
- [ ] Royal flying doctor service
- [ ] Government health department
- [ ] Rural clinical school
- [ ] Tertiary education sector
- [ ] Other: ____________

2. Time in practice

*2a) How long have you been in your current practice:

- [ ] Less than a year

*2b) How long do you plan to remain in rural general practice?

- [ ] Less than 6 months

3. Career stage

The year you graduated from your medical degree:

__________

4. Qualification set
Please indicate the qualification/s you hold from the list provided:
Choose more than one if required

- FRACGP
- FRACGP / FARGP
- FACRRM
- DRANZCOG
- Registrar in training
- Other: ________________________

*5. Medical degree

From which country did you obtain for your first medical degree

- Unknown

*6. Workforce role description

Choose from the list below which role best describes your current place in the health workforce:

- General practitioner
- Rural general practitioner
- Gp/vmo proceduralist
- GP rural generalist
- District medical officer
- Rural locum
- Academic
- Educator
- Other: ________________________

*7. Defining advanced rural skills

From the list below, which skills do you consider are advanced skills (procedural and non-procedural) relevant for rural general practice?
Choose more than one if required

- Aboriginal and Torres Strait Islander health
- Internal medicine
- Mental health
8. Advanced rural skills competencies

Choose from the list below which advanced rural skills you have acquired. (If you do not have an advanced rural skill, please choose ‘not applicable’ for questions 8 to 14).

Choose more than one if required

- Aboriginal and Torres Strait Islander health
- Internal medicine Mental health Paediatrics/Child health
- Small town rural general practice
- Anaesthetics
- Emergency medicine
- Obstetrics
- Surgery Palliative care Aged care
- Tropical diseases
- Chronic disease management
9. Of the skills selected in Question 8 – which are you still currently using in your community? Choose more than one if required

- Aboriginal and Torres Strait Islander health
- Internal medicine Mental health Paediatrics/Child health
- Small town rural general practice
- Anaesthetics
- Emergency medicine
- Obstetrics
- Surgery Palliative care Aged care
- Tropical diseases
- Chronic disease management
- Refugee health
- Defence
- Public health
- Not applicable
- Other: __________

- *10. Intention to continue to apply these skills

Do you intend to continue to use these skills in a rural area?

- Yes
- No
11. Advanced skill being used in practice

What supports do you require to maintain these skills:
Choose more than one if required

- Training opportunity
- Financial incentive
- Locum support
- Supervision
- Professional support
- Study leave
- Not applicable
- Other: ______________________

12. Competing factors

What external factors impact on your ability to practice these skills:
Choose more than one if required

- Specialist competition
- Service demand
- Skill maintenance
- Lack of inter-professional team
- Hospital infrastructure
- Credentialing arrangements
- Clinic infrastructure
- Lack of career pathway
- Lack of professional recognition
- Lack of remuneration
- Not applicable
- Other: ______________________

13. Competent in advanced rural skill but currently not using

If you are not currently using your advanced rural skill/s, what support do you need to regain competency to use these skills:
Choose more than one if required

- Not applicable (I am using my skill, or I haven’t acquired an advanced rural skill)
- Training opportunity
- Skill competency training
- Sub-specialty training
- Certification
- Opportunity in clinic
- Position in hospital
- Financial incentive
- Correct skill mix in the community
- Study leave
- Other: 

**14. Acquisition of an advanced rural skill**

Which of the following additional skills would you choose to undertake in order to meet a skill need in your community:  
Choose more than one if required

- Aboriginal and Torres Strait Islander health
- Internal medicine
- Mental health
- Paediatrics
- Small town rural general practice
- Anaesthetics
- Emergency medicine
- Obstetrics
- Surgery Palliative care Aged care
- Tropical diseases
- Chronic disease management
- Refugee health
- Defence
15. Acquiring a new advanced rural skill

What do you need to start:
Choose more than one if required

- Training opportunity
- Financial incentive
- Supervisor
- Professional support
- Study leave
- Other: 

If you would like to provide any further input, please contact the National Rural Faculty at rural@racgp.org.au.