The Rural Way

Implementation of a national rural generalist pathway

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WORLD LEADERS IN RURAL PRACTICE

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EXECUTIVE SUMMARY

Rural and remote communities require a strong generalist approach to provision of health services. In particular, communities require access to highly skilled doctors who are willing and able to provide a broad scope of clinical care, working in concert with other members of the health care team. That tradition, the tradition of 'Rural Generalist Medicine' is being eroded as a result of various factors, including trends to medical sub-specialisation in cities and a consequent diminished role for the generalist.

The practice of Rural Generalist Medicine is unique in the combination of abilities and aptitude that is required of a doctor for a distinctly broad scope of practice in a rural context. Rural Generalist Medicine is a concept that is grounded in the needs of rural communities, not on professional 'turf', nor professional craft-group identity or ambition.

Individual elements of the scope of Rural Generalist Medicine are shared across a number of professions and medical professional craft groups, including the care that is provided by those General Practitioners who are trained primarily in community-based primary care roles, hospitalists, career medical officers, emergency physicians, GPs-with-special interests as well as a range of consultant medical specialists. All these groups have their contribution to make. Similarly, there are still doctors who work to a comparably broad scope of practice in the urban context.

Rural Generalist Medicine is nonetheless a unique and essential component of health care if rural communities are to be assured of access to comprehensive primary care that is integrated with secondary and tertiary health care services. The strength of Rural Generalist Medicine is the ability to deliver quality, personalised and contextual care across the continuum of health services and from cradle to grave. The terms 'Rural Generalist Medicine' (the practice) and Rural Generalist' (the practitioner) are used throughout this report to describe that work.

THE SCOPING STUDY

This report seeks to identify key issues, enablers and barriers to establishing streamlined training and education for a career in Rural Generalist Medicine in regional and rural communities; including particular consideration for implementation issues in the prevocational years. A Reference Committee of key Stakeholders has been drawn together and has contributed to its development. Feedback from the broader ACRRM membership has been incorporated; and, a consultation of broader stakeholders has been undertaken.

AIMS FOR A NATIONAL RURAL GENERALIST PATHWAY

A nationally streamlined, rural training and educational pathway must ultimately lead to the provision of access to quality medical services for Australia's rural and remote communities, appropriate to their needs and location. To achieve this requires a pathway that:

- Is efficient, vertically integrated and nationally articulated.
- Directs trainees toward a long-term career in rural practice
- Leads to an expanded credentialed scope of practice, consistent with the needs of Australia's rural and remote communities.

- Produces an appropriately credentialed and motivated workforce for rural and remote communities; of a sustainable size; competent and committed to providing quality care, and, to providing services in a manner that enables an efficient use of available resources.

BACKGROUND

A carefully constructed, integrated training pathway has considerable potential to improve medical services for rural and remote Australians.

Rural and remote communities continue to experience medical workforce shortages.[1] Compared to their urban counterparts; rural doctors are working longer hours[2]; rural people are using medical services less[3]; receive less health funding[4]; and have a demonstrably poorer health status.[5]

In recent years the number of medical students being trained in Australia has more than doubled. This is not translating effectively to rural medical workforce retention.[6]

Changes in the broader health service context are prompting re-assessment of the assignment of roles across the professions, particularly toward greater cost efficiencies.[7] At the same time there is a growing consensus recognizing practitioners with the Rural Generalist scope of practice, combining flexibility and adaptability with a broad and advanced skill set as the necessary backbone to a sustainable rural system of care.

RG training pathways have commenced in all states and territories (except the ACT). A range of different pathway models have emerged. The most established Rural Generalist (RG) program, the Queensland Rural Generalist Pathway (QRGP) has been a landmark achievement in terms of rebuilding the state's rural workforce.

The variation between state/territory pathway models indicates an important role for national coordination. A major challenge for implantation is the surge of medical graduates that will be seeking access to training posts in the forthcoming years.

The road to a nationally articulated, vertical integrated Rural Generalist career path is primed. With careful construction; a national pathway has potential to reinvigorate rural practice and create a robust structural foundation for Australia's rural and remote medical services.

THE ROLE OF THE COLLEGE

The College has accepted responsibility for leadership of Rural and Remote Medicine for Australia. Implicit to this is a commitment to the communities of rural and remote Australia to actively advocate for a standards and education framework that ensures their medical service needs are met.

The Fellowship of ACRRM has been constructed to encapsulate a certified, core set of skills that are viewed as essential to providing the backbone of our rural and remote medical workforce.

[1] HWA. Health Workforce 2025 – Doctors, Nurses and Midwives. Vol 1. HW2025. 2013. (Ch. 17)
[2] AIHW. Medical Workforce 2012. National Health Workforce Series No. 8. Cat. No. HWL 54. Canberra: 2014. (S. 3.6)
[3] AIHW. Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure. Health and welfare expenditure series no. 50. Cat. No. HWE 50. Canberra: 2011. (S. 1.2)
[4] AIHW. HWE 50. 2011. Ibid. (S. 1.2)
[5] AIHW. Australia's Health 2012. Cat. No. AUS 156. Canberra: 2012. (Ch. 2)
[6] Mason J. Review or Australian Government Health Workforce Programs. 24 May 2013. (Ch. 2)
[7] Productivity Commission. Australia's Health Workforce, Research Report. Canberra: 2005. (Ch. 10)

The College recognizes the value of the many doctors in rural areas that do not have this particular scope. Maintaining a core workforce with the FACRRM scope of practice is nonetheless indispensable to universal access to medical care.

The College has a broader role in the national pathway process in leading efforts to drive innovation and promote continuing rural focus in all aspects of the operational program.

SUMMARY OF FINDINGS

- Increasing the number of rural trainees will only translate to a permanent and appropriately skilled workforce when combined with a targeted, multifaceted strategy. This approach must consider an appropriate skill set and motivations, the personal experience of training; and the ability of trainees to conceptualise rural practice as an aspirational long-term career.

- All states and territories (with the exception of ACT) have established a Rural Generalist training program. Differing models have been applied reflecting differences in health systems, infrastructure and underlying philosophies. A challenge for a national approach will be to ensure national consistency, portability, and coordination.

- Decades of reliance on recruitment policies to fill rural workforce vacancies with poor retention outcomes, and recent expansions in the medical student intakes have together created a major bottleneck. The number of trainees seeking training placement in forthcoming years is likely to outweigh the capacity of both metropolitan and rural hospitals and intense competition for training posts is anticipated.

- As has been the experience with medical schools, in situations of intense competition, without intervention, filtering processes allow access only to the academic super-performers at the expense of workforce considerations. It is critical therefore that access to necessary training posts is available to the graduates most likely to meet priority service needs of communities.

- There is a need overall to extend training beyond the traditional tertiary training centres. In the rural context where traditional approaches are impracticable, this requires creative solutions enabling quality assured training in diverse settings (community and hospital-based) with a minimum of resources.

ROLE DEFINITION AND RECOGNITION

- To successfully produce a permanent rural workforce, the pathway needs to present not just a rural training experience but a rural career path. Implicit to this goal is the need for trainees to build a professional identity for themselves; to be assured that their chosen career is esteemed and valued by society and the medical profession; and that it represents an economically viable career. Professional recognition, appropriate remuneration, and, active nurturing of a professional identity in rural medicine are all essential to achieving this.

SELECTION AND ATTRACTION

- There is a need to stem the leakage out of rural practice during prevocational training. In these critical early years of work and training, it is also essential to ensure access to training places for prospective rural doctors. An early 'provisional' selection process designed to identify trainees most likely to provide a competent, permanent rural workforce is required. Such a 'provisional pathway' will enable targeted funding for a program of support and professional identity development for the 'most prospective' trainees. Access for provisionally selected students to the Australian General Practice Training (AGPT) program should then be facilitated and simplified. Facility for lateral entry for appropriate candidates must be available at a later stage of training or career. The selection process must actively filter out candidates pursuing urban careers seeking access to specialist training posts through the pathway. It should be noted that the RVTS and Independent Pathways also provide a route to certified RG practice.

TRAINING PIPELINE

- There is considerable scholarship to support the contention that a continuous, vertically integrated training pipeline leads to successful outcomes for rural retention. The pathway should seek to ensure that as much training time as possible is spent in the rural environment (with rurally-based as well as remote, technology-enabled supervision and support). Rural time in the initial prevocational years is especially important, particularly as lasting personal relationships and lifestyle expectations tend to be formed at this time.

- Trainees in the pathway must have access to all necessary training. Firstly, (as outlined above) this requires provision of preferential access for the 'most prospective' trainees to training posts. Secondly, organisations need to be in place at the regional level to drive innovation, to create new training posts and collaborative training frameworks. Thirdly, it is imperative that rural and urban medical specialists be integrated into collaborative rural procedural training models to ensure quality assurance and enable skills acquisition.

- Efforts to vertically align the training pathway will be aided by consistency of standards and accreditation from the prevocational training years through to attainment of Fellowship. The pathway will involve diverse training arrangements. Simplicity, consistency and sensitivity to local circumstances will become increasingly important. This can be facilitated by a formal collaborative engagement between the relevant Colleges and standards authorities.

- Achieving workforce outcomes requires recognition of an appropriately broad scope of clinical practice. This scope should be defined in terms of its role in the rural and remote medical system of care. The promotion of Rural Generalist Medicine is essential to developing an effective Rural Generalist pathway. It produces doctors with a sufficiently broad scope of practice, selective advanced skills, competency across community and hospital settings; and an underlying community-orientation; to enable them to adapt to meet the needs as they emerge within their local community.

SUPERVISION AND MENTORING

- Specific and tailored support is especially important for a Rural Generalist pathway - firstly because the quality assurance framework will need to be more complex; secondly, because isolation and relocation creates additional personal pressures; and thirdly, because this can provide a useful framework for building professional identity and networks among the new generation of RGs.

- Provision of an adequate number of mentors and supervisors is a major challenge for the pathway particularly in the establishment years. Provision of adequate financial, industrial and administrative support is imperative.

- These efforts will need to be coupled with creative enabling strategies (including via video and telecommuncations) to engage all potential clinicians; including urban specialists, visiting consultant specialists and rurally-based clinicians across all work settings.

COORDINATON AND WORKFORCE PLANNING

- The emphasis on collaboration; vertical integration; customised delivery models; and alignment with changing workforce requirements, all underscore the need for leadership and coordination. This will be required at the regional, state/territory and federal level. ACRRM as the lead college for rural and remote medicine should also have a key role in ensuring a continuous focus on a rurally appropriate professional training experience.

RECOMMENDATIONS

In framing all recommendations, a general approach has been adopted of encouraging state and territory jurisdictions to develop their respective RG pathways in a way that will provide national cohesion and portability, and optimize their effectiveness in meeting workforce needs.

ROLE DEFINITION AND RECOGNITION

1. National Pathway Definition of Rural Generalist
Definition of 'Rural Generalist' as outlined by HWA Rural Medical Generalist Draft Framework should form the basis for credentialed practice and provide a standard for broad adoption.* This should be explicitly incorporated into the manifesto of an implemented National Pathway.

2. 'Scope of Rural Generalist Medicine' in Credentialing Frameworks
The 'Scope of Rural Generalist Medicine' should be adopted by all state and territory jurisdictions in a form adaptable to their respective credentialing frameworks such that it is able to be adopted where appropriate by their hospitals and health services.

3. Government Recognition and appropriate Remuneration
State/Territory and Federal governments should provide explicit recognition of the practice of Rural Generalist Medicine by doctors certified to do so. The value to the community of advanced skill-sets and wider scope of practice by Rural Generalists should be reflected in the frameworks for remuneration.

* NB. While the Framework document is still pending final approval, the Definition contained is the product of an extensive process of stakeholder consultation.

4. Rural Generalist representation on credentialing committees
At the Local Health Network (LHN) or regional hospital level all credentialing committees that engage in assessments related to the scope of Rural Generalist Medicine, should include representation by a practitioner credentialed to the Rural Generalist scope of practice.

SELECTION AND ATTRACTION

5. Register of Students interested in Rural Medicine Careers
A secretariat should be established for a Register of Students interested in careers in Rural Medicine. The register will be comprised of self-nominated final year medical students and interns. They will have access to talks, seminars, and careers advice. The aims are to facilitate a seamless transition into the RG program, to promote and recruit, and to inform candidates about their prospective career path. There should be a role for FRAME, ACRRM and other key stakeholders in this.

6. Provisional Selection Process
A 'Provisional Selection' process should be established at the outset of, or during the internship year (as determined by each jurisdiction). A quota of 'provisional' places to be created each year should be determined; and the same number of places should be set aside for that cohort in the AGPT program. Selection to AGPT should not be automatic but will be simplified and facilitated. The 'provisional selection' process should be rigorous and in accordance with College standards for Fellowship selection. It will assess each candidate's likelihood to fill the workforce needs (i.e. to pursue a career and reach a high level of competency as an RG and practice in rural or remote areas). 'Provisional Selection' should confer immediate benefits; including preferential access to training places and candidate advice and support along the continuum.

7. State and Territory level Coordinating Committee
Each state and territory should establish an appropriately representative organisation to determine the number of new RG pathway places to be created within their jurisdiction each year and also to determine an appropriate regional allocation of these places based on advice regarding capacity.

8. Facilitated AGPT Selection Process
Selection to the AGPT program for 'Provisionally Selected' candidates will be simplified. It will involve ratification of the 'provisional' selection as valid; and a quality assurance check (that the candidate has met an acceptable minimum, clinical and professional standard since selection).

9. Lateral Entry to the National Pathway
Facility for lateral entry to the program will be available. Training providers and/or Regional Collaborative Committees who identify appropriate candidates will be able to make submissions to their State/Territory Coordinating Committee to be considered and ratified as appropriate.

TRAINING PIPELINE

MAINTAINING THE RURAL FOCUS

10. Actively pursuing opportunities for rurally based Internships or rural experience
A policy should be established of endeavouring wherever practicable to utilise rural and regional hospitals and community based settings as training posts for internship placements. Rural exposure during internship should be viewed as a minimum requirement for trainees on the pathway.

11. Rural Generalists on staff in National Pathway hospitals
A policy should be established that all urban and major regional hospitals providing training in the RG pathway have RG practitioners on staff. Where appointments are not considered possible a second best option should be to ensure trainees have regular contact with a RG mentor and/or supervisor during their time in the hospital.

12. Additional KPI's for National Pathway Regional Training Providers
For RTPs participating in the RG training pathway, KPIs should be incorporated to ensure their alignment with its workforce goals. Specifically rural retention should be measured, 1, 3 and 5 years after completion of Fellowship. The results should be reported and publicised. A KPI which measures and incentivises training for provision of procedural practitioners should be included. This should measure provision of procedural practice upon completion of Fellowship and should similarly be measured 1, 3 and 5 years out.

13. Vertically integrated Accreditation and Standards
The accreditation process should be consistent across training posts throughout the RG pathway. ACRRM and CPMEC should undertake a process to ensure prevocational training posts also meet College standards.

14. Quarantining training places for the RG program
As a policy position each State/Territory program should commit to quarantining places for individuals selected to the RG pathway. There should be a senior departmental officer in place vested with authority and responsibility to ensure this occurs.

ENCOURAGING INNOVATIVE TRAINING SOLUTIONS

15. Integrating consultant urban specialists into procedural training and supervision
As part of the general principles in service provision, support for procedural RGs should be linked to regular visiting 'generalist specialists' who would act as mentors, supervisors and assist with the Safety and Quality Framework around rural procedural practice. This would include participation in advanced skills training on site; clinical audit; and, morbidity and mortality meetings with local staff. Additional learning 'intensives' would bring the RGs back to larger centres for additional hands on training. Telehealth could be utilised to enable remote supervision models with RG supervisors assisting in situ. Visiting consultant specialists should also be viewed as a potentially valuable training resource.

16. Prevocational Programs funding linked to Productivity and Innovation
An assessment of the funding structures of prevocational training programs should be undertaken with a view to improving their productivity; flexibility and innovation. In particular, incentives for cooperative and creative approaches, enabling optimal use of limited resources, should be considered.

17. Outcomes focused descriptions for RG training programs
More appropriate language is required to define the curriculum areas covered within each training post. Ill-fitted terminology is leading to misunderstanding about educational attainments. For example: the term 'rotation' is obsolete terminology to describe the full scope of the RG curriculum and learning covered in each clinical learning location or department.

18. Encouraging group learning events for RG pathway trainees
Educational events for Pathway trainees involving wide peer group interaction (e.g. web-based group tutorials, intensive workshops etc.) should be encouraged, particularly in internship and prevocational years. Funding structures of GPET and RVTS should specifically encourage these and provision of additional funding options should be investigated.

19. Remote Vocational Training Scheme (RVTS) to be considered part of the RG Pathway
The RVTS should be considered part of the RG pathway. Candidates selected to the RVTS should have access to the services and peer-networking activities of the Support Secretariat. The ACRRM Independent Pathway also provides a pathway to certified Rural Generalist practice.

KEY PIPELINE STRUCTURES AND PERSONNEL

20. Operational Director within in each state/territory
Each state and territory should have a dedicated officer in place with overall responsibility for the operation of their respective pathway.

21. Vertically integrated Support Secretariat
A dedicated Support Secretariat should be established. This should be available to trainees to provide a continuing port-of-call for personal and pastoral support (including peer interaction) throughout the duration of the training experience.

22. Dedicated Support Clinician for each trainee
Each trainee in the pathway should be designated a dedicated clinically-trained officer who has responsibility for checking their academic progress and providing quality assurance that their academic and supervision needs are being met. This officer should report to an operational director for the pathway.

23. Training and Career Pathway Plan
Each trainee should develop a training plan. This should determine a training pathway including a choice of advanced skills with consideration of workforce needs and the trainee's personal preferences. This exercise would be undertaken with a dedicated support clinician (see Recommendation 22 above) whose role entails responsibility for the trainee; as well as for fulfilling workforce planning requirements.

SUPERVISION AND MENTORING

24. Salaried Vocational Training
Vocational trainees should be remunerated through a fixed salary. This would simplify movement between community-based and hospital-based training settings. It would maximise portability, flexibility and opportunity for trainees on the RG pathway. It is noted that Medicare funding for services provided by AGPT registrars is drawn from a specific budget appropriation. As such it could be readily distributed through an alternative framework.

25. Support for National Pathway Supervisors and Mentors
Consideration should be given to ensuring that private practitioners who engage in supervision and mentorship activities are adequately supported in terms of funding for necessary resources, administrative support and recognition of the opportunity costs of their time. For supervisors and mentors employed in the public system consideration should be given to ensuring adequate administrative support and contracted time for educational activities.

COORDINATION AND WORKFORCE PLANNING

26. Regional Collaborative Committees
Regional Collaborative Committees should be established and include representatives of all key stakeholders in the ongoing operation of the Pathway. These should support and enhance the pathway's ongoing development. In particular, they should identify problems and endeavor to find regional solutions; and, identify opportunities for collaboration and innovation and actively work toward their implementation.

27. Commonwealth Officer responsible for National Pathway oversight
The Commonwealth officer with responsibility for oversight of the national program should have a specific brief to actively work to ensure training providers within the National Pathway are enabled through their guidelines to provide the training necessary to meet workforce outcomes.

28. Hospital Funding Contracts stipulate National Pathway Obligations
Commonwealth Hospital funding contracts should specify explicitly the responsibility that metropolitan hospitals have to meet workforce training needs for the entire region, not just the metropolitan environment. In particular specific reference could be made to ensuring access to training places for rural trainees and provision of specialist training services to rural trainees.

OUTLINE OF THE STUDY

Definitions related to Rural Generalist Medicine as applied in this study are clarified.

Section 1: provides a brief outline of the context in which this Report has been commissioned and highlights the broader structural shifts both in terms of the healthcare environment and the attitudes of the key players within it, that have foreshadowed it.

Section 2: provides the terms or reference and describes the methodological process involved with producing the Study.

Section 3: is a literature scope of the best knowledge and lessons from within Australia and internationally contained in scientific and relevant Grey literature that can inform the design of

a best-practice National Rural Generalist Pathway. It identifies the essential features of effective training programs, the potential barriers to their success and some prospective enablers.

Section 4: provides a broad outline for a functional National Pathway building on the experience of the various state and territory based RG training pathways and further exploring the concepts outlined in the HWA Rural Medical Generalist Draft Framework.

Section 5: sets out a more detailed analysis of key issues arising from the nationalization of the programs and the need to ensure the sustainability and continuing responsiveness of the programs. This section incorporates specific feedback from our wider ACRRM membership. Specific recommendations are given under the broad focus areas defined in the HWA Rural Medical Generalist Draft Framework.

NOTE ON DEFINITIONS USED IN THIS PAPER

RURAL GENERALIST and RURAL GENERALIST MEDICINE

These terms refer to practitioners as defined in the HWA RG Draft Framework; namely as those who have the skills to:

- Provide unsupervised, un-referred community or primary care of individuals, families and communities
- Work unsupervised to provide in-patient and emergency care in a hospital or related setting such as a remote health centre, multipurpose health service
- Provide extended specialised service in at least one approved medical discipline required to sustain comprehensive health care services in regional, rural and remote communities
- Provide services across the continuum of care in a range of settings and service delivery models including outreach where required (providing a dispersed specialist service such as community paediatrics, palliative care as examples)
- Apply a population health approach with relevance to the community in which they practice.

ADVANCED SKILLS

The terms '*advanced skills*' and '*extended specialised service*' for the purpose of his Study both refer to the ten specialist areas defined in the ACRRM Advanced Skills Training (AST) curriculum; namely: Aboriginal and Torres Strait Islander health, anaesthetics, adult internal medicine, emergency medicine, mental health, obstetrics and gynaecology, paediatrics, population health, remote medicine, academic practice, and, Rural Generalist surgery.

RURAL AND REMOTE MEDICAL SYSTEM OF CARE

This refers to the distinct systemic approach; required in order to provide rural and remote communities access to safe, effective and affordable health services as close to home as reasonably possible. The system of care comprises a network of colleagues and organisations that are linked and inter-reliant through professional and personal relationships, training pathways, referral pathways, distant and local supervision, ready access to telephone or online advice from a trusted colleague, continuing professional development, quality enhancement and advocacy for and with communities for improved health outcomes. The culture is one of patient–centredness and consideration for the community, thus including cultivation of professional and personal relationships, trust; and, flexibility around roles and tasks.

1. BACKGROUND

Universal access to medical care is the foundation stone of the Australian expectation of its national healthcare system. Rural and remote Australians however continue to endure pervasive workforce shortages.[8] These shortages coincide with rural people receiving less health funding[9], using health services less[10], evidencing lower health status[11]; and rural doctors working longer hours compared to their urban counterparts.[12] The government has identified recruitment and retention of doctors to practice in rural areas as the leading strategy to making improvements in this area[13]

1.1 RURAL GENERALIST MODEL AND RURAL SYSTEM OF CARE

Medical services models have evolved with broader technological and social changes and considerable focus is being brought to bear on more cost effective teamwork approaches.[14] There has been a growing recognition that a unique system of care exists in areas of geographic remoteness to tertiary medical facilities. Consensus is emerging that this represents the best approach to achieving quality of care for these areas. Practitioners with an RG scope of practice are the lynchpin of this model with the necessary breadth and depth of skills, and also with a philosophical commitment to flexibility and adaptability to define their role in accordance with community need. In particular they can fill the gaps in the continuum of care from primary care to secondary care through to tertiary care, applying models based on teamwork and a rural and remote 'system of care' (see definition).

The HWA RG Draft Framework defines a Rural Medical Generalist as a practitioner who has the skills to:

- *Provide unsupervised, un-referred community or primary care of individuals, families and communities*
- *Work unsupervised to provide in-patient and emergency care in a hospital or related setting such as a remote health centre, multipurpose health service*
- *Provide extended specialised service in at least one approved medical discipline required to sustain comprehensive health care services in regional, rural and remote communities*
- *Provide services across the continuum of care in a range of settings and service delivery models including outreach where required (providing a dispersed specialist service such as community paediatrics, palliative care as examples)*
- *Apply a population health approach with relevance to the community in which they practice.*[15]

[8] HWA. HW2025. Vol 3. 2013. Ibid. (Ch. 17)
[9] AIHW. HWE 50. 2011. Ibid. (S. 1.2)
[10] AIHW. HWE 50. 2011.ibid. (S. 1.2)
[11] AIHW. AUS 156. 2012. (Ch. 2)
[12] AIHW. HWL 54. 2014. Ibid. (S. 3.6)
[13] Parliament of Australia. Senate Inquiry into the factors affecting the supply of health services and medical professionals in rural areas. 2012. (Ch. 3, S. 3.44)
[14] Productivity Commission. Australia's Health Workforce, Research Report. Canberra: 2005. (Ch.10)
[15] HWA. Rural Medical Generalist Draft National Framework. Canberra: October 2013. (Pg. 8)

1.2 WORKFORCE DEVELOPMENT INITIATIVES

The more than doubling of medical student numbers in Australia has translated to far more doctors in training requiring placement in urban hospitals but not yet to a corresponding increase in FTE hours available to medical services.[16] The workforce shortfall is felt disproportionately in rural areas. This is perhaps best illustrated by the fact that average rural clinician work hours are considerably greater than those of their urban counterparts and increasing, while urban work hours are decreasing.[17] Furthermore there has been a steady decline in the provision of procedural care and expanded scope generalist practice. The current proceduralist workforce is ageing and an insufficient number of trainees are emerging to replace them.[18] [19] [20]

A plethora of initiatives by state and federal governments have had positive but ultimately insufficient impacts in terms of long term rural retention. In the decade 2000- 2010, only 28 Australian-trained new doctors per annum were recorded as entering the rural medical workforce;[21] and, more recent studies have found only 40% of graduates from the RCS programs are taking up permanent rural practice.[22] Even with the introduction of the GPET Rural Pathway, 58% of doctors who had attained their Fellowship through the rural pathway had left rural practice within 5 years.[23]

Major efforts have been made at the front end of the rural pipeline (e.g. new rural medical schools, Rural Clinical Schools (RCSs), John Flynn Scholarship Scheme (JFSS), Bonded Scholarship Program (BSP), mandated rural student recruitment etc.). However, efforts targeting the years following graduation and on to vocational registration as a specialist practitioner have been discontinuous and fragmented.

The proposed National Rural Generalist Pathway will articulate these efforts and complete the rural pipeline in the years that have been shown to be the most significant in influencing rural retention. It will be the final piece in the jigsaw toward creating a fully integrated pathway to a credentialed and recognized career as a Rural Generalist.

1.3 RECOMMENDATIONS OF RECENT REVIEWS

There is a broad recognition among Governments of the need to develop an integrated rural training experience. In particular the Australian Government Review of Health Workforce Programs (Mason Review, April 2013) made the following recommendation:

> *"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.*

[16] Mason J. 2013. Ibid. (Ch. 2)
[17] AIHW. HWL 54. 2014. Ibid. (S. 3.6)
[18] Health Workforce Queensland and New South Wales Rural Training Network. Medical Practice in Rural and Remote Australia: combined workforce agencies national minimum data set report. Brisbane HWQ. 2011.
[19] RWAV. RWAV Position Statement: GP Proceduralists. 2012.
[20] Rural Health West. Workforce Analysis: Rural General Practitioners in Western Australia. Profile of GP Proceduralists. 2012.
[21] Webber K. Parliamentary Inquiry into Overseas Trained Doctors: The 10-Year Moratorium. Melbourne VIC: Rural Health Workforce Australia. 11 February 2011. (Pg. 15)
[22] Eley DS, Synott R, Baker PG, Chater AB. A decade of Australian Rural Clinical School graduates – where are they and why? Rural and Remote Health. 2012; 12:1937.
[23] GPET website: http://www.gpet.com.au/News-and-events/News-Articles/RURAL-TRAINING-KEEPS-GPs-IN-RURAL-AREAS. Obtained: Feb 2014.

> *The model will need to build on existing programs and maintain access to primary care and private sector training through 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 incentivizing collaboration by local and regional agencies and supporting a local network approach."*[24]

The Mason Review identified that it had proceeded from the findings of the 2006 Productivity Commission Report[25] to Council of Australian Governments (COAG); and the HWA's 2013, 'Health Workforce 2025'[26]. The Productivity Commission report specifically noted that:

> *"…it (the rural and remote Australian health workforce) has been an 'incubator' for evolution in job design and other workplace innovation…. Improved outcomes are attainable, especially if broader reform frameworks make explicit provision to address rural and remote issues."*[27]

Both these reports pointed to the need to embrace innovation and new models of care, to increase the efficiency and effectiveness of the available health workforce and improve its distribution. [28] The 2013, HWA National Rural and Remote Health Workforce innovation and reform (RRHWIR) strategy further expanded on these themes with a specific focus on rural and`remote communities.[29]

In relation to Rural Generalists, the 2012 Senate Review into the factors affecting the supply of health services and medical professionals in rural areas specifically concluded:

> *"… if the purpose of a rural health workforce is to provide access to quality health care for communities in rural areas and that this goal is best advanced through a significant increase of Rural Generalist GPs."* [30]

1.4 RURAL GENERALIST PATHWAY DEVELOPMENTS

Over the last decade there has been a series of decisive steps toward the establishment of a national Rural Generalist pathway:

- 2007, Rural and Remote Medicine College and qualification recognized by AMC.
- 2008, Rural Generalist Medicine recognized as a specialty by the Queensland Government reflected in industrial recognition legislation.
- 2008, Queensland Rural Generalist Pathway (QRGP) program commences

[24] Mason J. 2013. Ibid. (Recommendation 4.1, Pg. 145)
[25] Productivity Commission. 2005. Ibid. (Ch. 10)
[26] HWA. Health Workforce 2025. Volumes 1,2,3. 2013.
[27] Productivity Commission. 2005. Ibid. (Ch. 10, Pg. 204)
[28] Mason J. 2013 ibid. (S. 4.1, 4.2)
[29] HWA National Rural and Remote Health Workforce Innovation and Reform Strategy. May 2013.
[30] Parliament of Australia. Australian Senate. Community Services Reference Committee. Review of factors affecting the supply of health services and medical professionals in rural areas. 2012. (Committee View: Ch. 3, S. 3.44)

- 2010, WA Country Health Service Rural Practice Program commenced.
- 2010, NOVA Review of QRGP, commissioned by HWA to provide advice on the potential to nationalize the model
- 2012, NSW Rural Generalist Training Program commenced.
- 2013, Tasmania Rural Generalist Pathway Director appointed.
- 2013, Victorian General Practice – Rural Generalist Program commenced.
- 2013, Ernst & Young Evaluation of the QRGP confirms positive outcomes of the program.
- 2013, NT Rural Generalist Pathway launched based on the QRGP model.
- 2013, HWA Rural Medical Generalist Draft National Framework drawn up providing an initial framework for a national pathway. (NB. While this has not yet received final approval - its current format is the product of an extensive process of stakeholder consultation.)

1.5 OUTCOMES OF THE QRGP MODEL

The QRGP warrants special attention as the most established and extensively documented of all the RG training programs. It is also exemplary of the potential of RG pathways to address the seemingly insoluble task of sustainably meeting rural medical workforce needs.

The Ernst and Young Report into the QRGP recorded the following outcomes:

- Critical Level 1 hospital vacancies (i.e. those leading to hospital closure) decreased by 96% between 2010 and 2012 (from 750 to 34)
- Critical Level 2 hospital vacancies decreased by 57% (from 1109 to 481)
- 8 doctors received fellowship (for the full RG scope of practice including advanced specialised skills) in rural and remote practices between 2010-2011
- 14 doctors completed fellowships in rural and remote practices in 2012 including: 1 with advanced paediatric skills; 2 obstetric proceduralists; 8 anaesthetic proceduralists; and 3 with advanced skills in emergency medicine.
- 76 rurally-based doctors were in year 5/6 of their fellowship training in 2013.
- Training pathway places have been consistently oversubscribed
- Current Trainees surveys found 44% intend to practice rurally from 15 years to permanently, 62.4% intend to practice rurally for a long period.[31]

Entire hospitals, previously at risk of closure are now run by the new cadre of RG proceduralists (many with blended employment arrangements); such as for example, the Kingaroy Hospital. This serves the South Burnett Catchment area with a population of 35,000. Since the commencement of the QRGP this has been able to reopen its surgical services and provided the busiest non-specialist birthing service in the state.[32]

In accordance with workforce exigencies the program has resulted in a large number of hospital appointments. It should be noted also that around 30% of the trainees in the program were reported as either wholly or concurrently in private practice in both 2011 and 2013.[33]

The QRGP model has been used loosely as the basis for all the subsequent state and territory based programs. Each state and territory has found the necessity to depart from the model to varying degrees as deemed appropriate to the exigencies within their respective jurisdictions.

[31] Ernst and Young. Evaluation and Investigative Study of the Queensland Rural Generalist Program. Queensland Health, Office of Rural and Remote Health. February 2013. (S.4.3, S.5.4).
[32] Based on advice from Peta Rutherford, Darling Downs Hospital and Health Service. Mar, 2014.
[33] Sen Gupta TK, Manahan DL, Lennox DR, Taylor NL. Comment on: Rural Generalism and the Queensland Health pathway-implications for rural clinical supervisors, placements and rural medical education providers. Rural and Remote Health. 2013; 13:2765.

1.6 THE WAY FORWARD

Outlined below is a scoping of the best knowledge and lessons from the experiences of the pilot programs already underway, from the academic literature, both national and international, and from the expertise of our membership and feedback and advice from key stakeholders. The report draws upon all these and further explores the propositions of the Draft National Rural Medical Generalist Framework to propose a way forward toward a nationally articulated, fully vertically integrated Rural Generalist Pathway.

2. STUDY METHODOLOGY AND APPROACH

2.1 TERMS OF REFERENCE

- To identify the key issues, enablers and barriers to establishing streamlined training and education for generalist practice in regional and rural communities. This will include consideration of the implementation issues and, in particular, the coordination and accreditation issues relevant to post-graduate medical education (i.e. postgraduate years one and two) on a national basis.

- To incorporate into the analysis the views of our broader ACRRM membership.

- To work with key authorities (Federation of Rural Australian Medical Educators (FRAME), Confederation of Postgraduate Medical Education Councils (CPMEC), ACE (Association of Chief Executives), Rural Doctors Association of Australia (RDAA), Australian College of rural and Remote Medicine (ACRRM)) to examine operational and implementation issues related to Health Workforce Australia's Rural Medical Generalist Draft National Framework.

- To consult with key education providers and stakeholders (including: Jurisdictions, GP Registrars Association, Australian Medical Students Network) regarding operational aspects of delivering more integrated rural training.

2.2 STUDY METHODOLOGY

STEP 1: LITERATURE SEARCH

To incorporate an evidence base to the advice contained in the report, a Medline search was undertaken of articles from 2000 till the current date both in Australia and overseas. The search did not aim to be exhaustive but to source the most relevant publications and extended, where appropriate, to cited articles arising from the initial search. A particular focus was given to the most recent Australian studies in view of the considerable contributions to our knowledge arising from the country's emergent rural training programs in recent times. The search extended to relevant Grey literature including Government Reports, College and Organisational Discussion Papers and Studies.

The literature was interrogated to identify the features associated with successful rural training programs and pathway arrangements and identify any challenges arising or that could be expected to arise from these in the current Australian context. Some initial recommendations are proposed either from the literature itself or as a logical extension of the lessons it contained.

STEP 2: STUDY REFERENCE COMMITTEE

A Reference Committee was drawn together from the five key stakeholders stated in the Terms of Reference for the project. These included: ACE, CPMEC, RDAA, FRAME and ACRRM. (Membership attached at Appendix I). The Committee was presented with a draft copy of the Literature Scope; a copy of the draft program outline as derived from the National Rural Medical Generalist Draft Framework; some background information to guide discussion in the focus areas. A day long workshop was devoted to developing advice and guidance on the 5 key areas as defined in the National RMG Draft Framework: Selection and Attraction; Professional Recognition; Maintaining the Rural Pipeline; Coordination and Workforce Planning; and,

Supervision and Mentoring. Consistent with the stated 'Project Aims" particular attention was given to these in the context of the early training phase.

STEP 3: ACRRM MEMBERSHIP FEEDBACK

ACRRM member feedback was collected through an online survey tool. A focus group approach was taken to this exercise. The responses informed further development. The perspectives of ACRRM registrars were identified as particularly important as both the recipients of the pathway experience and the people being nurtured toward becoming our future Rural Generalist practitioners. A second survey was undertaken specifically for this group. Questions in this survey sought the Registrars' perspective based on their experience.

The results from the Registrar Survey are incorporated into Section 5 as appropriate. Individual responses obtained from both surveys that reflect common themes are also included in this Section to inform and contextualize the discussions contained.

STEP 4: FINALISING THE WORKING DRAFT

An ongoing process of draft revisions; suggested changes, or lines of enquiry; meetings, emails and other communications ensued. A penultimate draft was circulated to the Working Group for final approval.

STEP 5: BROADER STAKEHOLDER FEEDBACK

The finalized draft was sent out to the broader stakeholder group.

3. LITERATURE SCOPE

The study explores the literature to identify the essential features of a best practice model for a nationally articulated, training pathway to Rural Generalist practice. It further seeks to identify what barriers to implementation exist, or are likely to emerge, and to point to any enabling strategies identified in the literature or logically extending from it.

The National Pathway goal as stated in the RMG Draft National Framework is:

> *"To create a coordinated, efficient training pathway that supports efforts to build a sufficient and sustainable RMG workforce with the necessary skills, ability, desire, recognition and identity. This is turn, will support the provision of access to a suite of medical services for people residing in rural, remote and regional Australia that is appropriate to their needs and location."*[34]

Applying this basic approach the key goal areas are defined as: growing a workforce: (1) of sufficient size to meet community needs; (2) competent to provide quality, safe rural medical care, and (3) applying a sustainable system of care for the rural context. And, finally to create a pathway apparatus to attain these, that is both efficient and coordinated.

Each of the first three goals is explored below with consideration to how the pathway might efficiently attain them. Some particular areas for attention relating to nationally delivery of the best practice model are then examined.

3.1 GOAL 1: BUILD A SUSTAINABLE RURAL WORKFORCE

3.1.1 RURAL LOCATION OF TRAINING

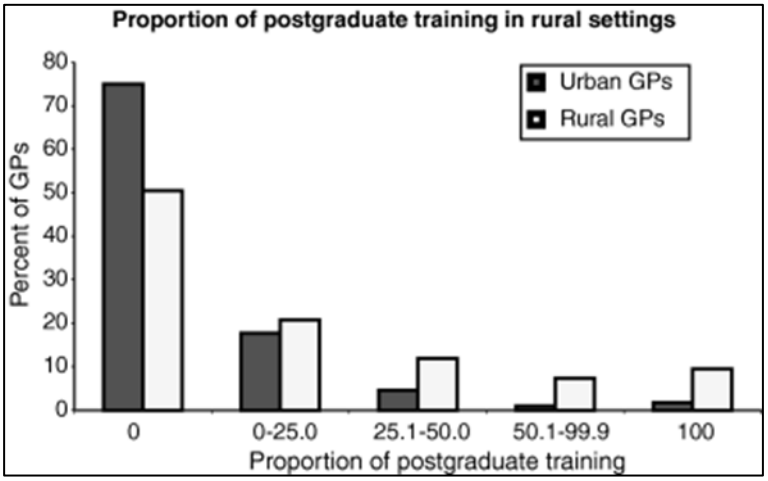
The clearest evidence regarding postgraduate training toward rural retention relates to training time spent in the rural area. Furthermore the relationship appears to increase as doctors progress through their post-medical school graduation years and likelihood increases with duration of time spent in rural areas (See Figure 1. below).[35] [36] For example Wilkinson et al found that those doctors reporting more than half their postgraduate training in rural locations were 10 times more likely to be rural doctors then those with no rural training.[37] The link between rural postgraduate training and rural practice is supported by studies in Canada[38], US[39] [40] [41], Japan[42] and Norway[43]. By way of example, the postgraduate training program in Finmark (Norway's northernmost county) whereby vocational registration can be obtained almost entirely

[34] HWA 2013. Ibid. (Pg.7)
[35] Wilkinson D, Laven G, Pratt N, Beilby J. Impact of undergraduate and postgraduate rural training, and medical school entry criteria on rural practice among Australian general practitioners: national study of 2414 doctors. Medical Education. 2003; 37: 809–814.
[36] Landry M, Schofield A, Bordage R, Bélanger M. Improving the recruitment and retention of doctors by training medical students locally. Med Educ. Nov 2011; 45(11):1121-9.
[37] Wilkinson D et al. 2003. ibid.
[38] Landry M et al. 2011. Ibid.
[39] Rosenthal TC, McGuigan MH, Anderson G. Rural Residency Tracks in family practice: graduate outcomes. Fam Med. Mar 2000; 32(3):174-7.
[40] Ross R. Fifteen-Year Outcomes of a Rural Residency: Aligning Policy with National Needs. Fam Med. 2013; 45(2):122-7.
[41] Acosta DA. Impact of rural training on physician workforce: The role of post residency education. The Journal of Rural Health. 2000; 16(3):254-261.
[42] Matsumoto M, Inoue K, Kanjii E. Long term effect of the home preference recruiting scheme of Jiichi Medical University Japan. Rural and Remote Health. 2008; 8:1-15.
[43] Straume K, Shaw DM. Effective physician retention strategies in Norway's northernmost county. Bull World Health Organ. 1 May 2010; 88(5): 390-394.

within the county, a 5 year post registration retention rate of 65% amongst it graduates has been attained.

Conversely, junior rural doctors' decisions to leave rural practice are commonly related to factors external to the medical experience particularly in response to family, spousal, lifestyle connections to the metropolitan setting.[44] This is consistent with the intuitive notion that the years following university graduation are often formative in terms of establishing lifestyle expectations, plans and meeting future life partners. By illustration, Laven et al., found that although rural background was a significant predictor of a decision to practice rurally, the rural background of the spouse was an even stronger predictor.[45] This is also supported by international studies. [46] While the pathway does not directly influence these personal decisions, intuitively, the more years spent in a rural location, particularly during post undergraduate studies, the greater the likelihood of retention success.

Figure 1. Impact of undergraduate and postgraduate rural training, and medical school entry criteria on rural practice among Australian general practitioners: national study of 2414 doctors[47]



3.1.2 TRAINING FOR RURAL MEDICAL SYSTEM OF CARE

The opportunity to practice the advanced skill set particularly procedural skills is an attraction to rural practice[48] [49] [50] and the ability to do this is associated with improved rural retention outcomes.[51] Econometric modeling even suggests that junior doctors would be prepared to take a salary reduction of between 20-25% in return for the opportunity to do procedural work.[52] The attraction of proceduralism for prospective

[44] Rogers ME, Searle J, Creed PA. Why do junior doctors not want to work in a rural location, and what would induce them to do so? Aust J Rural Health. Oct 2010; 18(5):181-6.
[45] Laven GA, Beilby JJ, Wilkinson D, McElroy HJ. Factors associated with rural practice among Australian-trained general practitioners. Med J Aust. 2003; 179(2): 75-79.
[46] Landry M et al. 2011. ibid.
[47] Wilkinson D et al. 2003. ibid.
[48] McGrail MR, Humphreys JS, Scott A, Joyce CM, Kalb G. Professional Satisfaction in general practice in rural Australia: does it vary by size of community? Med J Aust. 2010; 193:94-98.
[49] Ernst and Young. 2013. ibid. (S. 5.3)
[50] AHMAC Career Decision Making by Postgraduate Doctors: Key Findings. 2005. (Pg.3)
[51] Russell DJ, Humphreys JS, McGrail MR, Cameron (W)I, Williams PJ. The value of survival analyses for evidence-based rural medical workforce planning. Human Resources for Health. 2013; 11:65.
[52] Sivey P, Scott A, Witt J Joyce C, Humphreys J. Why junior doctors don't want to become General Practitioners: A Discrete Choice Experiment from the MABEL Longitudinal Study of Doctors. Melbourne Institute Working Paper Series. Working Paper No. 17/10. University of Melbourne. 2010.

rural doctors is also apparent in the international literature.[53] For example: the very successful Cascades rural postgraduate training program in Oregon, United States reported 79% of its graduates who are now practicing rural doctors have hospital admitting rights and 31% regularly practice obstetrics.[54]

Conversely, the challenges of the advanced skills requirements encountered in the rural setting, when coupled with inadequate training and supervision, lack of professional support, and excessive hours, can be a source of dissatisfaction particularly with junior doctors.[55]

3.1.3 SELECTION MATCHED TO PATHWAY GOALS

Selecting the 'best' applicants for the RG pathway involves a mechanism for not just determining the applicant's credentials to be competent for the particular skill set necessary for RG but also their 'likelihood' of practicing rurally. The GPET system, which until recently assessed purely on generic general practice credentials; has been considered to have had limited success at permanently attracting rural doctors.[56] Mandatory rural terms have also had lower retention outcomes and low satisfaction particularly for international medical graduates. [57] [58]

There is evidence-based consensus for the following as a strongly predictive basis for selecting student's likely to practice rurally.

- *Undergraduate rural clinical exposure*:[59] The predictive association increasing with the duration of the experience and the later it is in the program.[60]

- *Expressed interest in rural medicine*. [61] (In the Australian case, this can be transparently demonstrated through enlistment to the RCSs, rurally focussed undergraduate programs and also in the plethora of Government programs e.g. JFSS, RUSC etc.)

- *An interest in advanced and/or procedural practice.* Sivey et al. found that procedural practice was highly valued by some but not all junior doctors.[62] Logically, a focus on those most interested in the style and scope of practice most appropriate to rural needs would aid retention.

[53] Matsumoto M, Okayama K, Inoue K, Kanjii E, 'Factors associated with rural doctors' intention to continue a rural career; a survey of 3072 doctors in Japan.' Aust J Rural Health. 2005; 13(4):219:225.
[54] Brooks RG, Walsh M, Mardon RE, Lewis M, Clawson A. Acad. Med. 2002; 77:790-798.
[55] Smith DM. Barriers facing junior doctors in rural practice. Rural and Remote Health. 2005; 5:348.
[56] Campbell DG, Campbell DG, Greacon JH, Giddings PH, Skinner LP. Regionalisation of General Practice Training are we meeting the needs of rural Australia. Med J Aust. 2011; 194:S71–S74.
[57] Bayles SA, Magin PJ, Sweatman JM, Reagan CM. Effects of compulsory rural vocational training for Australian general practitioners: A qualitative study. Australian Health Review. 2011; 35: 81–85.
[58] McGrail MR, Humphreys JS, Joyce CM, Scott A. International medical graduates mandated to practice in rural Australia are highly unsatisfied: results from a national survey of doctors. Health Policy. 2012; 108:133-139.
[59] Wilkinson D et al. 2003. Ibid.
[60] Wilkinson D et al. 2003. ibid.
[61] Brooks RG, Walsh M, Mardon RE, Lewis M, Clawson A. Acad. Med.2002; 77:790-798.
[62] Sivey P et al 2010. Ibid.

- *Rural Background*. This is the personal characteristic most predictive of rural retention.[63] [64]

One challenge for a nationally articulated pathway is to ensure that selection is led by organisation/s committed to its goals. This is complicated in Australia by a need for congruence with the existing AGPT structure with its own set of national goals; the priorities of the state health departments who will in most cases be the initial employers; and the availability of training posts. An important strategy to this end is early selection by a dedicated authority. As one study has noted it is important to incorporate this with informed options for lateral entry to ensure that those who 'miss out' still have access.[65]

3.1.4 RURAL GENERALIST CAREER PATH

The 'rural pipeline' concept is becoming broadly recognized across the international literature as an essential element to producing rural doctors.[66] ACRRM is a recognized AMC specialist college with a fellowship reflecting a distinct model of practice but up till now, its practitioners have had to try to navigate a credentialed career path for themselves using the training resources of other specialties.

It is reasonable to assume that, as with other specialties, junior rural doctors will naturally aspire toward the career path of who they perceive to be their collegial elders: hence the value of continuing connectedness to the RG professional apparatus. There is evidence that time spent in urban hospitals, particularly during specialty rotations often exposes trainees to attitudes of negativity toward rural practice.[67] A perception of the inferiority of rural practice among trainees is predictive that they will not practice rurally,[68] [69] while rural clinical experience with an inspiring RG mentor is predictive of rural retention.[70]

An important challenge therefore is maintaining the sense of connectedness to the pathway during the intervening years: PGY 1-3. The leakage out of rural practice during these years has been specifically recognised as requiring attention in the Mason Report.[71] In Western Australia for example it has been reported that 100 applications were received for 66 RCS places in 2008 and in the same year WAGPET

[63] Dunbabin J, Levitt L. Rural origin and rural medical exposure: their impact on the rural and remote medical workforce in Australia. Rural and Remote Health. 2003; 3:212.
[64] AHMAC Career Decision Making by Postgraduate Doctors: Key Findings. 2005. (Pg.3)
[65] Kitchen S. Rural Generalism and the Queensland Health Pathway – implications for rural clinical supervisors, placements and rural medical education providers. Rural and Remote Health. 2013; 13:2359.
[66] Norris TE. The universal importance of the 'rural pipeline'. Aust. J. Rural Health. 2005; 13:203-204.
[67] McKenzie A, Beaton N, Hollins J, Jukka C, Holliins A. Supporting GP Advanced Rural Skills Training. Aust J Rural Health. 2013; 21:41–45.
[68] Robinson M, Slaney GM, Jones GI et al. GP Proceduralists: 'the hidden heart of rural and regional health in Australia. Rural Remote Health 2010;10-1402.
[69] Jones GI, DeWitt DE, Cross M. Medical students' perceptions of barriers to training at a rural clinical school. Rural and Remote Health 7: 685. 2007.
[70] Couper ID, Hugo JF, Conradie H et al. Influences on the choice of health professionals to practice in rural areas. S Afr Med J 2007;97:1082-6.
[71] Mason J. 2013. Ibid. (S. 4.1)

was only able to fill 17 of its 28 vocational training places.[72] This evidence again supports the early selection approach.

Another important consideration will be to ensure that during any periods of the term that may need to be spent in urban settings; trainees are still given the opportunity to remain connected to the pathway and the RG network. Ideally, a dedicated mentor and secretariat officer would be in place for the duration. In the QRGP these are established but in a reduced role in the vocational years.[73] The HWA RMG Draft Framework recommends applying a 'host region' approach maintaining employment with the 'host' region even during training terms elsewhere.[74]

3.1.5 RECOGNITION AND REMUNERATION

Considerable efforts at the undergraduate level have been invested in nurturing a sense of professional identity amongst undergraduate medical students interested in careers in rural medicine (for example, JFSS, RCSs, RAMUS and Rural Student Clubs). The efficacy of these efforts is evidenced by oversubscription to Rural Clinical School programs[75] and prevocational rural training programs.[76] [77]

In the broader Australian medical community RGs are commonly viewed as less capable than their urban specialist counterparts, and their jobs as less prestigious, [78] [79] These views are not supported by the evidence, and yet there is ample evidence to suggest that they dissuade trainees from practising rurally. [80] [81]

Recent studies point to the increasing relevance of the level of remuneration to the emergent trainee cohorts' motivation to rural practice.[82] The QRGP has already demonstrated considerable success in terms of recruitment of trainees and provision of permanent rural practitioners.[83] The Queensland program has made provision for formal recognition of a practitioner Senior Medical Officer (SMO) level with near specialist remuneration levels for a State Government recognised discipline of Rural Generalist Medicine. The Northern Territory Government is in the process of establishing similar arrangements. The equivalent programs in Victoria, Western Australia and New South Wales recognise a Vocational Medical Officer (VMO) level qualification which is undifferentiated from that obtainable with an FRACGP without undertaking additional advanced rural skills training. In some situations credentialing arrangements allow for remuneration of advanced skills. There is no national consistency to these arrangements.

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[72] Department of Health, Government of Western Australia, WACHS and Rural Health West. Rural Generalist Pathway Western Australia. Presentation by Duggan V, Program Development Manager, Rural Health West at ACRRM/RDAA 5th Scientific Forum 2008.
[73] Ernst and Young. 2013. Ibid. (S. 7.2.4)
[74] HWA. 2013. Ibid
[75] Department of Health, Government of Western Australia, WACHS and Rural Health West. 2008. Ibid.
[76] Deakin University; Monash University and University of Melbourne. The Deakin-Monash-Melbourne Regional Medical Training Program. February 2014.
[77] Sen Gupta TK, Manahan DL, Lennox DR, Taylor NL. The Queensland Health Rural Generalist Pathway: providing a medical workforce for the bush. Rural and Remote Health. 2013; 13:2319.
[78] Eley D et al. 2007. Ibid.
[79] Ernst and Young. 2013. Ibid. (S.4.3)
[80] Eley D et al. 2007. Ibid.
[81] Rogers ME, Searle J, Creed PA. Why do junior doctors not want to work in a rural location, and what would induce them to do so? Aust J Rural Health. 2010 Oct;18(5):181-6.
[82] Eley D, Young L, Shrapnel M, Wilkinson D, Baker P, Hegney D. Medical students and rural general practitioners: congruent views on the reality of recruitment into rural medicine. Aust J Rural Health. 2007; 15:12-20.
[83] Ernst and Young. 2013. Ibid. (S.4.3)

3.1.6 POSITIVE TRAINING EXPERIENCE

There is considerable interest for rural practice particularly among RCS graduates;[84] including among women who are an increasing percentage of the intake;[85] and rural training programs are commonly oversubscribed.[86] [87] [88] Subsequent negative rural training experiences can however lead to decisions to not practice rurally. A recent literature review found that such experiences were particularly persuasive for the younger generation of doctors.[89]

Commonly cited personal factors causing dissatisfaction include; a sense of social isolation, excessive relocation, and poor accommodation.[90] [91] Professional factors include; inadequate supervision, unpleasant on-call arrangements, and insufficient holiday opportunities due to lack of locums.[92] [93] (Unsafe workloads and insufficient support for safe practice are outlined in section 3.2.4 below).

Conversely, the extensive professional and administrative support program in place in the QRGP has been identified by its trainees as pivotal to their decision to enter and remain in the program.[94] Norway's Finmark training program attributed much of its success to its regular tutorials which provided a peer friendship and support network as well as being an educational tool.[95]

Managing the pathway experience is important: the professional experience: through supervision and mentoring; and, the social experience: by such strategies as creating social opportunities in the community, facilitating communications with peers, (e.g. Internet-based social networks with peers appear to diminish social isolation for rural rotation students),[96] ensuring satisfactory living arrangements and minimizing relocation.

The QRGP provides a good model whereby its secretariat staff support a smooth placement experience and reduce these work burdens from both the trainee and the supervisor. Trainees have reported treating the state secretariat as their first port of call most (53%) of the time and their supervisor (24%) of the time.[97] The clinical co-directors actively chart the educational program to match not just service needs but also the trainees' interests and personal preferences.[98]

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[84] Mason J. 2013. Ibid.(Ch. 4.1)
[85] Charles DM, Ward AM, Lopez DG. Experiences of female general practice registrars: Are rural attachments encouraging them to stay? Aust J Rural Health. 2005. 13: 331–336.
[86] Sen Gupta et al. 2013. Ibid.
[87] Deakin University; Monash University and University of Melbourne. The Deakin-Monash-Melbourne Regional Medical Training Program. February 2014.
[88] Rural Health West. 2012. Ibid.
[89] Viscomi M, Larkins S, Sen Gupta T. Recruitment and retention of general practitioners in rural Canada and Australia: a review of the literature. Can J Rural Med. 2013; 18:1.
[90] Viscomi M. et al. 2013. ibid.
[91] Deaville JA, Wynn-Jones J, Hays RB et al. Perceptions of UK medical students on rural clinical placements. Rural and Remote Health. 2009; 9:1165.
[92] Eley D. 2007. ibid.
[93] Jones GI, DeWitt DE, Cross M. Medical students; perceptions of barriers to training at a rural clinical school. Rural Remote Health 2007;7:685.
[94] Ernst and Young. 2010. Ibid. (S. 5.6-8)
[95] Straume K, Shaw DM. Effective physician retention strategies in Norway's northernmost county. Bull World Health Organ. 1 May 2010; 88(5): 390-394.
[96] Vickery AW, Tarala R. Barriers to prevocational placement programs in rural general practice. Med J Aust. 2003; 179(July): 19-2
[97] Ernst and Young. 2010. Ibid. (S. 5.2.2)
[98] Sen Gupta et al. 2013 Ibid.

3.1.7 SUMMARY:

FEATURES OF A TRAINING PATHWAY TO GROW A SUSTAINABLE RURAL WORKFORCE

- Maximal training in the rural location
- Training in the RG model incorporating advanced skills
- Recruits trainees with rural background; rural clinical experience; demonstrated interest in rural practice, particularly interest in the advanced scope of practice.
- A 'rural pipeline' experience; trainees feel part of an RG professional fraternity and career path
- Nationally consistent approach to recognition of, and remuneration for, RG and its higher skills set
- Trainees feel well supported and prepared for clinical challenges
- Trainees have adequate access to locums to avoid overwork
- Program is well coordinated, avoids unnecessary dislocation
- Special efforts are made to improve the social and lifestyle aspects of the rural experience.

WHAT ARE THE BARRIERS TO RURAL RETENTION?

- Perceptions of negativity from metropolitan-based specialist rotations conveyed to trainees
- Lack of connectedness to training pipeline during years 1-3
- Selection process compromised by conflicting administrative structures and priorities
- Workforce shortages create insufficiency of professional support and locum relief
- Rural location unsuited to trainee's spouse/partner (particularly due to limited work options)
- Changing locations for placements difficult for families/partners/wives

Lack of social, lifestyle and educational facilities within the rural towns themselves

WHAT ARE THE ENABLERS FOR RURAL RETENTION?

- Early selection controlled by organisations dedicated to Pathway goals
- Trainee cohorts selected that are already well prepared for and enthusiastic about RG
- Trainees establish lifestyle preferences, family and friends in the rural setting
- Trainees establish and maintain ambitions for a career in rural practice
- Enhanced social experience of training (e.g. dedicated social networking sites and events etc.)
- Local mentors/support staff assist to improve social experience in rural town (e.g. connecting trainees to local events, sporting competitions etc.)
- Adequate financing for lifestyle elements of clinical placements (e.g. accommodation)
- Placement coordinators - to ensure well organized experience and free-up supervisor and trainee from administrative burdens.

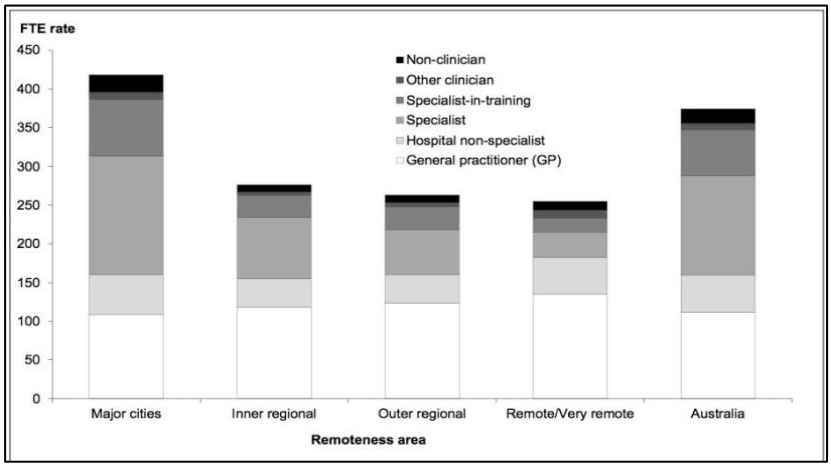
3.2.1 REQUISITE RURAL SKILLS SET

Advanced skills need to be available locally for emergency situations in rural areas. For example a Victorian study of small rural emergency departments over 12 months found that they encountered nearly all common presentations seen in full urban departments and performed most common procedures. [99]

[99] Baker T, Dawson SL. Small rural emergency services still manage acutely unwell patients: A cross-sectional study. 2014; 26:131-38.

Regular use of these skills increases the RG's competency for safe, quality care.[100] Furthermore, 'Quality care' implies delivering the healthcare that is demanded and as many members of rural communities prefer to receive advanced skills and procedural care, locally, these services become essential to its delivery.[101] Figure 2 below indicates the lack of specialist services in rural communities. [102]

Figure 3: Employed medical practitioners: FTE rate per 100,000 population by remoteness area and main field of medicine, 2012.[103]



3.2.2 TRAINING FOR SAFE RURAL PROCEDURAL PRACTICE

Opportunities to perform advanced and particularly procedural skills do not occur in rural training settings with the frequency typified in the tertiary specialist context. In this respect training requires a specially designed learning approach. There is evidence that with appropriate training doctors are both motivated to procedural practice and can improve their confidence in it.[104]

For rural proceduralists to maintain competence and confidence it is critical that their skills are learned and well practiced at the outset.[105] The training continuum approach is also important as competencies, confidence and experience need to be continually nurtured. One study highlighted that long periods between skills acquisition and practice can lead to a loss of confidence and potentially a decision to leave procedural practice; making even more critical the role of the mentor providing support and advice. [106] A consensus statement by obstetric care related Colleges in Canada highlighted that maintaining competence in obstetric care was dependent not on volume of services but mostly on an ongoing program of professional development.[107]

[100] Levitt LK. Use it or lose it: is deskilling evidence based? Rural and Remote Health. Jan-Dec 2001; 1(1):81.
[101] Hays RB, Veitch C, Evans RJ. The determinants of quality in procedural rural medical care. Rural and Remote Health. 2005; 5(4):473.
[102] AIHW.HWL 54. 2014. Ibid. (S.5.1)
[103] AIHW. HWL 54. 2014. Ibid. (S.5.1)
[104] ACRRM. Survey of Proceduralists. Brisbane. ACRRM 2007.
[105] Levitt LK. 2001. Ibid.
[106] McKenzie A. et al. 2013. ibid.
[107] Society of Obstetricians and Gynaecologists of Canada, the College of Family Physicians of Canada, and the Society of rural Physicians of Canada. SOGC Consensus Statement. 2008.

3.2.3 *QUALITY TRAINING*

Australian[108] [109] and Canadian[110] studies have demonstrated that properly resourced rural training is of as high a quality as urban training as demonstrated by students achieving equivalent or better academic outcomes than their urban counterparts.

3.2.4 WORKLOAD PRESSURES & SAFE PRACTICE

Complaints by rurally based trainees of overwork, and insufficient professional support in areas where they lack confidence are a common theme in the literature.[111] Acceptable, safe, work hours and adequate professional supervision are a major challenge in the current environment but remain an imperative; in the design of the training pathway.

Creative use of information and communication technologies can and do effectively augment professional support. Students from training programs report that although telemedicine and telecommunications with their colleagues are highly valued they cannot replace the support and confidence supplied by actual in-situ support staff.[112]

3.2.5 *LEARNING PATHWAY INTEGRITY AND SAFE PRACTICE*

The Australian Curriculum Framework for Junior Doctors, established by CPMEC in 2007 has defined a national scope of practice and expectations for rural curricula to cross-reference themselves against. This is valuable in maintaining a base level of uniformity in an innovative scenario involving training across a range of different work settings.

The GPTAP pilot program has demonstrated the potential for a training accreditation continuum across the prevocational and vocational training space matched to the Australian Medical Board, CPMEC, RACGP and ACRRM standards. Barriers to implementation identified have included: problems with achieving consistency with the standards of the two generalist colleges and the RTP accreditation processes; achieving consistency within states/territories with multiple RTPs; problems with achieving streamlined processes while allowing for the diversity of settings; and the need to clarify governance of accreditation in the prevocational training years.[113]

Safety and quality assurance require that the trainee workload is matched to their competency and confidence level at all times during the training program. A distinguishing feature of rural training is the diversity of health service training scenarios it incorporates.

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[108] Waters B, Hughes J, Forbes K, Wilkinson D. Comparative academic performance of medical students in rural and urban clinical settings. Medical Education 2006; 40:117-120.
[109] RCTS program consolidated reporting data, Department of Health and Ageing.(Cited in Mason J. 2013 Ibid).
[110] McKendry RJ et. al. Does the site of postgraduate family medicine training predict performance on summative examinations? A comparison of urban and remote programs. JAMC 2000; 163(6): 708-711
[111] Smith DM. Barriers facing junior doctors in rural practice. Rural and Remote Health. 2005; 5:348.
[112] Rogers ME, Searle J, Creed PA. Why do junior doctors not want to work in a rural location, and what would induce them to do so? Aust J Rural Health. Oct 2010; 18(5):181-6.
[113] CPMEC. General Practice Training and Accreditation Project: Final Report. 2013.

Conflicts have been reported for example where trainees have been unable to meet their clinical logbook requirements due to their employment responsibilities in areas where certain skills are unlikely to be required. Conversely, in urban hospitals rural trainees have commonly reported not having access to certain advanced skills training due to priority being given to those in the specific specialty program. [114]

Problems have also been reported in the QRGP where trainees have acquired advanced skills for unsupervised practice requiring consolidation at the same time as they are embarking on learning new skills in community-based practice. The conflict of roles can lead to stress. This highlights the importance of a planned and supported 'transition to practice' beyond the initial phase of advanced skills acquisition.[115]

Dedicated, continuing scrutiny of each individual trainee's circumstances and for ensuring adequate supervision is of elevated importance in a rural training pathway. These examples also illustrate the need for quarantined hospital training posts as required.

3.2.6 SUMMARY:

National Pathway features toward a workforce competent to provide safe, quality rural care to include:
- RG model reflecting the needs, and style of service delivery preferred by, rural communities.
- Advanced skills learned well at outset, used with ongoing CPD opportunities, and supported by mentors, to ensure continuing confidence and competence.
- Clinical skills provision supported by appropriate supervision, mentoring and preparatory training
- Dedicated trainee management to ensure each individuals learning pathway is coherent, safe, and complete.

BARRIERS:
- Decline in proceduralist practitioners creates a bottleneck in available trainers.
- Workload creep due to insufficient staff and locum difficulties
- Insufficient mentors
- Competition for training opportunities with other trainees
- Disruption from the proscribed program (due to health service exigencies)
- Training Program progress delayed by lack of opportunities to perform particular skills (due to lack or resources or lack of presentations in a rural setting)

ENABLERS:
- Dedicated officer to track individual trainees' progress, ensure competence for work requirements, and adequate support
- Quarantined hospital placements as required (especially for short rotations in larger centers to cover experience not available in the more rural setting)
- Dedicated coordinating body/officer to arrange each trainee's placements
- Organisational arrangements to facilitate coordination between involved stakeholders
- Program and credentialing flexibility to recognize and accommodate individual trainees varying circumstances.

[114] McKenzie A. et al. 2013. Ibid.
[115] Kitchener. 2013. Ibid.

3.3 GOAL 3: AN EFFICIENT, COST EFFECTIVE, SERVICE DELIVERY MODEL

3.3.1 RELATIVE RURAL MEDICAL CARE UNDERSPEND

There is considerable underspend by Governments on rural medical services relative to urban based services. Despite the lower socio-economic status, higher cost of living, and poorer access to facilities of rural Australians, studies have identified a rural health deficit for 2006-7 of $2.1 billion. This figure incorporates a shortfall of $811 million in Medicare funding; and, $850 million in pharmaceutical benefits.[116] Furthermore, in Australia currently there is 1 rural doctor for every 400 rural people and 1 urban doctor per 250 urban residents.[117] This translates to a 63% higher contribution in terms of individuals served, provided by rural doctors than their urban counterparts.

3.3.2 BUILDING RURAL PROCEDURAL CAPACITY

Even with a dedicated RG near specialist level remuneration structure (as exists in Queensland and Northern Territory), the development and expansion of a qualified RG workforce is projected to represent a net cost saving to the health system.

An evaluative case study of the QRGP has estimated the cost-effectiveness of training and credentialing trainees to perform procedural level skills and found a return on investment ratio of 1.2 (i.e. This implies that for every $1 investment, the QRGP returns a saving of $1.20). This reflects the cost savings conferred from the expanded capacity to perform procedures in rural hospitals (rather than relying on patient transport), against the incumbent wage increase costs to the health department of recognizing these skills.[118]

A 2007 study by the Rural Doctor's Association of NSW also found savings ranging from 12% to 52% to in provision of proceduralist care services at a District Hospital as compared to equivalent care by specialists at a Base Hospital.[119] This finding is supported by studies into private practitioners' as opposed to specialist hospitals' services in Iceland.[120]

3.3.3 HEALTH SERVICE TEAMWORK & ROLE FLEXIBILITY

Consistent with the findings of the Productivity Commission, the HWA Health Workforce 2025, and the Mason Review, the Australian health system needs to take a more flexible approach to the assignment of health tasks and roles to health professionals[121] in order to meet future demands.

The Rural and Remote Medical System of Care approach emphasizes building local capacity by flexibly assigning roles across the healthcare team enabling service

[116] AIHW. HWE 50. 2011. Ibid. (S. 1.2)
[117] AIHW. HWL 54. 2014. Ibid. (S.5.1)
[118] Ernst and Young. 2013. Ibid. (S. 9.1-3)
[119] Woolard L. Rural Doctors Association of New South Wales: derived NSW hospital data. (Unpublished data). RDANSW. 2007.
[120] Olafsson G, Sigurdsson JA. Out-of-hours service in rural areas. An observational study of accessibility, attitudes and quality standards among general practitioners in Iceland. Scandinavian Journal of Primary Health Care. Jun 2000; 18(2):75-9.
[121] Mason J. 2012. Ibid. (Executive Summary)

provision in a manner best suited to local circumstances.[122] [123] The RG scope of practice defines a practitioner enabled to maximally contribute within this system. RG pathway trainees should ideally be adaptable to work across the spectrum of employment arrangements and settings; as supervisors/mentors; and as providers of a broad range of services including some advanced skills.

In contrast a paradigm has evolved of office-based general practice and public sector work in hospitals being viewed as discrete professions. Symptomatic of the problem of this approach is a finding by McKenzie et al. that a decision to move from the public hospital system to general practice was correlated with a cessation of procedural practice.[124]

3.3.4 ADJUSTING TO MEET COMMUNITY NEEDS

In rural areas, resources and requirements differ from setting to setting so the pathway needs to accommodate the circumstances of each community. In its ideal form (as is the case with the QRGP)[125] the trainee's individual learning pathway would be matched to the requirements of the community in which they would eventually take up rural practice. For example they may assign a trainee an advanced skills post in anaesthetics who was based in a community with anaesthetic facilities and insufficient anaesthetists.

Sen Gupta has noted that (unlike in the past) it is more realistic to expect most rural doctors of the next generation to attain an RG skill set plus specialist level skills in one key area. The workforce planning goal then becomes to have 2 or 3 doctors with complementary advanced skills in one area.[126]

There is a clear role for planning and coordination with respect to advanced skills choices and training post locations. Vocational Indicative Programs are developed in the QRGP by Clinical Co-directors. The Ernst and Young report identified the need to further develop this approach and to build databases to describe available health service facilities; and training needs and opportunities.[127]

The further challenge for the pathway is to ensure training curricula incorporate this measure of flexibility, while still maintaining the core competencies to allow practitioners to practice anywhere.

[122] WONCA Working Party for Rural Practice. 2013. Ibid.
[123] HWA 2013: Rural Medical Generalist Draft National Framework. Canberra: October 2013. (Pg. 8)
[124] McKenzie A et al. 2013. Ibid.
[125] Sen Gupta TK, Manahan DL, Lennox DR, Taylor NL. The Queensland Health Rural Generalist Pathway: providing a medical workforce for the bush. Rural and Remote Health. 2013; 13: 2319.
[126] The Road Ahead. Med J Aust. Careers. 2013. https://www.Med J Aust.com.au/careers/197/7/road-ahead. Obtained Jan 2014.
[127] Ernst and Young. 2013. Ibid. (S. 7.1)

3.3.5 SUMMARY:

Features of a national pathway for an efficient, cost-effective rural system of care:
- Trains and supports procedural practice
- Training programs able to incorporate specific local needs/circumstances - ideally individual trainee pathways are matched to community in which they will take up rural practice.
- Flexible training and credentialing, enabling variation to the timing/order of training.
- Health service roles adjusted to local needs
- Exposure to a wide range of roles in the healthcare system to underpin flexibility

BARRIERS
- Shortage of qualified proceduralist mentors/supervisors (due to proceduralist shortages)
- Conflicts between training and health service responsibilities and their respective officers
- Conflicts arising due to dual funding streams state/federal leading to funding shortfalls
- Coefficient distribution of procedural skills

ENABLERS:
- CME programs to establish rural doctors in a continuing loop of trainer and trainee
- A single funding source to overcome state/federal funding conflicts
- A dedicated leader of training program at the regional level that is directly answerable to the management of the overall training pathway
- Making optimal and even creative use of facilities available - including using linkages with organisations such as AMSs, RUSCs, RCSs etc. as appropriate.

3.4 MANAGEMENT OF A BEST PRACTICE NATIONAL PATHWAY

3.4.1 COOPERATIVE APPROACHES TO COLLABORATION

The challenge in a cooperation based model will inevitably be to manage complexity and conflicts. One report has found that at the regional health service level, leadership by health professionals is a key strategy in managing these.[128]

A study into the experience of Prevocational General Practice Placements Program (PGPPP) has identified issues arising from conflicts between rural placement responsibilities and hospital service demands, joint state-federal funding arrangements, and organizational issues between the various stakeholder organisations. The authors recommended that conflicts such as these should be managed at the local level by a Director of Clinical Training who would ideally be a practicing private practitioner with an adjunct role in the hospital system.[129]

The involvement of community-based training and hospital training means that funding for the former tends to come in the form of medical rebates for services and in the latter case is funded directly by states/territories. In the current context of workforce shortages in both settings these problems are likely to be exacerbated. For example, Vickery et al. reported that funding for clinical practice of PGPPP doctors in Western Australia would not cover a sufficient number of clinical hours to match

[128] Doherty JE, Couper ID, Campbell D, Walker J. Transforming rural health systems through clinical academic leadership: lessons from South Africa. Rural and Remote Health. 2013; 13: 2618.
[129] Vickery AW. Tarala R. Barriers to prevocational placement programs in rural general practice. Med J Aust. 2003; 179 (July): 19-21.

curriculum requirements. In this instance the suggested solution was an agreement by all parties at the outset on the number of hours required per trainee and that funding arrangements be made in accordance.[130]

This underscores the need for a dedicated body to provide flexibility, leadership and coordination either at state or federal level and also for a similar leadership role at a regional level. These would ideally be inclusive of all relevant stakeholders but would require an individual officer to take a dedicated leadership role.

3.4.2 BUILDING THE TRAINER WORKFORCE

Despite the need, there is an insufficiency of proceduralists in rural and remote Australia and in some areas their numbers continue to decline. [131] [132] [133] The reasons for this cited in the literature are varied and complex they include; issues relating to excessive indemnity costs and inadequate remuneration, but they are also related to inadequate resourcing for training and CME; and, negativity and lack of encouragement throughout the largely urban hospital based training experience.[134] [135]

The diminution of the procedural skills being practiced poses a challenge to the pathway as it implies a shortage of available proceduralist supervisors/mentors. There is a nexus between sustaining and promoting proceduralism among senior rural doctors and training the next generation.

Support and CME for current proceduralists should be viewed as integral to the pathway and in this regard more needs to be done. McKenzie et al. have found that a majority of new RGs that have completed advanced skills training in Queensland do practice procedurally but that their use of skills diminishes over time and often coincides with a move away from the public health system to general practice. The study authors recommended that consideration should be given to financing an additional year of training post-fellowship. [136]

3.4.3 INCENTIVISATION AND LEADERSHIP

The Pathway will be characterized by involvement of a multiplicity of organisations with respective sets of priorities and goals. Sustainable success will only be possible if central coordination is led by organisations incentivised entirely to the Pathway goals. In the context of the QRGP, appropriate incentivisation is attained through a central organizing unit based as a standalone unit within Queensland Health. It is significant that this has been augmented by formal legislative recognition of the RG specialty and the RG College as providing professional leadership and consistency to the program.

There has been only fragmented rural pathway organization to this point in the interim postgraduate years prior to AGPT enrolment. Furthermore it has been

[130] Vickery AW. et al 2003. Ibid.
[131] RWAV. RWAV Position Statement: GP Proceduralists. 2012.
[132] Rural Health Workforce Australia. Medical Practice in Rural and Remote Australia: National Minimum data set (MDS) Report as at 30 November 2009.
[133] Rural Health West. Workforce Analysis: Rural General Practitioners in Western Australia. Profile of GP Proceduralists. 2012.
[134] Robinson M et al. 2010. Ibid.
[135] ACRRM. Barriers to Maintenance of Procedural Skills in rural and remote Medicine and Factors Influencing the relocation of Rural Proceduralists. Report 1.ACRRM Research Projects. 2002.
[136] McKenzie A, Beaton N, Hollins J, Jukka C, Hollins A. Advanced rural skills training: are recently qualified GPs using their procedural skills? Rural and Remote Health. 2013; 13:2159.

suggested that the RTP structure associated with the AGPT program lacks sufficient incentivisation to engage in efforts toward vertical integration. As a competitive, disarticulated structure there can be a tendency to focus efforts on internal, local priorities.[137]

3.4.4 *ALLIGNING WORKFORCE AND TRAINING REQUIREMENTS*

There is a clear need for leadership at the outset of the course to ensure access to trainee places as required. In previous rural training programs in New South Wales for example, inadequate coordination had led to a failures to match proceduralist trainees to positions in hospitals, (and this problem was an explicit motivation for implementing the NSW RG-GP program).[138] There is also a role for continued high-level direction as trainees work their way through the pathway to ensure short-term rotations that may be required are also available.

The QRGP achieves this through central coordination by the state health department. There are complications with this approach in other states and territories with the decentralization of such decisions to the district hospital level.

The Health Workforce Agency has identified the need to ensure that training posts are assigned congruent with training and workforce needs and capacities, together with long-term workforce requirements.[139] This has also been identified by the QRGP Evaluation as an area for further development.[140]

3.4.5 SUMMARY:

Specific management goals of best practice National Pathway:

- Workforce and training goals are congruent (short and long-term)
- National agreement and recognition of the RG career
- Flexibility of trainees for credentialing purposes during pathway
- Coordination of health service and pathway training requirements
- Sufficient training capacity and guaranteed placement

BARRIERS

-Bottlenecks as programs take time to establish themselves in terms of personal and training facilities against a history of declining proceduralists, rural doctors in general and increased numbers of interns and interns training in the rural setting.
- Non-transportability of credentials across state jurisdictions
- Potential for workload creep due to insufficient staff and locum difficulties
-Conflicts between training and health service responsibilities and their respective officers
- Conflicts arising due to dual funding streams (state/federal)
- Loss of RG focus toward developing and sustaining specialised training posts due to a multiplicity of professional organisations involved.

[137] Campbell D, Greacen J, Giddings P, Skinner L. Regionalisation of general practice training — are we meeting the needs of rural Australia? Med J Aust. 2011; 194 (11): 71.
[138] NSW Department of Health. Securing a Stable medical workforce for rural communities: a discussion paper. NSW Department of Health. 2011. (Pg. 2)
[139] HWA. HW2025. Vol 3. 2013. Ibid. (Ch.7)
[140] Ernst and Young. 2013. Ibid. (S.7.2)

ENABLERS:

- Explicit recognition of the RG College as shaping the pathway
- CME programs to establish rural doctors in a continuing loop of trainer and trainee
- A dedicated leader of training program at the regional level that is directly answerable to the management of the overall training pathway
- Making optimal and creative use of facilities available - including using linkages with organisations such as AMSs, RUSCs, RCSs etc. as appropriate.

4. PROPOSED NATIONAL PATHWAY OVERVIEW

4.1 AIMS FOR THE OPERATON OF THE NATONAL PATHWAY

The ultimate goal is to produce practitioners with the capacity and motivation to meet workforce requirements. The National Pathway must therefore create an efficient organisational framework leading to a credentialed scope of practice and professional orientation that is consistent with meeting the needs of Australia's rural and remote communities.

Operational aims extending from this goal are:

To provide a well supported, integrated training experience from the point of medical school graduation through to the attainment of full qualification as a Rural Generalist Practitioner with associated Vocational Registration and employment status; competent to provide the full advanced skill set , requisite of practice in rural and remote settings. These skills and qualifications would need to be fully transferable across jurisdictions and the full gamut of rural/urban settings.

This will involve ensuring:

- participants are adequately supported and prepared for safe practice at each stage;
- minimal disruption and dislocation to trainees;
- as much training time as practicable in non-metropolitan settings; and,
- efficient and cost effective use of available facilities.

The recommendations proposed aim is to encourage state/territory jurisdictions to construct their respective training pathways in accordance with overall integration and portability requirements and ultimate workforce goals. In view of the variation between jurisdictions in terms of health systems and available infrastructure, a flexible approach has been taken. The Commonwealth's responsibility for overall workforce planning and health budgets, and the Colleges and other authorities' requirement to meet quality imperatives are also given consideration.

4.2 PATHWAY OUTLINE

The pathway will commence via a dedicated 'Provisional Selection' process at an early point during the prevocational years. (This should be at the outset of internship or later in PGY1 as deemed appropriate). It will recognize and certify the advanced procedural and other competencies for rural and remote practice obtained in the course of training described by award of FACRRM or the award of FRACGP; (with the additional award of FARGP), reflecting attainment of specific advanced rural skills. Ideally, this would also acknowledge training time towards seniority within each state's health system.

Figure 4: Pathway Experience from Medical School to Fellowship

Training Phase	Year	NRGP	Benefits/Support		AGPT****	ACRRM	RACGP*	Employment status
Undergrad/ Graduate	Final Year		Interested students register (support and advice)					Student
Internship	PGY 1	Application to RGP**		PGPPP				Intern (AMB registered)
NRGP Pre-vocational	PGY 2	Provisional Selection	Secretariat Support & quarantined training post places & Salaried trainee position & Designated Support Clinician	PGPPP	Application to AGPT	Core Clinical Training	Pre-requisite hospital year (with paediatric term)	Junior Doctor
	PGY 3			AGPT or RVTS	AGPT Selection	Advanced Specialised Training***	Advanced Skills Training (Extended Skills &/or FARGP)	Registrar
NRGP Vocational	PGY 4	Vocational Fellowship Training		AGPT or RVTS		Primary Rural & Remote Training	GP Terms 1&2	SMO (Provisional Fellow); or Private practitioner; Or, VMO; or, MORPP, MSRPP
	PGY 5			AGPT or RVTS			GP Term 3 & Extended skills/ FARGP	
	PGY 6	CME				FACRRM	FRACGP + Adv Rural Skills	SMO (Rural Generalist) ; or Private practitioner; Or, VMO; or, MORPP, MSRPP

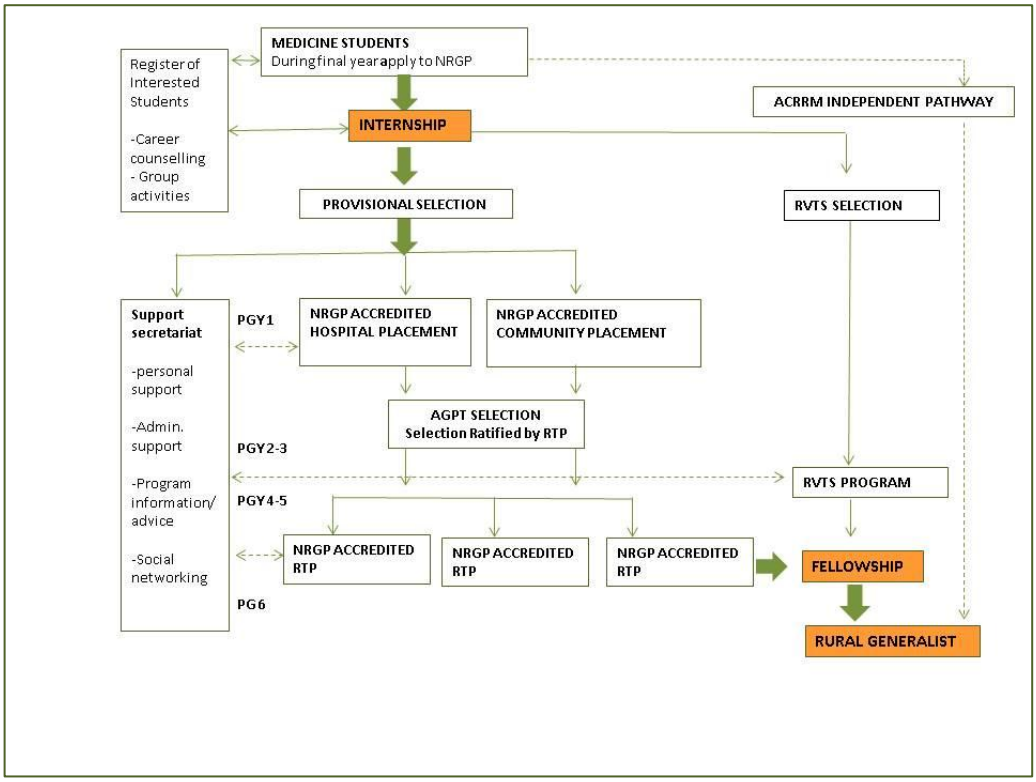
** Vocational training to FRACGP requires, as a pre-requisite, prior completion of a year of hospital rotations (including an approved paediatric term) and two years training in general practice (inclusive of 6 months extended skills). To be credentialed for Rural Generalist Practice, extended training and evidence of achievement of competencies through an individually approved Fellowship of Advanced Rural General Practice (FARGP) is required.*

*** May alternatively occur at outset of Internship.*

****Advanced specialized training may be undertaken at any time from PGY3-5*

*****AGPT selection process is given for clarification. It should be noted that RG trainees may undertake the RVTS or Independent Pathway.*

Figure 5: National Pathway Process – Broad Overview



4.3 NATIONAL PATHWAY KEY OFFICERS AND ORGANISATIONS

STATE/TERRITORY LEVEL COORDINATION COMMITTEES

There should be an organisational structure within each state and territory to set an annual intake quota for the pathway for that jurisdiction each year. The group will also ratify applications for candidates for lateral entry on a case by case basis.

Decisions regarding annual quotas and allocation will require stakeholder input as appropriate regarding:

- Maximum target able to be funded
- Accredited placement capacity within each region
- Number of specialty posts able to be quarantined
- Availability of suitably qualified applicants

REGIONAL COLLABORATIVE COMMITTEES

The concept for these Committees was proposed in the HWA Rural Medical Generalist Draft Framework.[141] Their membership should extend to all relevant stakeholders including but not restricted to: LHNs/regional hospitals, ACRRM, RACGP, RTP's or and other participating training consortia, Trainees, Rural Clinical Schools, Regionally based Private Practitioners, Medical Locals, Aboriginal Medical Services or other public, community-based health service providers, and Clinical Co-Directors.

The Committees should be involved with supporting and advancing the pathway at the regional level, including such activities as:

- Selection of RG trainees to pathway training places
- Providing advice on regional workforce planning as it relates to the RG pathway

[141] HWA. RMG Draft National Framework. 2013. Ibid. (Pg. 54-5)

- Identifying, developing and negotiating training posts
- Development of innovation collaborations to enable advance skills posts
- Assisting with the process of quarantining places for RG pathway trainees.

COLLEGES

ACRRM is the principle college for Rural and Remote Medicine and is able to take a leadership role with respect to selection, accreditation and standards as well as trainee support and professional fraternity building. RACGP also has a key role particularly with respect to quality assurance for trainees on its Fellowship program. Consistent with the Rural and Remote Medicine system of care approach it is important that efforts be invested in actively promoting collaborations with other relevant medical specialist colleges and Joint Consultative Committees (JCCs).

RG PROGRAM DIRECTOR FOR EACH STATE/TERRITORY

Each jurisdiction should have in place an appointed officer with operational responsibility for the entire RG program within their state/territory. It is critical that this officer be vested with sufficient authority to ensure its continuing integrity and alignment with workforce requirements, especially on key issues such as access to training posts.

DEDICATED CLINICAL SUPPORT OFFICERS FOR EACH TRAINEE

Each trainee should have a delegated officer with responsibility for mapping and checking their individual academic progress. An important element for this role will be developing an individualized training pathway plan which considers both the trainees personal preferences and workforce requirements.

OFFICER FOR NATIONAL INTEGRATION

There should be an officer of the Commonwealth Department of Health vested with responsibility for national integration of the pathway. They would ensure portability of qualifications, and alignment with overall workforce planning.

5. NATIONAL PATHWAY IMPLEMENTATION: KEY ELEMENTS

The broad areas for implementation defined in the HWA Rural Medical Generalist Draft National Framework have been used as a basis for further exploration and development. These are: Recognition of the Role of the Rural Medical Generalist; Attraction and Selection into the Pathway; Rural Training Pipeline; and, Coordination and Workforce Planning.

Note: Barriers that have been identified by the Reference Committee, through the Member Surveys or in the Literature Scope are highlighted where relevant to the discussion.

5.1 RURAL GENERALIST DEFINITIONS AND RECOGNITION OF THE ROLE

5.1.1 GOALS FOR A NATIONAL PATHWAY

ROLE DEFINITION

The Rural Generalist definition should reflect the best scope of practice for meeting workforce needs across the diversity of settings in rural and remote Australia. It should describe an ideal model for future decades.

ROLE RECOGNITION

- *National agreement on, and common understanding of, what constitutes a Rural Generalist.* An essential element of this is the understanding that Rural Generalist Medicine is not defined by geography of the workplace, but possession of a certified scope of practice.

- *Attaining broad recognition of the role across the profession and the wider community and ultimately an appreciation of its aspirational status: as an altruistic, intellectually and professionally challenging endeavour.* This will enable development of trainees' sense of professional identity and career purpose; motivation to rural medicine and professional satisfaction.

- *Broad recognition and integration of the Rural Generalist Scope of Practice within credentialing and administrative frameworks.* This is necessary in order that quality assured training and practice can take place; compliance barriers can be minimized and appropriate medical appointments can be made.

"Rural generalist proceduralists (particularly O and G, anaesthetics and ED trained) represent a return to generalist medicine that will be critical to filling shortages in rural Australia that will probably never attract specialists in these fields……"

Comments of ACRRM Registrar
ACRRM Registrar Survey

"Many still have not heard of the rural Generalist profession and many who have, seem to see it as a poor cousin of other medical professions."

Comments of Registrar
ACRRM Registrar Survey
Feb, 2014.

5.1.2 DISCUSSION

Barrier identified by the Scoping Study: Lack of a common understanding of the nature of Rural Generalist Medicine

There is not a uniform understanding within the profession and its governance of what Rural Generalist practice does, or should encompass.

Rural Generalist Medicine is defined by a scope of practice; which maximizes its practitioners' usefulness in a rural and remote medical system of care. It is not practiced by all doctors located in rural areas. The scope delineates the essential skills

for practicing geographically far from a large number of alternative medical staff, and without the full complement of tertiary facilities. The specialty skill set can be held by practitioners across the spectrum of employment including (but not restricted to), in private practice, in hospitals, or a combination of both.

There is an emerging consensus around a definition of Rural Generalist Medicine as stated in the Queensland Government legislative frameworks, the outlines for the Rural Pathways in all states and territories; in the HWA RMG Draft Framework and also as outlined at the recent World Summit on Rural Generalist Medicine. This needs to be formally ratified by governance to promote broader understanding.

ACRRM registrars represent the next generation of RGs. The ACRRM Registrars' Survey respondents expressed a very positive and altruistic outlook for the future of their profession. They defined the ideal shape of their profession in the future as involving a broad and flexible scope of practice, incorporating advanced and especially procedural skills (specifically identified by 66% of respondents) and a mix of public and private practice (specifically identified by 27% of respondents). They specified a clear connection between their service provision and community needs. They overwhelmingly viewed recognition of the profession (90%) and remuneration reflecting its advanced skill set (97%) as significant motivators to careers in rural practice.

"I thing the rural generalist probably is the most exciting of areas, with doctors having to have a broad range of skills I think GP training with additional skills in anaesthetics, obstetrics, surgery or some other subspecialty is important. …"

"It (Rural Generalist Practice) is very important for rural Australia."

"I think it will be the heart of rural practice….."

ACRRM Registrar
ACRRM Registrar Survey
Feb 2014.

Barrier identified by the Scoping Study: Scope of Rural Generalist Medicine is not always explicitly reflected in clinical governance frameworks for work in health department facilities.

CREDENTIALLING AND SCOPE OF PRACTICE

To meet workforce needs the pathway must lead to qualifications which enable provision of advanced and procedurals skills in hospitals. Credentialing and Clinical Privileging frameworks need to support this. The clearer the framework, the more the health system can enable doctors to practice wherever demand for services dictates: be it in private practice, hospitals or both.

Credentialing and provision of clinical privileges for RGs providing procedural and other advanced services in rural and remote settings is especially complicated; firstly because of staff and resource limitations in rural and remote settings; and, secondly, because the rural system of care which often involves a range of models of collaborative service provision with remote urban specialists. With the establishment of the hundreds of Local Health Networks with discrete internal processes throughout the country, a uniform standard becomes especially valuable.

The ACRRM curriculum has been framed to describe the scope of practice and its Fellowship qualification incorporates associated requirements for maintenance of professional standards. This provides a convenient mechanism for linking scope of practice to qualifications and credentials.

Officially endorsed recognition of this scope of practice by state and territory jurisdictions would enable hospitals to recognize this and facilitate a simple process for adoption within each Local Health Network's individual credentialing framework. The consistency of these standards would enhance quality assurance across state/territory health services.

Queensland provides a useful model. The state's legislated recognition of Rural Generalist Medicine has enabled it to be specified as a 'preferred' or 'required' qualification on employment position descriptions and in advertised position descriptions. It has also allowed it to be articulated as a specific scope of practice to ease adoption by hospital credentialing committees. An additional tool in this process is a state-wide Rural Generalist Credentialing Committee, comprised of practitioners in the specialty area.

At the Local Health Network or regional hospital level all credentialing committees which engage in assessments related to the scope of Rural Generalist Medicine, should ideally include representation by a qualified Rural Generalist.

Barrier identified by the Scoping Study: RG training programs require a more advanced level of training; higher levels of professional responsibility and more challenging working hours, then those associated with other generalist practice qualifications. There is little recognition of these higher skills and minimal motivation to acquire them.

RECOGNITION AND REMUNERATION

In Queensland, the State Recognition of Practice Committee was formed to apply AMC based Guidelines to assess and formerly recognize the specialty of Rural Generalist Medicine for the purposes of employment remuneration under the Medical Practitioners Registration Act 2001. As a 'recognised qualification' this was able to be specified as 'required' or 'preferred' in position descriptions and thereby able to attract an appropriate salary classification. The Northern Territory is also developing an Enterprise Bargaining Agreement to reflect this distinct professional classification.

There is no comparable industrial award in any other state or territory. The recognized end point of all RG programs is either the FACRRM or the FRACGP (together with the FARGP) but there is no legislated acknowledgement of the more advanced skill set. Hospitals commonly have fee-for-service frameworks in place to offer higher remuneration for the higher level services that these doctors may provide. There is no formal consistency to these arrangements varying between hospitals and over time and they cannot provide a solid reference point for trainees determining their future career path.

A framework that is clear and consistent and provides additional remuneration where warranted is required. Official state/territory and nation wide recognition of the skill set; together with an adoption of a consistent approach across all state/territory hospitals and/or Local Health Network's to remuneration for provision of advanced skills services as defined in the ACRRM curriculum can achieve this. Remuneration for Medicare-billed services would benefit also from special recognition of the advanced skill set.

"…Needs to have a meaningful valuable career available at the end.

"A clearly defined pathway into a senior position is vital to encourage people to consider rural practice."

"There is a great need for rural generalists. The profession needs to be recognised by other Colleges more."

"The recognition is more important than the money."

Comments of ACRRM Registrars
ACRRM Registrar Survey
Feb, 2013

5.1.3 RECOMMENDATIONS

1. National Pathway Definition of Rural Generalist
Definition of 'Rural Generalist' as outlined by the HWA Rural Medical Generalist Draft Framework* should form the basis for credentialed practice and provide a standard for broad adoption. This should be explicitly incorporated into the manifesto of an implemented National Pathway.

2. 'Scope of Rural Generalist Medicine' in Credentialing Frameworks
The 'Scope of Rural Generalist Medicine' should be adopted by all state and territory jurisdictions in a form adaptable to their respective credentialing frameworks such that it is able to be adopted where appropriate by their hospitals and health services.

3. Government Recognition and appropriate Remuneration
State/Territory and federal governments should provide explicit recognition of the practice of Rural Generalist Medicine by doctors certified to do so. The value to the community of advanced skill-sets and wider scope of practice by Rural Generalists should be reflected in the frameworks for remuneration.

4. Rural Generalist representation on credentialing committees
At the Local Health Network or regional hospital level all credentialing committees that engage in assessments related to the scope of Rural Generalist Medicine, should include representation by a practitioner credentialed to the Rural Generalist scope of practice.

* NB. While the Framework document is still pending final approval, the Definition contained is the product of an extensive process of stakeholder consultation.

5.2 SELECTION AND ATTRACTION

> "Streamline selection, recognise the multifactorial supports required, choose good enough candidates, make their administrative burden as light as possible, gain efficiencies in mutual recognition of accreditation requirements, value contributions to responsive rural clinical endeavour, find ways of telling the most isolated that we are doing a good job……"
>
> Comments of Registrar ACRRM Registrar Survey Feb 2014.

5.2.1 SELECTION AND ATTRACTION: GOALS FOR THE PATHWAY

The ultimate aims of the attraction and selection processes are rural and remote workforce outcomes. In an environment of limitations both to funding and to accessing necessary training posts it is particularly important that those deemed most likely to form the backbone of a future rural workforce, are targeted, supported, and their interest in rural careers nurtured.

Accordingly, access to the RG Pathway should be given to those deemed most likely to provide the quality services required to meet the workforce needs of rural and remote Australia. This needs to include a measure of professional competency, and likelihood of practicing long-term in rural and remote locations. There is a need to ensure that there is at least a critical mass of recruits likely to be both competent and motivated to provide the core advanced skills for rural and remote practice.

5.2.2 DISCUSSION:

INTERESTED MEDICAL STUDENTS REGISTER

To attract medical students on to the postgraduate RG pathway a linking structure between medical school and pathway selection is needed. This organisation should proactively recruit, promote and facilitate the passage from final year medical school to enlistment in the RG pathway; or, as appropriate enlistment in rural careers in other specialty programs.

This could be a minimal structure building on the pool of 'interested' students already assembled through rural student clubs, John Flynn Scholarship Scheme (JFSS) members, RAMUS members, and rural scholarship holders. These students should be the focus of efforts, but there should be facility for other interested students to enlist.

A database of these 'interested' final year medical students would enable focused recruitment efforts and facilitate for these students (who hopefully will provide the core of the subsequent RG pathway cohort) a seamless transition into their rural medical career with a group of professional peers.

A minimal investment of resources would enable; talks to target student groups; webinars, targeted social events to promote and explain the nature of rural careers; and provision of an advice and career counselling service not just to those interested in rural generalist careers but also rural medical careers in other specialties. The secretariat for MRBS and other scholarships is already in place fulfilling this role for scholarship holders and could easily extend to the wider pool of interested students.

There is a role for FRAME in this initiative to provide continuity with the undergraduate support experience and ACRRM as the lead College for rural medicine, and secretariat for the Scholarship schemes and this should also be encompassing of other stakeholders.

Barrier identified by the Scoping Study: Selection through AGPT occurs several years after medical school and represents a break in the training pipeline.
Barrier identified by the Scoping Study: Selection through AGPT has only peripheral involvement by Colleges and is not directly linked to the RG Pathway.

Barrier identified by the Scoping Study: Competition for places is already intense and likely to increase. Access to places is already becoming difficult for students in RG pathway programs.

PROVISIONAL PATHWAY SELECTION

RATIONALE

Selection to supported fellowship training is by and large carried out under the auspices of the AGPT. This represents a break in the training pipeline as it occurs several years after medical school graduation. This means trainees have spent these most formative of years establishing social networks and relationships, lifestyle expectations and career path intentions before they enter its rural pathway.

Secondly, AGPT selection is not clearly integrated into the RG Fellowship pathway. Although it is selection to qualify for supported training to the end points of either the FRACGP or the FACRRM, the Colleges have not had direct input into the operation or the determinations of the process. It is a requirement under AMC Guidelines that Colleges ensure the integrity of the learning process for all Fellows; in particular they stipulate that the selection process must be consistent with the College's published criteria and principles and that its application should be monitored for consistency.[142]

"I chose to become a doctor with the ONLY intention of becoming a rural generalist in a <rural location>* regional community. I hope I will be able to practice O and G in a small town hospital and either work at that hospital or do part time GP. I think that rural people prefer this kind of model of health."

Comment of ACRRM Registrar
ACRRM Registrars' Survey
Feb 2014.

*Rural location removed to preserve anonymity.

A third problem, which is likely to be vital in the initial development years when competition for training posts is likely to be intense; is ensuring access to necessary training posts for graduates most likely to meet priority workforce needs. The experience of medical schools in Australia has shown that without intervention, in extreme competition for places, filtering processes tend to restrict access to academic super-performers at the expense of workforce considerations.

A strategy to address all these issues would be to formally recruit trainees to the RG training pathway through a 'Provisional Selection' at the outset of their internship (or during their internship as preferred).

- This would enable the provision of preferential access to necessary training positions for the candidates most likely to meet workforce needs. Furthermore these positions could be designed to maximize exposure to rural experience.

- This could enable access at the outset of training to a formal support structure which would be in place, providing a continuing point of personal contact with the RG pathway infrastructure for the duration of the training experience.

- Selection will define a pool of priority students to target funding for rural-specific training opportunities. Additional to the educational benefits, this would provide valuable peer-networking and professional identity building; which the literature and student feedback concur are important components of professional resilience and satisfaction.

[142] AMC Specialist Education Accreditation Committee. Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council. 2010. (Pg 16.)

SELECTION PROCESS MATCHED TO WORKFORCE GOALS

The prevocational selection process needs to have the explicit aim of selecting applicants' based on their likelihood to meet workforce needs i.e. to pursue a career and reach a high level of competency as an RG. It should comply with fellowship standards of relevant colleges.

> "(Select on the basis of) desire to work in a rural context (not just a stepping stone to metropolitan specialist training.)"
>
> Comment of ACRRM Registrar ACRRM Registrars' Survey Feb 2014.

Scholarship supports the connection between demonstrated interest in a rural career and rural retention. "Demonstrated interest" can be transparently validated given the plethora of optional undergraduate rural student activities available such as rural student clubs, JFSS etc. An interest in the RG scope of medicine should also be given consideration. These should be considered in concert with academic credentials.

Intense competition for training places will increase the risk that candidates pursuing careers in urban specialist practice will apply for Provisional Selection as a means to access these places. The process must take active efforts to filter out such candidates.

LINKING PROVISIONAL SELECTION TO AGPT SELECTION

This selection process would be of a provisional nature as it preempts entry to vocational training and its incumbent selection process. The challenge then is to provide some certainty to recruits to the pathway without undermining the vocational selection process.

> "There must be a method for those who really see the light later an opportunity to join a rural pathway; we have doctors who were inspired as students / interns / PGY2/3 to become fellow rural doctors. BUT rural clinical school students must be fast tracked"
>
> Comment from Member ACRRM Member Survey Feb, 2013

A viable solution would be to quarantine a certain number of places in the vocational training program equal to the number provisionally selected. The trainees would not be given automatic entry and the location of their training would be negotiated. It is noted that this proposal is comparable to quarantining arrangements already in place within the AGPT framework for ADF graduates and also in WA where the state government has successfully negotiated at a ministerial level, additional AGPT places according to local need.

The Provisional Selection process will comply with standards for the relevant Colleges and hence aligned with AGPT processes. For efficiency then AGPT process will be simplified.

Barrier identified by the Scoping Study: Selection to Rural Pathway prevents access to competent junior doctors who miss selection, or who become interested later in their careers.

LATERAL ENTRY

There is a strong case for directing limited funding and places to the trainees assessed as the most likely to become competent, long-term RGs. There is also good reason to keep the pathway open. It is likely that there will be outlier individuals who will come late to the idea of rural practice or who the selection process has failed to identify. A clear process should be in place to facilitate selective lateral entry in these cases.

Training providers and/or Regional Subcommittees who have knowledge of interested, eligible candidates should be encouraged to put together submissions for their inclusion on the pathway to their State/Territory Coordination Committee (or equivalent) for consideration and ratification.

SELECTION PROCESS

Provisional Selection:

Coordination Committees (or equivalent) within each state or territory should make a determination on how many RG pathway places will be created each year and how they will be distributed across the regions. This would involve consideration of funding limitations, availability of accredited training posts and regional capacities.

Applicants assessed as eligible for consideration for the pathway should be selected at the regional level; giving consideration to their locational preferences and in compliance with relevant College guidelines.

Induction into the Pathway

Selected trainees will be inducted into the pathway. This will confer preferential access to training places; pastoral support including facilitated social networking; and ideally group training opportunities with their fellow RG pathway cohort.

AGPT Selection:

Candidates would need to formally apply to AGPT to gain access to its sponsored places. They could apply directly to one or multiple RTPs as preferred.

There is clearly an opportunity to economise effort and treat the provisional selection process as a validated sieve of eligibility. The task then would be to insert a quality assurance checkpoint; confirming that candidate's academic and professional performance since Provisional Selection had met an acceptable minimal standard.

It would be timely at this point to give candidates the opportunity to opt out of the RG pathway if they are no longer interested. In this case they would no longer be eligible for a place in the RG pathway but would be able to enroll for general entry. This would avoid wasted efforts and open up a place for alternative candidates and facilitate opportunities for lateral entrants.

Selection will again be undertaken at the regional level to determine a placement location and will be in accordance with relevant College guidelines.

In the regional selection for AGPT places there would be a value in Dedicated Support Clinicians having a role in this process with respect to the trainees with whom they have developed Training and Career Maps (see Recommendations 22 and 23). There may be a role at the regional selection level during both processes for Regional Collaborative Committees (see Recommendation 27).

ACRRM REGISTRAR PERSPECTIVES

The ACRRM Registrar Survey reflected a consistent view (74% of respondents) that selection should seek to identify those who are deemed likely to practice in rural settings. The most consistently specified requirement for selection was some form of demonstrated rural interest (42%) and several stressed the need to avoid selecting trainees seeking access to specialist training places for urban careers. Other recurring themes with respect to important attributes to guide selection were:

- Community mindedness;
- Commitment to rural health;
- Rural background , and understanding of, and appreciation for rural lifestyle;

- Commitment to ongoing community-responsive practice throughout career and skills maintenance;
- Attraction to the RG scope of practice (including advanced and procedural skills, community-responsiveness, broad scope); and,
- Commonly specified personality traits were: flexibility, adaptability, resilience, teamwork skills, adventurous spirit.

5.2.3 RECOMMENDATIONS:

5. Register of Students interested in Rural Medicine Careers
A secretariat should be established for a Register of Students interested in careers in Rural Medicine. The register will be comprised of self-nominated final year medical students and interns. They will have access to talks, seminars, and careers advice. The aims are: to facilitate a seamless transition into the RG program; to promote and recruit; and, to inform candidates better about their prospective career path. There should be a role for FRAME, ACRRM and other key stakeholders in this.

6. Provisional Selection Process
A 'Provisional Selection' process should be established at the outset of, or during the internship year (as determined by each jurisdiction). A quota of 'provisional' places to be created each year should be determined; and the same number of places should be set aside for that cohort in the AGPT program. Selection to AGPT should not be automatic but will be simplified and facilitated. The 'Provisional Selection' process should be rigorous and in accordance with College standards for Fellowship selection. It will assess candidate's likelihood to fill the workforce needs (i.e. to pursue a career and reach a high level of competency as an RG and practice in a rural or remote areas). 'Provisional Selection' should confer immediate benefits; including preferential access to training places and candidate advice and support along the continuum.

7. State and Territory level Coordination Committee
Each state and territory should establish an appropriately representative organisation to determine the number of new RG pathway places to be created within their jurisdiction each year and also to determine an appropriate regional allocation of these places based on advice regarding capacity.

8. Facilitated AGPT Selection Process
Selection to the AGPT program for "Provisionally Selected" candidates will be simplified. It will involve ratification of the 'provisional' selection as valid; and a quality assurance check (that the candidate met an acceptable minimum, clinical and professional standard since selection).

9. Lateral Entry to the National Pathway
Facility for lateral entry to the program will be available. Training providers and/or Regional Collaborative Committees who identify appropriate candidates will be able to make submissions to their State/Territory Coordination Committee to be considered and ratified as appropriate.

5.3 TRAINING PIPELINE

5.3.1 TRAINING PIPELINE: GOALS FOR THE PATHWAY

To ensure a continuous experience of rural practice -oriented training that provides a clear pathway to a professionally certified rural career aligned with workforce goals. This needs to be well supported. It should include maximal rural exposure, and nurturing of a professional identity as an RG, and should ensure jurisdictional transportability of qualifications.

> "I would quit my job in <rural location> and uproot my family to complete my FACEM if the ruralist pathway didn't exist."
>
> Comment of ACRRM Registrar ACRRM Registrars' Survey Feb 2014
>
> *Rural location removed to preserve anonymity

5.3.2 DISCUSSION:

DELIVERING AND MAINTAINING THE RURAL WORKFORCE FOCUS

The pathway needs to ensure that training maintains its focus on rural workforce development while still maintaining its intrinsic educational standards.

Responses to the ACRRM Registrars Survey regarding their training, demonstrated a diversity of experiences across the country. Many were very positive. The recurring themes among respondents were the appreciation for a clear, well structured pathway including the need for pathway planning; the importance of individualized mentoring and supervision; the need for better access to specialist training posts and more opportunities to extend training in procedural and advanced skills; and more financial support for training.

Barrier identified by the Scoping Study: Maintaining connection to the pipeline prior to internship accreditation.

- *EARLY SELECTION*

As outlined in the Literature Scope there is a plethora of evidence to suggest the value of the continuity of the training pipeline. The obvious breakpoint in the pipeline as noted in the Mason Report is the space between medical school and the commencement of vocational training.[143] As outlined in section 5.2.2 above "Provisional Selection" during internship training is a key strategy to address this.

Barrier identified by the Scoping Study: Lack of exposure to Rural Generalists, and information about the specialty; and, an absence of Rural Generalists in urban hospital training experience.

- *INTERNSHIPS THAT ARE RURALLY BASED OR INCLUDE RURAL EXPERIENCE*

Internship is the commencement of the medical career and up till recently has been an entirely urbanizing experience, based on highly specialised urban practice environments.

It is envisaged, particularly in the forthcoming years that training posts in metropolitan hospitals will become increasingly scarce. Efforts are already underway to extend internships beyond these settings. There should be a proactive effort to ensure this process includes consideration and creation of new post options in rural and regional hospital and community settings.

[143] Mason J. 2013. Ibid. (S. 4.1, Pg. 135)

These efforts notwithstanding, it is considered that a compulsory rural exposure component for all trainees in the Pathway over the course of years PGY1 and PGY2 should be a minimal requirement of the training pathway.

- *ACCESS TO SKILLS TRAINING POSTS*

It is noted that there is likely to be intense competition for training places. There is a strong argument that trainees selected to the pathway are 'priority' candidates as the through the selection filter they have been assessed as likely to meet future workforce priority needs. State and Territory jurisdictions should be encouraged to establish a formal structure to ensure that these trainees have quarantined access to necessary places.

It is anticipated that even with mechanisms in place, a creative and enabling approach will need to be undertaken by training providers to ensure that the relevant training experience is attained; and by regional organisations and health services to build training post capacity.

"I think rural experience as a medical student/junior doctor rotation is valuable in preparing doctors for life as a rural generalist. I have had an experience where one consultant and one registrar have spoken negatively about rural GP obstetrics as a career pathway. I think this can be very influential especially for junior doctors so it is important to link them in with mentors or change the culture of consultants towards rural generalism."

Comments of ACRRM Registrar
ACRRM Registrar Survey
Feb 2014

- *RG'S IN METROPOLITAN AND REGIONAL HOSPITALS*

Most internships in Australia are entirely or predominantly based in metropolitan tertiary hospitals. There are virtually no Rural Generalists on staff in these. The Mason Report describes rural exposure during these years as vertical integration's 'missing link'.[144]

For interns and junior doctors in urban settings; there is little exposure to rural role models, access to information about rural training is not always available and often provided by people who are themselves ill-advised or have negative attitudes.

"When junior doctors are exposed to rural GP's (the GP with the lot) they usually find them inspiring, and then start to recognise it as a specialty."

Comment of ACRRM Registrar
ACRRM Registrars' Survey
Feb 2014

It is noteworthy that as outlined in the Literature Scope and also reflected in member feedback, experiences during time spent in urban hospitals have been reported as often being associated with an attitude of negativity toward rural practice and uncooperativeness toward procedural skill training opportunities.

There needs to be Rural Generalist practitioners interacting with trainees at all points of the training continuum. In particular there need to be RGs on staff in metropolitan hospitals where some pathway training will occur. These ideally would be located there in person but could if necessary be available remotely and provide regular visits. These will maintain the integration of the rotation specialty to the RG scope and also ensure that there is always a role model of the RG profession.

Barrier identified by the Scoping Study: RTPs constitutions need to be better incentivised for vertical integration and some key workforce goals. There are disjunctions between internal GPET processes and Fellowship program standards and guidelines.

[144] Mason J. 2013. Ibid. (S. 4.1, Pg 135)

- *INCENTIVISING AGPT TRAINING TO RURAL WORKFORCE OUTCOMES*

There is a need to review GPET's internal guidelines as they pertain to the workforce goals of the rural training pathway.

Currently there are no Key Performance Indicators (KPIs) related to retention rates for pathway fellows. KPI's relating to rural retention need to be given priority status and be publicly reported and they should measure retention 1, 3, 5 years out.

There is currently also insufficient incentivisation for training for, and encouragement of careers as providers of procedural and other advanced skills which are a critical area of workforce need. KPI's could also be adopted which identified and rewarded workforce outcomes in terms of provision of procedural skills and continued provision of these skills as measured 1, 3, and 5 years out. (This additional measure is in consideration of the finding from the Literature Scope that many new proceduralists are ceasing practice after just a few years see section 3.4.2).

- *CLARIFICATION OF TRAINING ACCREDITATON REGIMES FOR RURAL CONTEXT*

The diversity of rural training settings, the relative lack of professional support, and the involvement of advanced skills training together contrive to create an environment where clear and relevant guidelines are especially important. The more innovation is cultivated the more important the collaborative standards become to ensure safety and quality.

Efforts are underway to streamline the process of accreditation nationally following from the General Practice Training and Accreditation Project (GPTAP) which demonstrated the viability of a vertically integrated accreditation process. The exigencies of the FACRRM and FARGP program and arising from training delivery in the rural context are complex and ill-fit to a standardized national approach. This could potentially act as a barrier to innovation.

Colleges have responsibility to accredit and ensure standards associated with their own Fellowships. This is also implicit to compliance with AMC guidelines for Accreditation of Medical Specialties.[145]

ACRRM and RACGP have already undertaken a joint exercise together with CPMEC to accredit the RTPs (i.e. the Bi-College Accreditation of RTPs). It should be noted that this is viewed as a streamlining process and that the programs are not of an equivalent standard.

Currently accreditation of PGY1 in all jurisdictions is the province of the state/territory PMCs. There is a set of national standards for intern training/supervision (which must be met in order to gain registration with the Australian Medical Board. States/territories can also apply their own standards in addition to national standards, and Colleges could apply their own standards in a similar way. It is considered that this will deliver the necessary streamlining and quality assurance.

> "….I worked in the <regional location>* ED for the last 12 months and frankly other doctors just don't get it yet. There is no benefit training in an environment where CT scanning is possible 24 hours per day and then to go and work in a town where the nearest CT scanner is 2 hours away. You just don't learn how to make clinical decisions in the same way."
>
> Comments of ACRRM Registrar
> ACRRM Registrar Survey
> Feb 2014
>
> *Regional location name removed to preserve anonymity.

[145] AMC Specialist Education Accreditation Committee. Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council. 2010.

ENCOURAGING INNOVATIVE TRAINING SOLUTIONS

There is a need for Government supported leadership toward encouraging innovative and creative mechanisms to deliver RG training. These should make optimal use of rural and remote Australia's limited health service facilities and be cost-effective. There are a range of initiatives and strategies that arise from this approach.

- *SUPPORTING INNOVATION IN GOVERNMENT FUNDED RURAL TRAINING*

  The Mason Report considered the financing structures of the PGPPP program and recommended further exploration into alternative approaches to rural training and financing. The Murray to Mountains scheme was given as an example of an innovative approach which involves trainees being based and employed within the rural location and sent to metropolitan hospitals where necessary.[146]

  There is merit in considering funding models for all prevocational training programs with a view to identifying opportunities to make these more productive. In particular options should be explored for rewarding innovation and creativity which enables maximized rurally-based training and optimal use of available health service facilities.

  One strategy would be to reward/prioritise programs that can demonstrate development of successful cooperative arrangements with a range of diverse service providers.

Barrier identified by the Scoping Study: The difficulties in accessing training and guidance from specialists for trainees in remote and rural settings.

- *SPECIALIST INTEGRATION IN RURAL PROCEDURAL TRAINING*

  There is a requirement to support procedural RGs through a program of regular visits from 'generalist specialists' who are normally based in urban and regional hospitals. These doctors could act as mentors, supervisors and assist with the Safety and Quality Framework around rural procedural practice. This would include participation in advanced skills training on site; clinical audit; and, morbidity and mortality meetings with local staff. Additional learning 'intensives' would bring the RGs back to larger centres for additional hands on training.

  Telehealth could be utilised to enable remote supervision models for trainees with RG supervisors assisting in situ. Fly-in Fly-out specialists should also be viewed as a potentially valuable training resource for these collaborative models. Specialists in private hospitals should also be viewed as a potential training resource.

  "Good supervisors both specialist and generalist and having them work together. Specialist supervisors alone do not have the skills to enable RGs to make the transition from hospital specialty training to RG practice"

  Comment of member ACRRM Members Survey Feb 2014

  The engagement of medical specialists to underpin quality assurance and ensure appropriate training will be especially important during the foundational years as a procedural workforce is rebuilt.

[146] Mason J. 2013. Ibid. (S. 4.1, Pg. 134)

Barrier identified by the Scoping Study: The structure of training reflects a metropolitan, highly specialised paradigm.

- *PROGRAM STRUCTURE REFLECTS RURAL AND REMOTE PARADIGM*

  There is a need to refresh the language of training structures to fit the rural paradigm. For example: the term 'rotation' is ill-fitted to the rural and remote practice paradigm as rotations tend to disguise the diversity of measurable skills that are learned in the rural and remote setting. More appropriate language is required to define the curriculum areas covered within each training post.

- *FINANCING INNOVATIVE GROUP TRAINING MODULES*

  The Rural Emergency Medicine Workshops in the first year of the QRGP training program attended by all RG trainees; demonstrate an innovative approach to meeting training requirements. These have been successful not only in satisfying educational requirements but also in providing a valuable opportunity for professional identity formation and establishing a peer network at the outset of postgraduate training.

  Funding structures of GPET, RVTS and PGPPP should specifically encourage inclusion of educational events that involve peer group interaction (e.g. web-based group tutorials, intensive workshops etc.).

  There is a particular value in having some activities involving all trainees across the state/territory or country (not just at the regional level), particularly in the prevocational years. Alternative funding sources (i.e. not tied to region-specific delivery) would be required to facilitate these.

- *OTHER PROGRAMS WITHIN THE RG PATHWAY*

  The RVTS goals and structure are consistent with the RG pathway and its trainees form an important element of the emergent RG workforce. Trainees on this pathway should be RG pathway trainees and qualify for the same benefits as other trainees, namely access to the Support Secretariat and any associated peer networking opportunities. Their training directors should offer parallel services to those proposed for the Dedicated Support Clinicians.

  It should be recognised that the ACRRM Independent Pathway provides an alternative route to a certified Rural Generalist scope of practice and as such is should also be viewed as part of the national RG Pathway.

- *ALTERNATIVE PATHWAYS*

  The Pathway could provide an organisational basis for development of Joint College Post Fellowship credentials for example the Generalist Emergency Medicine (GEM) qualification. A possible new credential could be an RG Rural Health Physician.

KEY PIPELINE ORGANISATIONS AND PERSONNEL

Barrier identified by the Scoping Study: Personal circumstances commonly impede rural and remote training.

- *PASTORAL SUPPORT SECRETARIAT*

Rural training programs are distinguished by the need to leave home, relocate and travel. They involve leaving family and friends, professional isolation, continuing dislocation and relocation, and a higher level of professional responsibility and stress. These issues could be expected to increase proportionately with degrees of remoteness and involvement in advanced skills training. As indicated in the literature review these are a major source of dissatisfaction, stress and attrition for many rural trainees.

> …remote work is remote and often the on call doctor is it, no one to come on at 1700 for the evening shift. …"
>
> Comments of Registrar ACRRM Registrars Survey Feb 2014

There is a strong case therefore for providing a secretariat within each state/territory which is a continuous, single reference point throughout the duration of the program providing personal support. Trainees association with this secretariat would commence at the point of 'Provisional Selection' and continue through to fellowship. This would provide pastoral support and a basis for formation of a sense of common purpose among the trainees.

> "Have one person responsible for overall training of each doctor as with too many people involved it becomes too easy to be forgotten when you are 600km away and are busy……."
>
> Comments of member ACRRM Members' Survey Feb 2014.

The secretariat should provide a continuous home-base for trainees. Its primary goal should be pastoral support. Additionally, it would act to develop a peer-based support network and build a sense of professional identity and fraternity. The secretariat should be resourced to offer wide-reaching peer networking events and activities. These could potentially extend to the broader rural medical trainee community.

- *OPERATIONAL DIRECTORS FOR EACH STATE/TERRITORY*

There needs to be an officer employed by each state or territory with status sufficient to influence ministerial level decision making as required to ensure the continuing viability and integration of the Rural Generalist pathways in each state and territory. This would include addressing access to training posts for the pathway's trainees.

> "More coordination between clinical supervisors and the planning bodies so trainee does not have to hustle and beg for relevant training term by term. The uncertainty of the whole thing undermines motivation.''
>
> "Potentially giving people the option of earlier on knowing where they might undertake their training - allow for more forward planning."
>
> Comments of Registrars ACRRM Registrar Survey Feb 2014.

- DEDICATED SUPPORT CLINICIANS

Each trainee should have a delegated officer with responsibility for mapping and checking their individual academic progress. An important element for this role will be to map an individualized training pathway with the trainee who considers both the trainees personal preferences and workforce requirements.

As the pathway emphasises diverse training arrangements and settings, this role is considered especially important in ensuring training quality assurance. It also satisfies the requirements of trainees to provide certainty and clarity to their learning experience. They will also provide a mechanism for articulating

training pathways to workforce needs.

- *INDIVIDUAL TRAINING AND CAREER PATHWAY MAPS*

  The QRGP has in place a Vocational Indicative Planning process which aims to match educational, personal (including family) and workforce needs with available posts and other requirements. These are drawn up and revised at regular intervals in consultation with each trainee and their Clinical Director.

  These provide a useful model for adoption across the national pathway. They address trainees' desire for certainty and forward planning. They also provide a mechanism for articulating the development of training pathways (which are consistent with trainees' personal preferences) with workforce needs. In particular they can be a means of developing a skills base within each region. This can facilitate a future paradigm whereby rural regions can accommodate a cluster of doctors with complementary advanced skills reducing the pressure on any one doctor.

- *STATE/TERRITORY BASED COORDINATION COMMITTEE*

  An appropriately represented forum needs to be established within each state or territory which can make determinations regarding the number of RG pathway places to be created each year and the appropriate regional allocation for these places. This ensures administrative control of training place numbers and their alignment with regional accredited training post capacity. They should also provide a structure for keeping the pathway open, by considering and ratifying submissions for lateral entry to the program.

5.3.3 RECOMMENDATIONS:

MAINTAINING THE RURAL FOCUS

10. Actively pursuing opportunities for rurally based Internships or rural experience
A policy should be established of endeavouring wherever practicable to utilise rural and regional hospitals and community based settings as training posts for internship placements. Rural exposure during internship should be viewed as a minimum requirement for trainees on the pathway.

11. Rural Generalists on staff in National Pathway hospitals
A policy should be established that all urban and major regional hospitals providing training in the RG pathway have RG practitioners on staff. Where appointments are not considered possible a second best option should be to ensure trainees have regular contact with a RG mentor and/or supervisor during their time in the hospital.

12. Additional KPI's for National Pathway Regional Training Providers
For RTPs participating in the RG training pathway, KPIs should be incorporated to ensure their alignment with its workforce goals. Specifically rural retention should be measured, 1, 3 and 5 years after completion of Fellowship. The results should be reported and publicised. A KPI which measures and incentivises training for provision of procedural practitioners should be included. This should measure provision of procedural practice upon completion of Fellowship and should similarly be measured 1, 3 and 5 years out.

13. Vertically integrated Accreditation and Standards
The accreditation process should be consistent across training posts throughout the RG pathway. ACRRM and CPMEC should undertake a process to ensure prevocational training posts also meet College standards.

14. Quarantining training places for the RG program
As a policy position each State/Territory program should commit to quarantining places for individuals selected to the RG pathway. There should be a senior departmental officer in place vested with authority and responsibility to ensure this occurs.

ENCOURAGING INNOVATIVE TRAINING SOLUTIONS

15. Integrating specialists into procedural training and supervision
As part of the general principles in service provision, support for procedural RGs should be linked to regular visiting 'generalist specialists' who would act as mentors/ supervisors and assist with the Safety and Quality Framework around rural procedural practice. This would include participation in advanced skills training on site; clinical audit; and, morbidity and mortality meetings with local staff. Additional learning 'intensives' would bring the RGs back to larger centres for additional hands on training. Telehealth could be utilised to enable remote supervision models with RG supervisors assisting in situ. Visiting consultant specialists should also be viewed as a potentially valuable training resource.

16. Prevocational Programs funding linked to Productivity and Innovation
An assessment of the funding structures of prevocational training programs should be undertaken with a view to improving their productivity; flexibility and innovation. In particular, incentives for cooperative and creative approaches, which enable optimal use of limited resources, should be considered.

17. Outcomes focused descriptions for RG training programs
More appropriate language is required to define the curriculum areas covered within each training post. Ill-fitted terminology is leading to misunderstanding about educational attainments. For example: the term 'rotation' is obsolete terminology to describe the full scope of RG curriculum and learning covered in each clinical learning location or department.

18. Encouraging group learning events for RG pathway trainees
Educational events for Pathway trainees involving wide peer group interaction (e.g. web-based group tutorials, intensive workshops etc.) should be encouraged, particularly in the Internship and prevocational years. Funding structures of GPET and RVTS should specifically encourage these and provision of additional funding options should be investigated.

19. Remote Vocational Training Scheme (RVTS) to be considered part of the RG Pathway
The RVTS should be considered part of the RG pathway. Candidates selected to the RVTS should have access to the services and peer-networking activities of the Support Secretariat. The ACRRM Independent Pathway also provides a pathway to certified Rural Generalist practice.

KEY PIPELINE STRUCTURES AND PERSONNEL

20. Operational Director within in each state/territory
Each state and territory should have a dedicated officer in place with overall responsibility for the operation of their respective pathway.

21. Vertically integrated Support Secretariat
A dedicated Support Secretariat should be established. This should be available to trainees to provide a continuing port-of-call for personal and pastoral support (including peer interaction) throughout the duration of the training experience.

22. Dedicated Support Clinician for each trainee
Each trainee in the pathway should be designated a dedicated clinically-trained officer who has responsibility for checking their academic progress and providing quality assurance that their academic and supervision needs are being met. This officer should report to an operational director for the pathway.

23. Training and Career Pathway Plans
Each trainee should develop a training plan. This should determine a training pathway including a choice of advanced skills with consideration of workforce needs and the trainee's personal preferences. This exercise would be undertaken with a dedicated support clinician (see Recommendation 22 above) whose role entails responsibility for the trainee; as well as for fulfilling workforce planning requirements.

5.4 SUPERVISION AND MENTORING

5.4.1 SUPERVISION AND MENTORING: GOALS FOR THE PATHWAY

To ensure that trainees in the program have access to sufficient supervision and mentoring for safe, quality service provision and training. To provide supervisors and particularly mentors who are role models in terms of inspiring trainees toward rural careers and also in terms of demonstrating best practice medicine. Implicit in these goals is the need to recruit and retain supervisors, to adequately train and maintain professional standards for these clinicians, and to ensure they themselves are adequately supported.

5.4.2 DISCUSSION

The major challenge to the provision of supervision and mentoring is the lack of available clinicians to provide these services particularly with the imminent so-called 'tsunami' of medical graduates about to enter the postgraduate training space.

SELECTING TRAINEES SUPERVISORS/MENTORS WANT TO TRAIN

It is important to note that mentorship and supervision is minimally remunerated. Rural doctors are motivated to this out of an altruistic commitment to the future provision of care for their communities and as a way to contribute to the future of these services. Some also hope to train doctors to eventually replace them in their private practice. Many have reported finding, training doctors who have no interest in rural careers as a disheartening experience.

Conversely, a program dedicated to placing students in the program who are motivated to rural careers and will be genuine protégés for the mentor/supervisor workforce will make the experience far more appealing and attractive.

"I want quality dedicated rural doctors who will take over from me in the future, providing the full gamut of rural health services."

"… In <rural location>* we have up to 6 trainees per year on this pathway but only 2 in the last 10 years with any procedural skills (i.e. 2 out of 60). It is a joke as many of them are OTDs whose families remain in Sydney whilst they do their contribution time in the bush"

"Having a suitable replacement, rather than getting stuck with doctors who are just marking time while we provide everything for them"

Comments on challenges for supervision/mentorship. ACRRM Members Survey. Feb 2014

*Rural location name removed to preserve anonymity.

Barrier identified by the Scoping Study: There are insufficient qualified rural clinicians to meet the training demand. Most training is unpaid.

Barrier identified by the Scoping Study: Supervision can involve considerable burdens in terms of reporting and other administrative requirements

ADEQUATE FUNDING FOR PRIVATE PRACTITIONER SUPERVISORS/MENTORS

There is concern among private practitioners that they cannot afford to take time out of their daily practice for their educational responsibilities. There is also a need in many cases to invest in specific resources to accommodate trainees in their surgery these also require adequate financial support.

REDUCING THE ADMINISTRATIVE WORKLOAD

Clinicians able to provide supervision and training are in short supply relative to the imminent trainee demand. They are consistently reporting stress and excessive workloads. Time invested in administration is uneconomic. As much as possible administration should be minimised and work should be delegated to non-clinical administrative staff.

INNOVATIVE EDUCATIONAL STRATEGIES

Creative solutions need to be explored which enable quality assured training with minimal burdens upon supervisors; for example, through the use of web-based technologies. Urban specialists should be engaged as appropriate in assisting rural doctors in situ through visits or online technologies. Funding arrangements should be structured to incentivise and reward creative approaches and development of enabling strategies, (See recommendations 13-18 above).

Barrier identified by the Scoping Study: Supervisors have no designated training time and have to either compromise training or compromise health service responsibilities

DEDICATED TRAINING TIME

The problem commonly cited among supervisors of lack of designated training time is clearly symptomatic of a general workforce shortage as are the associated excessive workloads of qualified RGs. This is cause for considerable stress among trainers and should be given priority consideration.

Barrier identified by the Scoping Study: Operational conflicts in moving between hospital (state funded) training and community (usually Medicare sponsored) practice based training.

SALARIED TRAINEES

One approach that could be integrated into the RG Pathway would be provision of salaried trainees. This would address the many barriers and conflicts that exist for trainees in providing work in both the private (usually Medicare sponsored) and hospital (state funded) systems.

Salaried positions would enable seamless movement across the two-tier system foregoing the necessity for creating individual contracts each time trainees move. Salaries could be based on PGY levels (as they are currently for hospitals) or equivalent for IMGs (i.e. years since attaining general registration). This system would augment the pathway's ability to ensure training across the employment spectrum and expand possibilities to build training post capacity.

This could potentially also provide a simpler and more transparent funding process. The discrete pool of funding available to fund Medicare services provided under the auspices of the AGPT program could be diverted instead to a program of funded trainee salaries.

Barrier identified by the Scoping Study: Insufficient financing and availability of CME for proceduralists and absence of professional support particularly in the first few years of procedural practice.

TRAIN THE TRAINER FUNDING

There should be consideration given to extending existing programs to providing CME opportunities to equip emerging doctors in particular with the appropriate skills and confidence to themselves provide supervision. This is particularly important for procedural practitioners. As outlined in the Literature Scope, CME is viewed as critical to maintenance of confidence and competence. Furthermore there is evidence that practitioners are losing their confidence several years after completion of Fellowship qualification. There is a need to better finance and support their continuing education and also to provide mentoring to bolster their professional confidence.

5.4.3 RECOMMENDATIONS:

24. Salaried Vocational Training
Vocational trainees should be remunerated through a fixed salary. This would simplify movement between community-based and hospital-based training settings. It would maximise portability, flexibility and opportunity for trainees on the RG pathway. It is noted that as Medicare funding for services provided by AGPT registrars is drawn from a specific budget appropriation. As such it could be readily distributed through an alternative framework.

25. Support for National Pathway Supervisors and Mentors
Consideration should be given to ensuring that private practitioners who engaged in supervision and mentorship activities are adequately supported in terms of funding for necessary resources, administrative support and recognition of the opportunity costs of their time. For supervisors and mentors employed in the public system consideration should be given to ensuring adequate administrative support and contracted time for educational activities.

5.5 COORDINATION AND WORKFORCE PLANNING

5.5.1 COORDINATION AND WORKFORCE PLANNING GOALS FOR THE PATHWAY

All key stakeholders to the development of the Pathway share a common goal of building a quality, sustainable rural workforce. Stakeholders have nuanced perspectives and conflicting priorities. The nationally integrated pathway needs to provide a coordinating structure that can balance these such that all key players remain focused on this common goal.

Best practice coordination and planning should also provide a mechanism for driving innovation; and, for a continuous process of identifying threats and opportunities and addressing them.

"From my experience working in <rural location>* it is important to have a good skills mix and adequate staffing to allow a healthy work life balance.

The loss (almost non-existence) of the rural general surgery is a loss not only for the community but also for their generalist colleagues who lose skills in managing minor surgical conditions and the anaesthetics required for procedures.

To me this is symbolic of a general attitude of 'why do it in a rural area if we can do it in a bigger facility?". This needs to be reversed completely…."

Comments of Registrar ACRRM Registrars' Survey Feb 2014.

*Location name removed to preserve anonymity.

5.5.2 DISCUSSION:

THE COMMONWEALTH PERSPECTIVE

It is recommended that the office commissioned for the national pathway within the Commonwealth Department of Health should incorporate responsibility to continue to ensure that GPET guidelines for participating RTP's enable and encourage them to provide the training that is required to meet specific workforce outcomes.

The Commonwealth must ensure that hospital grants to states and territories are spent in a manner which is consistent with their workforce planning requirements. The Commonwealth could take an active role in holding hospital's accountable for their spending choices with regard to the RG Pathway. One approach to this problem recommended in the Mason Report was discrete training funding.[147]

Another approach is to have required activities contractually specified. Metropolitan and larger regional hospitals are required to provide services across the wider region as a condition of their funding contract. This requirement needs to be tied to specific service obligations. In particular, the terms of the contract, could stipulate that RG pathway trainees have access to quarantined training places. It could also entail arrangements for the metropolitan hospitals to lend the specialist expertise of their staff to rural hospitals (either in person or electronically) for training and quality assurance purposes.

THE STATE/TERRITORY PERSPECTIVE

Jurisdictions must meet immediate health system needs which can potentially subsume long tem planning. The States/territories also have to manage the conflicting internal priorities of individual hospitals, Local Health Networks and services. The organisational focus required to address these problems should be provided through the appointment of a sufficiently empowered program leader within each state and territory.

There is no mechanism directly linking the GPET program, (whose training providers prepare the vast bulk of the state/territory's rural workforce), to state/territory service priorities. As outlined above the role of Dedicated Support Clinicians that

[147] Mason J. 2013. Ibid. (Recommendation 9.4)

report to the Operational Director in each jurisdiction, mapping training pathways with trainees and advocating ensuring their access to required training placements could provide an important conduit. (See Recommendation 20, 21 and 23).

THE REGIONAL PERSPECTIVE

- *REGIONAL RGP COLLABORATIVE COMMITTEES*

  The HWA RMG Draft National Framework identified the value of an organisation at the regional level with broad representation to facilitate and drive collaborations to enable innovation in rural medical delivery.[148]

  As identified in the Literature Scope the success of the Pathway depends greatly on its ability to adopt effective collaborative approaches to program delivery. It would be important that these were inclusive of all key stakeholders.

  Some of the key areas in which these Committees might enhance the effectiveness of the RG pathway are:

  - Providing advice on regional workforce planning as it relates to the RG pathway
  - Identifying and developing training posts
  - Development of prevocational training opportunities
  - Development of innovation collaborations to enable advance skills posts
  - Selection of RG trainees to Vocational Training places
  - Assisting with the process of quarantining places for RG pathway trainees.

5.5.3 RECOMMENDATIONS

26. Regional Collaborative Committees
Regional Collaborative Committees should be established and include representatives of all key stakeholders in the ongoing operation of the Pathway. These should support and enhance the pathway's ongoing development. In particular, they should identify problems and endeavor to find regional solutions; and, identify opportunities for collaboration and innovation and actively work toward their implementation.

27. Commonwealth Officer responsible for National Pathway Oversight
The Commonwealth officer with responsibility for oversight of the national program should have a specific brief to actively work to ensure training providers within the National Pathway are enabled through their guidelines to provide the training necessary to meet workforce outcomes.

28. Hospital Funding Contracts stipulate National Pathway Obligations
Commonwealth Hospital funding contracts should specify explicitly the responsibility that metropolitan hospitals have to meet workforce training needs for the entire region, not just the metropolitan environment. In particular specific reference could be made to ensuring access to training places for rural pathway trainees and provision of specialist training services for rural procedural and advanced skills training.

[148] HWA Rural Medical Generalists Draft National Framework. 2013. Ibid. (Pg. 55)

ACRONYMS

ACE	Association of Chief Executives
ACEM	Australasian College for Emergency Medicine
ACF	Australian Curriculum Framework (for Junior Doctors)
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
AIHW	Australian Institute of Health and Welfare
AHMAC	Australian Health Ministers' Advisory Council
AMS	Aboriginal Medical Service
AMB	Australian Medical Board
AMWAC	Australian Medical Workforce Advisory Council
ANZCA	Australia and New Zealand College of Anaesthetists
AST	Advanced Skills Training
ARST	Advanced Rural Skills Training
BSP	Bonded Support Program
CME	Continuing Medical Education
CPMEC	Confederation of Postgraduate Medical Education Councils
COAG	Council of Australian Governments
DOH	Department of Health
FACCRM	Fellow of the College of Rural and Remote Medicine
FARGP	Fellowship in Advanced Rural General Practice
FITCH (Project)	Feasibility of Intern Training for Community Health (Project)
FRACGP	Fellow of the Royal Australian College of General Practice
FRAME	Federation of Rural Medical Educators
FTE	Full Time Equivalent
GEM	Generalist in Emergency Medicine (qualification)
GPET	General Practice and Training Accreditation Pilot
GPTAP	General Practice Training Accreditation Pilot program

HWA	Health Workforce Agency
IMG	International Medical Graduate
JCC	Joint Consultative Committee
JFSS	John Flynn Scholarship Scheme
KPI	Key Performance Indicator
LHN	Local Hospital Network
MRBS	Medical Rural Bonded Scholarship
NMTAN	National Medical Training Advisory Network
MORPP	Medical Officer with Right of Private Practice
MSRPP	Medical Superintendents with Right of Private Practice
NRGP	National Rural Generalist Pathway
NRHA	National Rural Health Alliance
RRHWIR	National Rural and Remote Health Workforce Innovation and Reform (Strategy)
NSW RGTP	New South Wales Rural Generalist Training Program
PGPPP	Prevocational General Practice Placements Program
PMC	Postgraduate Medical Council
RACGP	Royal Australian College of General Practice
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RDAA	Rural Doctors' Association Australia
RDWA	Rural Doctors' Workforce Agency
RG	Rural Generalist
RGP	Rural Generalist Pathway (Queensland)
RHW	Rural Health West
RHWA	Rural Health Workforce Australia
RRHWIR	(National) Rural and Remote Health Workforce Innovation and Reform (Strategy)
RTP	Rural Training Provider

RVTS	Remote Vocational Training Scheme
RWAV	Rural Workforce Agency Victoria
VR	Vocational Registration
VGP-RGP	Victorian General Practice – Rural Generalist Program
VMO	Visiting Medical Officer
SMO	Senior Medical Officer
WACHS	Western Australia Country Health Service
WACHS RPP	Western Australian Country Health Service Rural Practice Pathway
WHO	World Health Organisation
WONCA	World Organisation of Family Doctors (i.e. World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians).

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APPENDIX I

REFERENCE COMMITTEE MEMBERSHIP

ACE REPRESENTATIVE:	**Professor Scott Kitchener** *Representative* Other roles include: Medical Director and Chief Executive Officer, Queensland Rural Medicine Education Senior Rural Medical Practitioner and Board Member , Clifton Co-Op Hospital Medical Director , Screen For Life Australia
ACRRM REPRESENTATIVES:	**Professor Richard Murray** *President* Other roles include: Head of the School of Medicine, James Cook University
	Associate Professor David Campbell *Censor-in-chief* Other roles include: Director of the Monash University, East Gippsland Regional Clinical School Board member and Director, Rural Workforce Agency, Victoria
	Ms Marita Cowie *Chief Executive Officer* Other roles include: Member of Management Committee, Queensland Rural Generalist Pathway
CPMEC REPRESENTATIVE:	**Associate Professor Elizabeth Chalmers** *Board Member* Other roles include: Chair: Northern Territory Postgraduate Medical Education Council George Marel Medal recipient, for contributions to prevocational medical education and training in Australia and New Zealand
FRAME REPRESENTATIVE:	**Professor Judi Walker** *Chair* Other roles include: Head of School of Rural Health, Monash University
RDAA REPRESENTATIVES:	**Professor Dennis Pashen** *Board member* Other roles include: Adjunct Professor James Cook University and Griffith University
	Ms Jenny Johnson *Chief Executive Officer* Other roles include: Consultant, Health Workforce Queensland