Data and the Role of Rural Clinical Schools: What data and what roles?

Dr Remo Ostini
A/Prof Srinivas Kondalsamy-Chennakesavan
Dr Bushra Nasir
Prof Sarah Strasser
Prof Geoff Nicholson
- The University of Queensland Rural Clinical School
Outline

• A brief history of Rural Clinical Schools
• What data?
  – Technical issues
• How to use the data
• The role of Rural Clinical Schools
• Informing the RCS role
A brief history of Rural Clinical Schools (RCS)

- Program launched in 2000 in 10 locations; 4 more in 2006-07 (also RMS’)
- To provide extended blocks of medical student training in locations outside metropolitan areas
- Various models used including longitudinal integrated clerkships and block rotations
- Sit along side University Departments of Rural Health (conceptually, & sometimes physically)
- Precursor to Regional Training Hubs
A brief history of Rural Clinical Schools (RCS)

The View from UQ

- UQRCS set up in 2001
- Four sites – Rockhampton, Bundaberg, Hervey Bay, Toowoomba
- Provide Phase 2 (Clinical) training; to about 150 medical students across all sites
  - Block rotations in 3rd or 4th year (or both)
- Also support Medicine in Society (MiS) placements across Southern and Western Queensland and beyond
  - All UQ domestic students for one 8 week rotation in a rural location
What data?

• Much data collected from/about medical students
  – Heavy reliance on surveys and questionnaires; mostly retrospective

Rural Clinical Schools can access data:
• From or about RCS students, collected by others (not RCS)
  – Medical Deans Medical Schools Outcomes Database (MSOD)
  – FRAME (Federation of Rural Australian Medical Educators)
• Internal RCS data collections
  – Administrative (University)
  – Specific school-based; e.g., UQRCS Entry-Exit surveys
What data?

Rural Clinical Schools data access (cont’):
• About RCS medical graduates (external sources)
  – Australian Health Practitioner Regulation Agency (AHPRA);
    • All registered medical practitioners in Australia; updated annually
  – Medicine in Australia: Balancing Employment and Life (MABEL)
    • Annual since 2008; approximately 10,000 respondents annually; mostly not RCS graduates; increased focus on rural workforce in recent years
What data?

Rural Clinical Schools data access (cont’):

• Internal RCS data collections: a UQRCS example: UQMediCoS

• Survey all UQ medical students (via MiS rotation)
  – Detailed rural background; reasons for clinical school choice; practice intention

• Graduates: Previously...
  – Detailed rural background; postgraduate training; current practice, including satisfaction
What data?

UQMediCoS (cont’):  
- Graduates: Next step  
  - Critical points in medical career journey; factors associated with those points; level of control graduates have  
  - Particularly as these distinguish between rural and urban medical practitioners  
  - Includes a survey and a structured interview component
Technical issues

- Data collection success can depend on how seriously students/graduates (& the medical school) take it
- Can be complicated to get external data; often student data only from your students
- Can be complicated & resource intensive to develop and deliver robust internal data collections
- Question redundancy across data collections; response burden (and competing priorities at end of medical school studies)
- Low response rates
Technical issues

• Data analysis can be resource intensive
• Low response rates, small cohorts and the nature of rurality can result in sparse data implications for data analysis
  – More serious problem for more complex analyses (which often provide answers to the deeper questions)
• Is Rural/Metropolitan the right distinction? Rural-Regional-Metropolitan better? (sparse data problem just got worse...)
• Data linkage challenges
• National (funder) perspective or local focus?
• Consistency or flexibility in data collection?
How to use the data

• Two approaches: Use what’s available or collect your own
• Or do both, either independently or combined with or without all the challenges of data linkage

• Collecting your own often means you only know about your own students (less generalisable)
• Working collectively means that you have less control over the content and validity of the resulting data

• Ultimately, the data that is collected (which data collection is prioritised) and what is done with it should be driven by the purpose of Rural Clinical Schools
The role of Rural Clinical Schools

• To respond to rural medical workforce shortages
  – So we try to produce doctors who are more likely to want to practice rurally (or less likely to be prevented from pursuing a rural practice interest/intention)
  – Evidence that we are having some success

• Variation in workforce need across rural communities potentially complicates this task
  – Do we understand this variation?

• The original RCS scheme was also intended to address Indigenous health
The role of Rural Clinical Schools

• Other (also important?) roles?
  – encourage rural health professionals to take up academic positions
  – improve the range of rural health care services in rural communities across Australia
  – strengthen the health workforce in rural communities across Australia*

• Improve the health of rural communities

(We have almost no data on most of this...)

*urbis – RCS-UDRH report 2008
Informing the RCS role

• More data? Different data? Better questions?
  – To better understand the process of how RCS’ have an effect/can better have an effect
• Should we explicitly investigate the other roles that RCS’ play?
• More purposeful strategy: less descriptive, less reactive, less fragmented, more prospective

Challenges

• Changing definitions of rural background
• Changing geographic classifications
• Changes to locations over time within classifications
• Lack of uniform standards for reporting outcomes
Conclusion

• We can say with some confidence that Rural Clinical Schools have been successful at increasing the size of the rural medical workforce
  – Thereby improving access by some measures
• Time to move to the next step?
  – Better calibrating medical education with rural community need
  – Better supporting student agency as they prepare for possible rural practice
  – Ask better questions about rural community health needs and role of medical workforce in meeting those needs