NATIONAL RURAL HEALTH ALLIANCE INC.

Position Paper

on

Supporting and promoting rural medical prevocational training and practice

April 2012

This Paper represents the agreed views of the National Rural Health Alliance, but not necessarily the full or particular views of all of its Member Bodies. It was current as at 16 April 2012 and will be amended from time to time as there are further developments.

Supporting and promoting rural medical prevocational training and practice

Introduction

Essentially all of the more than 2,600 2011 graduates from Australian medical schools were able to find internship positions in 2012. However the number of medical graduates per year is projected to increase to almost 3,800 in 2015[1]. It is essential that there are sufficient internships and pre-vocational training positions in postgraduate years 2 and 3 (PGY 2 and 3) for these large cohorts of junior doctors.

These increases in the number of junior doctors provide the opportunity to boost the number of young doctors who gain some of their early medical experience in a rural setting and thus are motivated to work in rural and remote Australia in the longer-term. This apparently simple change to the distribution of training places can contribute to an immediate and ongoing solution to medical workforce shortages in rural and remote Australia. Together with other elements of a refurbished recruitment and retention system, this will contribute to a steady supply of Australian trained doctors to rural and remote areas.

Already there are several initiatives underway that are changing the landscape of rural medical training and developing clearer pathways to rural practice. They include:

- work in several jurisdictions to develop clear and supported pathways to rural practice;
- the proposal from the Rural Doctors Association of Australia that there be a national approach to the training of rural proceduralists, with the development of a *National Rural Advanced Training Program*[2]; and
- Health Workforce Australia's work on a wide range of projects including:
    - the Rural Medical Generalist Pathways Project;
    - the Rural and Remote Health Workforce Innovation and Reform Strategy;
    - Clinical Training Reform and Clinical Placement projects; and
    - projects to improve information and data on Australia's health workforce.

The Alliance is strongly supportive of all of this work and is keen to cooperate to advance these efforts in any way it can. However, many of these projects will take some time to come to fruition and the Alliance wishes to focus on more immediate action that can increase the numbers of prevocational doctors receiving high quality training and experience in rural or remote areas so that they are more likely to take up rural practice.

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[1] Medical Training Review Panel Fourteenth Report

[2] http://www.rdaa.com.au/Uploads/Documents/Final%20National%20Advanced%20Rural%20Training%20Pathway%20%2823.2.12%29_20120223022456.pdf

Further support for rural training in PGY 1, 2 and 3

In recent years, a range of Commonwealth programs have greatly increased the number of students with a rural background studying medicine and ensured that most of them have exposure to rural placements during their studies. State and Territory Health Departments are largely responsible for the training and employment of junior doctors and have made good progress in increasing rural training opportunities for them. However, further action is required to ensure that these training experiences are more consistently positive and encourage these young doctors to commit to working in rural areas for at least part of their career.

Such further action could take several forms.

- Medical graduates from a rural background and those who have demonstrated a commitment to rural practice through membership of Rural Student Clubs or undertaking rural placements should be given preferential access to rural training posts. This system has been successfully implemented by the Clinical Education and Training Institute (CETI) in NSW and could be replicated in other jurisdictions.

- Wherever possible, rural hospitals should be the base from which PGYs 1-3 can undertake their training and rotations, with the possibility of a rotation to a city hospital if necessary. This occurs in Victoria and Queensland and to a limited extent in Western Australia and South Australia. These systems should be expanded as quickly as possible.

- Training for junior medical officers should be delivered through an integrated program which covers the years between graduation and commencement of vocational training (at least PGYs 1 and 2) to achieve the competencies described in the Confederation of Postgraduate Medical Councils (CPMEC) document *Australian Curriculum Framework for Junior Doctors*.

- In rural areas, such integrated training could be based in larger rural general practices (which are likely to have links with the local hospital, aged care service and ambulatory care or community health service) and supervised by the GPs of the practice.

- The standards set by accreditation bodies for training posts have developed over the years for metropolitan situations and are often not appropriate for rural situations. For example, prescribing certain numbers and types of staff without reference to setting can mean that training places cannot be established, or funding levels tied to the achievement of accreditation cannot be accessed. Greater flexibility is essential to increase the number of training sites in the rural context for prevocational doctors.

- Completion of prevocational training should be judged on competency-based assessments using the Australian Curriculum Framework for Junior Doctors (along the lines of the recently opened Workplace Based Assessment program pilot for international medical graduates seeking general registration).

All in all a more proactive and flexible approach is required, and State and Territory Health Departments, Postgraduate Medical Councils, the Australian Health Practitioner Registration Agency (AHPRA) and the Medical Board of Australia should be encouraged to work collaboratively and quickly to implement these proposals.

Supervision and support for prevocational doctors

There are well-established and effective systems of support for the clinical training of medical students. Integrated Regional Clinical Training Networks (IRCTNs) established by Health Workforce Australia (HWA) facilitate, identify and align clinical training placements across the higher education and clinical training sectors at a local and regional level. University Departments of Rural Health (UDRHs) and Rural Clinical Schools (RCSs) provide a multitude of supports, including accommodation, for medical students who undertake rural placements and for their clinical supervisors.

Such support systems as these should be extended to include doctors in PGY1-3 and the medical practitioners who provide supervision and teaching to them. Given their additional workloads and responsibility, the Department of Health and Ageing (DoHA) would need to review funding and guidelines for UDRHs and RCSs. The situation regarding the relatively new IRCTNs would need to be explored with HWA, with a few to establishing its capacity and appropriateness for providing support in the pre-vocational years.

Rural Local Hospital Networks (LHNs), IRCTNs and Medicare Locals have a great opportunity to create vertically integrated teaching and clinical supervision teams incorporating registrars, prevocational doctors and medical students and could include other professions to provide inter-professional supervision.[3] These teams would work across the region and could encompass general practice, Aboriginal Medical Services and a range of other local service providers.

Medical practitioners who provide clinical supervision and teaching cannot carry their usual full clinical load and should receive training in teaching and supervision[4]. Adequate remuneration is required for rural general practitioners to be released from direct service provision so that they can provide high quality teaching and supervision. All rural LHNs should be funded to provide teaching and clinical supervision through the employment of additional registrars and doctors.

Direct on-site supervision is obviously the preferred option for junior doctors. However, indirect and distance supervision, mentoring and support have become accepted practice in some rural and remote parts of Australia. The Australian College of Rural and Remote Medicine (ACRRM) Independent Pathway[5] and the Remote Vocational Training Scheme (RVTS)[6] both provide successful models of distance supervision. The DoHA, ACRRM and RVTS should consider ways and means of broadening the availability of high quality supervision, mentoring and support from a distance.

Mentoring by more senior rural doctors and development of broad networks in rural communities is very important in giving junior doctors a positive, rewarding experience of rural practice. The Rural Australian Undergraduate Medical Scholarship (RAMUS) scheme provides rural doctor mentors for scholarship holders, which is one of the crucial elements in

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[3] *Future models of general practice training in Australia,* Jon D Emery, Lesley P Skinner, Simon Morgan, Belinda J Guest and Alistair W Vickery, Medical Journal of Australia 2011; 194 (11): S97-S100

[4] *In-practice and distance consultant on-call general practitioner supervisors for Australian general practice?* Susan M Wearne, Medical Journal of Australia 2011; 194 (40):224 -228

[5] http://www.acrrm.org.au/files/uploads/How%20to%20Apply%202011%20Guide_0.pdf

[6] http://www.rvts.org.au/

firming up their commitment to 'go rural'. The NSW Rural Doctors Network runs a successful NSW Rural Resident Medical Officer Cadetship Program which offers a mentorship program, relocation allowance, career path support and leadership opportunities within the RDN. The introduction of mentorship into all rural scholarship programs and the provision of rural career path and other support should be considered by HWA, DoHA and jurisdictional Health Departments.

Infrastructure

The Alliance hears repeatedly that one of the biggest barriers to increasing the number of training places in rural and remote areas is the lack of infrastructure. To be effective, workforce programs that aim to address shortages of doctors in rural areas must specifically address this issue or work in conjunction with infrastructure funding programs.

Sites where clinical training and supervision are provided require additional clinical, communication and IT infrastructure. This is a particular issue for general practices in small rural towns.

Finding affordable accommodation for junior doctors, visiting health professionals and students is a major issue for many rural towns and has been made more difficult in some regions where there is a large fly-in, fly-out workforce in other industries. Specific infrastructure funding programs may be necessary to address this issue.

HWA, DoHA and the Department of Regional Australia, Local Government, Arts and Sport (DRALGAS) may be able to focus infrastructure programs to increase the availability of accommodation.

UDRHs and RCSs are very experienced and successful in managing accommodation for students on rural placements. If the number of UDRHs and RCSs was increased, the region(s) covered by them increased and their role expanded to include junior doctors, they could help make sure that available accommodation is utilised effectively and equitably.

Promoting the benefits of rural training and practice

The National Rural Health Students Network (NRHSN) reports that students frequently receive strong negative messages about rural placements and practice from staff in medical schools. Much media coverage of rural practice presents the view that being a country doctor is very hard work and that only those who are paid significant incentives or who are forced to (such as overseas trained doctors) will go to rural areas. There is also a perception that junior doctors in rural areas may experience a lack of support for continuing professional development and may have limited access to advanced or specialist training.[7] [8]

However the fact is that rural training and practice have a great many advantages and benefits. For example, Roberts et al reported that medical students on longer rural

[7] Tolhurst HM, Stewart MS. Balancing work, family and other lifestyle aspects: a qualitative study of Australian medical students' attitudes. *Med J Aust* 2004; 181: 361-4

[8] 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.

placements felt that they had a lot of opportunities that they would not get in city hospitals; they experienced complex interactions with patients and their families, clinical teachers and other health care staff, and students; and were afforded a higher level of autonomy than that allowed in more traditional settings[9]. An evaluation of the NSW Rural Resident Medical Officer Cadetship Program found that these junior doctors experienced a broader scope of clinical training, diverse caseloads, a greater level of responsibility for clinical training, more 'hands on' training and the opportunity to do a wider range of procedures[10] .

There is a range of programs aimed at encouraging junior doctors to take up rural practice, such as the HECS reimbursement scheme[11] and the General Practice Rural Incentives Program[12]. However, these programs are not well known or publicised to medical students and junior doctors – some Medical Deans seem to be unaware of the HECS reimbursement program.

The Alliance will make a concerted effort to gather and publicise information and stories that portray rural training and practice in a positive light. Audiences to be targeted will include Medical Deans and staff of medical schools; rural communities and high schools (working in conjunction with the NRHSN); Australian Medical Students' Association; Doctors in Training Groups; and Resident Medical Officers' Associations; and other similar groups.

The Alliance will seek to work with Health Workforce Australia and the Department of Health and Ageing to promote the skills, experience and benefits to be gained from a medical career in rural and remote areas; the career paths available; the incentives and programs available to assist doctors to establish themselves in rural practice; and the personal benefits to be gained.

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[9] *A longitudinal integrated placement and medical students' intentions to practise rurally*
Chris Roberts, Michele Daly, Koshila Kumar, David Perkins, Deborah Richards & David Garne, *Medical Education 2012: 46: 179-191*

[10] *Junior Doctors Working in Rural New South Wales: An evaluation of the NSW Rural Resident Medical Officer Cadetship Program*, NSW Rural Doctors Network, 2004

[11] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/HECS

[12] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/GPRIP

Attachment

Member Bodies of the National Rural Health Alliance

ACHSM	Australasian College of Health Service Management
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRIG)	Australian Psychological Society (Rural and Remote Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CHA	Catholic Health Australia (rural members)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Pharmaceutical Society of Australia (Rural Special Interest Group)
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RHW	Rural Health Workforce
RFDS	Royal Flying Doctor Service
RHEF	Rural Health Education Foundation
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RNMF of RCNA	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health