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PLAN TO RURALISE JUNIOR DOCTOR TRAINING

The release in June 2011 of the National Rural Health Alliance's *Plan for a greater number of interns for rural, regional and remote settings in 2012* generated welcome support and feedback from many sources. That feedback made it apparent that internships will be available for essentially all 2011 medical graduates and encouraged the Alliance to re-focus its proposal on postgraduate years two and three (PGYs 2 and 3).

This revised Plan does that and has a set of recommendations which, if implemented, would increase the number of positions for PGY2s and 3s in rural and remote areas and in primary care (cf. hospital) settings. Important parts of this Plan would see additional resources provided for the teaching and supervision of these junior doctors, especially for their clinical supervisors, as well as appropriate infrastructure to accommodate PGYs 2 and 3 in rural and remote primary care settings.

Considerable investments of money, energy and other resources have been made into increasing the number of medical schools and medical students across the country, and into initiatives that promote future rural practice. And responses from State and Territory Health Ministers to the first version of the Alliance's Plan make it clear that all jurisdictions have taken steps to support expansion of the number of internship and junior doctor training positions. Nevertheless, given the number of new graduates expected in the next few years, it is clear that there are still gaps in the training pathway for medical students, and that still more can be done to ensure that sufficient of them choose rural or remote practice.

All Australian-trained medical graduates should have the option of pre- and post-vocational training positions in rural and remote areas, including Australian-trained international medical students who can demonstrate an interest in rural practice.

Although this Plan focuses on doctors, the Alliance believes it has implications and parallels for other health professions, such as dentistry, nursing, allied health, optometry and paramedicine.

- **Take advantage of 'the rural pipeline'.** Students and young graduates who have demonstrated a commitment to rural practice or who have a strong rural connection (e.g. more than six years of their childhood spent in a rural area[1]) should be given preferential

[1] *Nature of association between rural background and practice location: A comparison of general practitioners and specialists,* Matthew R McGrail, John S Humphreys, and Catherine M Joyce, BMS Health Services Research 2011 http://www.biomedicacentral.com/a472-6963/11/63

entry to rural training posts or placements. The Australian General Practice Training (AGPT) and the Prevocational General Practice Placements (PGPPP) programs are effective in increasing exposure of general practice trainees to rural experience, but there is no explicit policy within these programs to ensure that an adequate proportion have a strong rural connection. In Victoria and New South Wales, rural Regional Training Providers (RTPs) are able to select partially on the basis of individual applicants' "connection to rural". This needs to be expanded nationally to ensure a significant intake of rural-origin applicants and graduates of rural clinical schools[2].

- **Introduce rural generalist training nationally.**
    - There is increasing interest among medical students and junior doctors in rural generalist pathways and the Queensland model has been successful in attracting junior doctors to rural practice and meeting some of the requirements of the Queensland health system. Other jurisdictions are developing their own approaches to the training of rural generalists and the Rural Doctors Association of Australia is advocating the introduction of a National Rural Advanced Training Pathway[3]. There needs to be a national approach to analysis of the costs and benefits of this model, so there can be greater clarity for new graduates and junior doctors of what is available. Health Workforce Australia could lead this national work.
- **Use innovative solutions to increase the number of training places available.**
    - Reduced working hours, shorter rotations and job sharing[4] have been proposed as potential ways of adding to the stock of accredited intern and junior doctor training places. Limiting the hours that individuals are allowed to work would also reduce the occupational health and safety and clinical risks associated with long working hours.
    - It is not suggested that non-traditional placements should encompass the whole of junior doctor training, but rather that they provide opt-in opportunities to gain a broader range of experience outside tertiary teaching hospitals and spread the load of supervision across the health system. There should be expanded options for junior doctors to undertake part- and full-year training in rural settings. In some jurisdictions, resident positions in rural and regional hospitals can be filled by having junior doctors based in the city do one rotation in the rural/regional hospital. Such partnerships between city and country health services and training providers can help build the capacity of rural health settings to accommodate PGY2 and PGY3 students.
    - A number of State/Territory jurisdictions have already introduced a range of non-traditional placements for junior doctors, such as in rural general practice, Aboriginal Medical Services (AMSs), palliative care and paediatrics. Hopefully the number of such positions can be increased, including through the use of still other settings such as the Royal Flying Doctor Service (RFDS), radiology, pathology and perhaps medical administration.

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[2] *Regionalisation of general practice training – are we meeting the needs of rural Australia?* D G Campbell et al, Medical Journal of Australia 2011: 194:11

[3] http://www.rdaa.com.au/Uploads/Documents/Policy%20position%20-%20RGP%20_20110408011607.pdf

[4] *An urgent challenge: new training opportunities for junior medical officers*, Brendan J Crotty and Terry Brown, Medical Journal of Australia 2007: 186: S25–S27

In any such expansion of intern and junior doctor training positions, a number of challenges need to be addressed in order to ensure that patient safety and community needs are taken care of, and that junior doctors receive positive clinical experiences.

1. Postgraduate Medical Education Councils (PMECs) and the Medical Board of Australia will need to act cooperatively and quickly to accredit the new positions.
2. More clinical supervisors need to be found, supported and adequately remunerated.
3. Health Workforce Australia has funded State/Territory-wide integrated regional training networks through the head offices of Health Departments. For effective coordination of training programs and placements in rural areas, localised networks also need to be established. These will build on existing programs and resources and make best use of the scarce human and physical resources available in those areas.[5] These regionalised networks would need to include Regional Training Providers, Medicare Locals, Local Hospital Networks, University Departments of Rural Health (UDRHs) and Rural Clinical Schools (RCSs). The regional and local structures being established in Western Australia (described below) provide a model on which these could be based.
4. Still more clinical and community infrastructure needs to be provided to accommodate greater numbers of junior doctors, including in settings which have not had a history of having them.

- **More supervisors and different ways of supervising.**
    - In a recent article in the MJA, Susan M Wearne has described a model for consultant on-call GP supervisors (CoGs). It proposes that CoGs would be expert clinicians who are relieved of their own clinical load and have received special training in teaching and supervision[6]. COGs would fit well with the concept of integrated regional training networks described by Lyle and Perkins[7] - the rural networks referred to above.
    - Indirect and distance supervision are already accepted practice in rural and remote parts of Australia and represent perhaps the area of greatest potential for increasing supervision in rural and remote areas. The Australian College of Rural and Remote Medicine (ACRRM) Independent Pathway[8] and the Remote Vocational Training Scheme (RVTS)[9] both provide successful models of distance supervision. Increased funding for these programs would increase the number of junior doctors supervised and enhance the feasibility and sustainability of health services in rural and remote Australia.
    - Another potential source of clinical supervisors is doctors who are approaching the end of their career, semi-retired and newly retired. A project to identify existing barriers discouraging senior doctors from clinical supervision, and finding ways to overcome them, would be beneficial.

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[5] Lyle, D. and Perkins, D. (2010), Health Workforce Australia: For all?. Australian Journal of Rural Health, 18: 179–180. doi: 10.1111/j.1440-1584.2010.01158.x

[6] *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

[7] Lyle, D. and Perkins, D. (2010), Health Workforce Australia: For all?. Australian Journal of Rural Health, 18: 179–180. doi: 10.1111/j.1440-1584.2010.01158.x

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

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

- International Medical Graduates working in rural and remote areas may also be a source of supervisors for PGY2 and PGY3 doctors. Ways and means need to be investigated and appropriate supports provided to capitalise on this relatively untapped resource.
- The increased focus on interdisciplinary learning and team based practice offers the possibility of experienced practitioners in different professions contributing to the teaching and assessment of interns and junior doctors[10] and this potential should be explored. This is particularly relevant in rural and remote Australia, where a number of nurse practitioners, remote area nurses, Aboriginal health workers, pharmacists and physiotherapists have a high level of relevant experience and expertise.

- **Provide more education, training and remuneration for clinical supervisors.**
  - UDRHs and RCSs actively support medical students on rural and remote placements, including in non-traditional settings. They also provide education and support for clinical supervisors in rural areas. RCSs have created a rural clinical educator pathway through which clinicians can become involved in supervision. These systems should be further extended.
  - Significant funding and development has gone into provision of facilities and staff to provide training and supervision in major teaching hospitals. State, Territory and Commonwealth Governments should allocate similar funding to develop training and supervisory capacity in the full range of settings in rural areas.
  - Much time and energy is required for rural practitioners to make all the arrangements necessary to become accredited as clinical supervisors. The integrated regional training networks discussed above and Medicare Locals should collaborate with the PMECs to support rural practitioners in this task.
  - The teaching and supervision of medical students and junior doctors takes general practitioners away from patient care and creates additional work for other practice staff. Adequate remuneration that is routinely available (for example provided through the Practice Incentives Program administered by Medicare) should be available to doctors willing to do this important work.
  - Emery *et al* advocate vertical integration of teaching in general practice and the creation of teaching teams incorporating GP supervisors, registrars, prevocational doctors and medical students.[11] This would create an ongoing system for teaching and clinical supervision into the future.

Coordinate and fund nationally.... but

Over the next few years, the large cohort of 2011 graduates will progress into PGY 2 and 3 and beyond. This presents an immediate opportunity to address the longstanding shortfall in doctors in rural and remote areas of Australia so that people in those areas can enjoy access to services similar to their city cousins. It also presents an opportunity to increase the primary care workforce in order to shift the focus of the health system from hospital to primary care.

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[10] *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

[11] *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

A coordinated and expanded system is essential to ensure that all of these graduates can complete the necessary postgraduate training to become competent and confident doctors. The system should ensure that:

- at least 30 per cent of new internships and PGY 2 and 3 positions are established in rural and remote areas (in line with the proportion of the population in these areas);
- a major and growing proportion of these positions incorporate community-based practice supportive of primary health practice; and
- funds are available to:

    - set up integrated regional and local training networks;
    - accredit additional training positions in rural and remote areas;
    - establish necessary infrastructure (including teaching facilities and accommodation for junior doctors); and
    - train and remunerate increased numbers of clinical supervisors.

Health Workforce Australia (HWA) has been funded "to provide more effective and integrated clinical training for health professionals, support workforce reform and more efficient workforce use, and provide effective, accurate planning of health workforce needs".[12] HWA is therefore the appropriate body to develop and implement system changes to ensure that the health workforce of the future in rural and remote areas meets the needs of the 32 per cent of the population who live there.

Additional allocations to these various rural training and support measures are justified by the primary care funding deficit in rural and remote areas which amounts to at least $2.1 billion a year. This equates to a shortage of 25 million services, and includes a rural Medicare deficit which has now reached $1 billion a year[13]. Implementation of this plan to 'ruralise' internships and junior doctor training would reduce the rural primary care deficit by increasing access to general practitioners and medical specialists.

Other activities that HWA would need to undertake include:

- a national marketing strategy that capitalises on the benefits of the 'rural pipeline' and shows a clear rural pathway for junior doctors; (students and junior doctors who represent the potential future rural health workforce should be involved in the development and design of such a marketing strategy);
- clarifying indemnity issues for junior doctors in non-traditional training places; (unlike the situation in State or Territory funded situations, in primary care or non-government positions, it is not always clear where responsibility for indemnity cover lies);
- identifying successful regional initiatives which have the potential for wider application - and then promoting them broadly.

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[12] *Health Workforce Australia: Agency resources and planned performance*, Available from URL: http://www.health.gov.au/internet/budget/publishing.nsf/Content/2010-11_Health_PBS_sup4/$File/HWA.rtf

[13] *Fact Sheet 27 The extent of the rural health deficit*, National Rural Health Alliance, March 2011

Currently, jurisdictional PMECs have a crucial role in accrediting training positions. The Confederation of PMECs has an overarching role which should be utilised to facilitate streamlined processes and national consistency in the shortest possible timeframe.

.... let a thousand flowers bloom

There are already many innovative activities relating to internships and junior doctor training being undertaken across Australia.

- Western Australia is implementing a range of strategies to enhance rural and remote opportunities for doctors, including:
    - regional and local education structures to provide teaching and administration support to both junior doctors and supervisors;
    - training positions so that the junior doctors are employed;
    - simulated training environments; and
    - financial support for travel and accommodation for junior doctors.

- In New South Wales, a Rural Surgical Futures project is being developed which incorporates the networking of hospitals; vertically integrated supervision, including a supervising doctor, senior registrars, interns and students; some distance supervision; and an interface between universities and hospitals which allows integrated learning through the Rural Clinical School and setting up of simulations run by a clinical nurse educator.

The establishment of integrated regional training networks to coordinate training programs and make the best use of scarce human and physical resources in rural and remote areas[14] will enable unique localised solutions to be developed.

The HWA will play a lead role in implementing this plan, including by funding and facilitation. HWA should also be required to communicate broadly throughout the health and education sectors about successful initiatives and engender the wider adoption of strategies that are effective. At the same time, HWA needs to address any overarching barriers to implementation of this plan.

In summary

The increased numbers of medical students expected to graduate from Australian medical schools over the next few years offers a once-in-a-lifetime opportunity to redress the maldistribution of doctors which has a significant impact on the health and wellbeing of people living in rural and remote areas.

[14] Lyle, D. and Perkins, D. (2010), Health Workforce Australia: For all?. Australian Journal of Rural Health, 18: 179–180. doi: 10.1111/j.1440-1584.2010.01158.x

Rapid and collaborative effort is needed to put in place a range of initiatives to make sure that students and junior doctors with a commitment to rural training and practice have access to clear pathways through medical school and, following graduation, to rural practice. Greater numbers of training placements in rural and remote areas and excellent clinical supervisors are essential, along with appropriate infrastructure and support and remuneration for supervisors. Regional and local training networks must be established to integrate and facilitate these activities.

Funding for these initiatives is justified on the basis of rural and remote Australia receiving its fair share of the health education dollar and being compensated for the deficit of health expenditure, estimated at a minimum of $2.1 billion a year.

Health Workforce Australia has a leading role in ensuring that action occurs quickly and efficiently - and in a coordinated manner. State and Territory Governments need to identify and fund increased numbers of training positions in rural and remote areas and Postgraduate Medical Education Councils and the Medical Board of Australia should act quickly to accredit new positions.

University Departments of Rural Health and Rural Clinical Schools have demonstrated their success in supporting the education and training of health professionals in rural and remote areas and they must be part of the solution. As Medicare Locals and Local Hospital Networks become operational, they too will have significant roles in addressing rural health workforce shortages.

Creative approaches to challenges have long been a feature of health services in rural and remote Australia, and this augurs well for action to work with the current cohorts of medical students to reduce the shortages of doctors in rural and remote areas. All that is needed now is a little extra resource and the political will of governments and other relevant agencies and organisations.