RURAL MEDICINE IN AUSTRALIA

Education and Training for Rural Practice The Preparation, the Practice and the Politics

Introduction by Professor Roger Strasser
Director, Monash University Centre for Rural Health

Australia is a large country and as a federation of six states and two territories, came into existence in 1901. The population is about 18 million of which 75% is concentrated in the major urban areas. The vast, sparsely-populated rural and remote areas present significant challenges to Australian health services.

Education and training for rural practice are provided by a range of different institutions and organisations. Graduate training for rural general practice is provided as one component of the Royal Australian College of General Practitioners (RACGP) Training Programme. The Australian College of Rural and Remote Medicine (ACRRM) was established in 1996 and includes a focus on education standards and clinical qualifications for rural and remote practitioners.

Australia also has rural health training units in all states, mostly in non-metropolitan locations. GPs across Australia belong to local networks called Divisions of General Practice. Most rural Divisions are actively involved in continuing medical education (CME) and each state has a Rural Divisions Co-ordinating Unit (RDCU) which receives funding for rural GP CME.

The Australian Government's GP Rural Incentives Programme has a number of functions, including increasing the number and skills of rural GPs, organising training grants to GPs relocating to rural areas and the provision of funding for locum relief, which facilitates continuing education and skills training.

Rural Secondary School Initiatives in the Recruitment of the Health Professionals

Dr David Gill, Medical Consultant, South Australian Health Commission and Professor Roger Strasser

In 1992; following research which showed that students from a rural background were more likely to return to country areas after graduation, the Rural Practice Training Unit in South Australia and the Monash University Centre for Rural Health in Victoria embarked on a strategic recruitment initiative.

This initiative included the following activities :

South Australia:

- Survey of careers consultants and principals in rural schools to establish the current level of interest in a medical career.
- Preparation of a career information kit for every identified secondary school.
- Information visits by sixth-year medical undergraduates and rural training unit staff to high schools.
- Advocacy for increased rural entry into medical schools.
- Sponsorship of identified school pupils to attend pre-university entrance examination preparation courses and meet medical students.
- Organisation of comprehensive medical work experience programmes for rural secondary students.
- Acting as a mentor and advisor to rural teachers, students and their parents.

Victoria:

- Video and booklet *A Great Career where You Live*, developed in 1993; updated and distributed more widely in 1997.
- Medical student visits to rural secondary schools to talk on opportunities.
- An Open Day Rural Forum, started in 1995 and run by medical student members of the Rural Practice Association, aimed at rural secondary school students.
- Rural hospital careers nights, a joint collaboration by the University of Melbourne and Monash University, held at ten major rural hospitals in Victoria.
- Residential workshops for senior secondary school pupils, for information on rural medical careers and university entry.
- Internet website, with information and links with related websites.
- Health careers banner display for use at careers expos.
- Medical undergraduate placements with families of rural secondary school pupils.
- Support and resources to hospitals and health agencies to complement their activities at Rural Health Week.

The future intention is to integrate rural secondary school activities into mainstream rural health and education events throughout the state. This will work through a co-ordinated marketing strategy, involving the Victoria State Government Department of Education and the formation of regional networks.

SPINRPHEX: Students and Practitioners Interested in Rural Practice, Health Education Xetera

Dr Ray Power, Ms Melissa Jewell and Dr Charles Nadin
Western Australia Centre for Remote and Rural Medicine

The SPINRPHEX Club, established in 1990 and the first of its kind in Australia, comprises medical and nursing students interested in rural practice. The club holds regular meetings and outings which attract between 80 and 90 people. It offers students the opportunity to find out about rural life and fosters a sense of community among rural health professionals.

The members' support network has been strengthened by the mentor groups established over the past year.

There is an annual camp and outings to the Royal Flying Doctor Service and other rural locations. The club has been successful for the following reasons:

- the camaraderie among members;
- the empowerment of the club executive to run the activities;
- the support of WACRRM; and
- the change in attitude within the medical school towards the stature of rural practice.

The Bush Bursary Scheme in New South Wales

M Kirsty McEwin and Ian Cameron
Rural Doctors' Resource Network, Mascot, New South Wales

The main aims of the Bush Bursary Scheme are to give medical students positive experiences of rural life and practice and to encourage them to work in rural areas. The scheme provides selected medical students with bursaries worth A$2 500 and in return the students spend three weeks in rural communities.

Co-ordinated by the Rural Doctors' Resource Network and funded by local government, the scheme also involves local communities in the selection of students and subsequent placements. Experience has shown that local community participation is crucial to the success of such initiatives. Given the different bodies involved in such schemes, the co-ordinating role of the Rural Doctors' Resource Network is vital to avoid fragmentation, waste or duplication.

Teleconference for Rural GP Training

Dr Sarah Strasser, Dr Robert Hall, Dr Graeme Jones, Professor Roger Strasser, Monash University Centre for Rural Health, Moe, Victoria

GP registrars in rural and remote areas find it difficult to attend vocational training group learning sessions. Monash University brings doctors and their families together for two weekend release programmes a year and co-operates with the RACGP Training Programme to provide fortnightly telephone conference seminars for rural trainee doctors linked to rural GP resource people.

Fortnightly evening seminars are held by teleconference, with 15-20 people on line and 3-6 people round a speaker phone at Monash. The format is an hour of "talk back", with the GP registrars encouraged to discuss cases and clinical experiences with the resource people. The weekends focus on learning practical skills for rural medicine and exploring family and social aspects of rural practice.

Feedback from GP registrars has been very positive and they enjoy the opportunity to maintain fortnightly links with other rural trainees and experienced GPs. The Victorian Rural GP Seminar Programme has proved to be an effective way of providing an educational programme specifically on rural medicine for geographically-dispersed GP registrars.

Monash University Second Year Medical Student Rural Attachment

Dr Charles Kerr, Dr Susan Strasser, Dr John Togno, Professor Roger Strasser, Monash University Centre for Rural Health, Bendigo Division

Experience in rural areas is an important part of the first three years' study and second year students at Monash are attached to rural and provincial hospitals. They participate in a programme that includes:

- one or two days with the district nursing service;
- a shift with an ambulance crew;
- a day with the area geriatric team and home-based geriatric support service;
- a day with the Aboriginal health worker, where there is one;
- sessions with community physiotherapy, Hospital in the Home, Diabetic Educator; and
- any other community-based services available.

Problems encountered include accommodation, transport, student resourcefulness and weekend programmes. Solutions to these problems include student billets contacted by the co-ordinator, student information kits and hospital information kits.

Initiation and Evaluation of Mentor Contacts for Rural Medical Undergraduates

Dr David Campbell, Ms Anne Kleinitz, Dr Lexia Bryant, Professor Roger Strasser, Monash University Centre for Rural Health

The Monash University Rural Mentor Scheme was introduced in 1993 and in 1996 the first-year medical students' Mentor Scheme was redeveloped with an emphasis on the initiation of contact between mentor and students, plus intensive support for the first year of contact.

When the concept of mentoring by rural GPs was introduced, 36 students took part and were matched with a mentor. Initial personal contact was made by telephone and response was enthusiastic. Subsequently a letter of introduction was sent to mentors and students and a "Meet your Mentor" dinner was held in May 1996. A Rural Mentor Scheme Newsletter was then issued and students and mentors were encouraged to contact each other regularly. While the Rural Mentor Scheme is seen by all parties as valuable, it is important to undertake an evaluation of the scheme to ensure its continued success.

Food and Drugs: Additional Ingredients in Rural Undergraduate Medical Education

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Monash University Centre for Rural Health

Medical students are expected to absorb vast amounts of information during their studies. Medical schools are trying to train students to work within health care teams, but knowledge and experience of other team members' work is limited. Research showed that the knowledge of nutrition assessment and writing and interpretation of prescriptions was limited. Students confirmed that during training they had very little contact with dietitians or pharmacists.

To try and address these and similar issues, Monash University Centre for Rural Health provides a multi-disciplinary tutorial programme during the final year medical students' three-week compulsory rotation. Health care professionals such as dietitians and pharmacists give the students valuable insight and information, which will assist when they work in rural and remote areas. Student feedback indicates that the tutorials were informative and clinically relevant — learning "the right kind of material at the right time". This kind of training improves doctors' understanding of the role of other health professionals and the contribution they can make to the health team.

Rural Medical Family Network

Ann Graham, Joanne Radnor, Steve Kirkbright
Monash University Centre for Rural Health

Research shows that a key factor in the retention of rural health professionals is the family. The Rural Medical Family Network was formed to improve the recruitment and retention of rural GPs through family-based initiatives.

Wide-ranging strategies, developed over the past four years, include the development of networks within each state, regular teleconferences, mentor systems, newsletters, data gathering, needs surveys, booklets, information packages, undergraduate hosting programmes and associates programmes at CME meetings.

The Network receives funding from Commonwealth GP Rural Incentives Programme Family Support Grants and makes a significant contribution to the complex task of improving the rural medical workforce and the health of the rural population in Australia.

The Australian College of Rural and Remote Medicine The World's First Rural Medical College

Dr Thomas Doolan, Honorary Director of Education, the Australian College of Rural and Remote Medicine, Kilcoy, Queensland

The Australian College of Rural and Remote Medicine (ACRRM) was established in March 1997 by the Rural Doctors Association of Australia (RDAA). A world first, the college aims to develop and maintain education and training of the highest standards at both vocational and continuing education levels for rural and remote medical practice.

ACRRM has around 500 fully-subscribed members and a growing number of associate members. The ACRRM Prospectus incorporates some 25 position papers on key issues and will serve as a blueprint on future policy articulation.

The imperatives underpinning the college's development are:

- rural and remote medicine has emerged as a discipline in its own right, with general practice as a subset of this discipline;
- there is a need for a dedicated educational programme, to develop and maintain standards within this discipline;
- appropriate education and training are key aspects of a strategy in the recruitment and retention of rural doctors; and
- the longstanding shortage of doctors in rural and remote areas, in conjunction with the above issues, has also provided a workforce rationale for the establishment of ACRRM.

Rural Training in the Royal Australian College of General Practitioners: Current Status and Future Directions

Dr Sarah Strasser, Director of Rural Training
The Royal Australian College of General Practitioners Training Programme, Melbourne

The RACGP provides vocational training for general practice in Australia. The Rural Training Stream (RTS) started in 1994 and has developed to become a mature, flexible programme, able to meet the challenges of delivering high quality, rural education and training to enable general practitioners to work competently and confidently in the bush.

A number of strategies has been developed to encourage regis-

trars to consider rural and remote general practice as a preferred career option.

Within the training programme as a whole these include :

- selection to the training programme includes a significant rural weighting, based on previous rural life experience, rural professional experience, attitude and adaptability to a rural lifestyle;
- GP registrars enrolling after 1995 undertake training in areas of medical service need, mostly in rural and remote areas;
- the release of the RACGP Training Programme in 1997 reframed the vocational training for general practice, with emphasis on the GP supervisor/registrar dialogue with adult-style learning in the practice setting.

Specific to rural training:

- the Rural Training Stream was introduced in 1994;
- the Graduate Diploma in rural general practice is awarded to registrars who complete the Rural Training Stream requirements, including a full year of Advanced Rural Skills Training;
- the Rural Training Stream was opened up in 1997 to any registrar with an interest in rural general practice and an increasing number of disciplines became available for Advanced Rural Skills training;
- a move towards decentralisation in 1997, with regionally-run programmes;
- significant specific benefits announced in 1997 for RTS registrars, including extra educational, financial and support incentives; and
- an IT strategic plan has been approved for 1998 to provide E-mail and Internet access to all rural registrars and GP supervisors.

Inherent in these strategies is a process of raising awareness of what the issues are for rural and remote general practice and providing support where it is needed. Initiatives for promotion, orientation, educational programmes, staff development and training help bring the country to the city and vice versa.

The future direction for the RACGP is to work collaboratively with other educational organisations to optimise the achievement of common goals. This includes increasing the flow of competent and confident GPs into rural and remote areas.

Advanced Training for General Practice: Training Rural GPs for the 21st Century

Dr John Togno, Dr Lexia Bryant, Dr Robert Hall, Professor Roger Strasser, Monash University Centre for Rural Health, Victoria

The Victorian Advanced Training for General Practice programme is a post-graduate training programme for doctors who want a career in general practice or for general practitioners undertaking retraining or upskilling. The VATGP programme offers six-month positions or 12-month positions in a variety of clinical areas relevant to general practice.

The VATGP programme includes :

- special skills training to support development of "value-added" metropolitan general practice;
- advanced rural skills posts which contribute to the RACGP Rural Training Stream;
- training for academic general practice;
- upskilling of established urban and rural GPs;
- training for new health service development and administration roles for GPs in Divisions of General Practice; and
- bridging training for doctors returning to general practice after a period away or from another field of medicine.

The VATGP programme offers senior registrars a personalised package of education and training which includes:

- in-service training/supervised clinical experience supported by relevant specialists and a GP supervisor/mentor;
- learner-centred education packages about the conceptual basis of general practice, evidence-based medicine, roles and tasks of the GP, future directions in general practice;
- special student status in the graduate studies programmes at Monash University;
- enrolment (for discounted fees) in relevant subjects, modules, post-graduate courses offered by Monash University; and
- senior registrars will be encouraged to complete a small research or education project.

Moving Rural Health Education, Training and Support from Fringe to Mainstream

Di Wyatt, Executive Director, Co-ordinating Unit for Rural Health Education in Victoria Inc.

Twenty-eight percent of the Australian population live in rural and remote areas, but they are serviced by only 18% of the total GP workforce in Australia and 12% of the specialist medical workforce. Research also shows that there are further shortages in other health care professions, particularly pharmacy, most major therapies and specialist nursing.

A major factor contributing to the shortage of health care professionals in rural areas is the education and training system. Governments have introduced a number of initiatives to respond to this issue, but the educational sector on the whole has been slow to respond.

Educating a workforce to address the highest areas of need has not been a priority for many of Australia's tertiary institutions. The majority of schools and training facilities focus on producing graduates that fulfil academic requirements and few train graduates to be competent practitioners, able and willing to serve in rural areas. Education and training for rural practice has been on the fringe of mainstream teaching.

The recruitment of health professionals to rural practice and the support for their retention require multi strategies which include education, training and support.

The Co-ordinating Unit for Rural Health Education in Victoria (CURHEV) was established in 1995 to improve access to and quality of health services for everyone in rural Victoria. CURHEV encourages activities across the various education and training levels; pre-tertiary, undergraduate, post-graduate and continuing education. CURHEV aims to facilitate the introduction of education and training for rural practice into the mainstream of Victoria's educational system.

Politics of Change in Rural Health Care

Professor Max Kamien, Department of General Practice, University of Western Australia

Change in political attitudes to the shortage of rural doctors and health workers for rural people in Western Australia did not just happen — it was made to happen.

Prior to 1985 there was always a shortage of doctors, locums and new partners. Questions in parliament, letters to the editor, double page descriptions of woe and TV exposés were all one-off, ad-hoc and unsuccessful attempts at seeking a solution. Triennial elections were due by the end of 1985 and the result rested on six marginal seats, four of which were rural with problems in recruiting and retaining doctors.

I contacted doctors in these constituencies and suggested they write about their concerns to their MP. Enough did so to cause the four sitting members to express concern to the Minister of Health, who followed the usual response of defusing their concerns by

ordering a ministerial enquiry.

The Government was returned by a narrow margin, but the Minister of Health lost his seat. The new minister, unaware of the promise of an enquiry, had to be persuaded into it. The enquiry included views of key players in rural areas, including over 70% of rural doctors. It made 51 recommendations, the chief of which was to set up the WA Centre of Remote and Rural Medicine (WACRRM).

After a number of meetings with the Minister and Commissioner of Health and discussions with other groups, I submitted a report. The Minister said that he did not like the recommendations and refused to publish it. It was apparent that he had not even read the executive summary and was relying on the advice of the Commissioner for Health and his political adviser. Intervention through his rural constituents led to a change of mind and 800 copies of the report were duly published.

Some of the recommendations were taken up and the influential County Medical Foundation convinced the medical school to accept affirmative entry for high school students shown to be at a 10% disadvantage. WACRRM was funded by the State Government with an initial grant of A$2-million. Various medico-political bodies put in bids for it, but the best place was in a university structure.

Analysis and Principles

- Change requires external and internal stimuli.
- An official enquiry is a powerful stimulus around which change agents can structure and reinforce their arguments.
- Governments are most responsive around the time of elections.
- Letters from influential constituents are a powerful stimulus to a sitting politician in a marginal seat. Newspapers and TV are helpful, but by their short-term interest are not a sufficient influence by themselves.
- Chairs of committees of enquiry and committee members must believe in their findings and recommendations, and fight for them.
- Members of parliament are very sensitive to the views of their constituency electoral members.
- Governments change, so don't put all your eggs in the basket of one party.
- Universities do respond to external finance, political influence (if in their better interest) and to research.
- Change agents require strong constituencies such as CMF and Rural Student Clubs to ensure that things do not slip backwards.
- Outside funding requires regular review mechanisms to ensure that rural money is spent on rural projects.
- There is nothing like success (and funding) to maintain change in medical schools.

Australian Rural Practice: Conclusions

Dr Bruce Chater

The Australian rural doctor's scene has been characterised by the image of the rugged individualist, tainted by the isolated alcoholic, the so-called cowboy or individual doctors who could not co-operate in a small town. These negative images have, in the past, been used to strip rural areas of their facilities and to downgrade practice.

There is a need to develop an image more appropriate to a modern age and expectations of both doctor and doctored. The image needs to be backed by quality — quality training, practice and life style. There is a need to define the practice of rural medicine and to develop the discipline further. We need a balance between exclusivity making rural practice unreachable and mediocrity making it ineffective. The quality approach also requires greater assistance, greater rewards and greater recognition.

The recent past

In our pre-conference workshops we dealt with three main topics — preparation, practice and politics. The recent history shows significant progress in these areas.

Preparation:

- Vertical integration — secondary school, university, vocational training and CME.
- University recognition.
- Standards — curriculum development.
- Training RHTU, individual enthusiastic efforts.
- CME — specific rural programmes filling the gap between available specialist and community-based general practice continuing education.
- Re-accreditation — anaesthetics, obstetrics.
- Technology — satellite technology.

Practice:

- Lifestyle support — Rural Family Network.
- Women/generational change — consideration of lifestyle issues and more women entering rural general practice.

Politics:

- Separation of ACRRM from RACGP.
- The development of a more rural emphasis in RACGP.
- Multi-disciplinary RHTU.
- Political interest in the rural areas and their needs (and votes).
- RIPIC — national approach with state responsibilities encouraged.

The future

Preparation:

- Standards will develop further.
- Training will become more specific.
- Re-accreditation will continue but be rationalised.
- The present training packages will be modularised to suit CME.
- Technology will allow more backup but still (hopefully) be rural controlled.

Practice:

- Single-doctor towns will develop into one-and-a-half or two-doctor towns.
- There will be further development of locum support.
- Women and men's (generational change) need for more flexible working arrangements will provide a mutually beneficial environment for doctor partnerships in rural areas.

Politics:

- Two colleges with competition between ACRRM / RACGP will provide choice for rural doctors.
- Multi-disciplinary RHTU will become mixed-campus, discipline-specific teamwork oriented.
- Political interest will continue, but with a backlash from urban areas wanting what we have and asserting that they have the same problems.
- RIPIC will develop into a retention as well as recruitment scheme, with adequate remuneration.

Summary

The future rural doctor in Australia will, we hope:

- be more competent and confident;
- be more specifically trained and recognised for such;
- be more effectively supported;
- be more likely to be female;
- have a more balanced lifestyle;
- be able to access appropriate CME more easily.

The recent history of rural medicine in Australia has been turbulent and at times acrimonious, but never dull. The political impasses have clouded the enormous steps forward in the development of rural training and practice. The future looks equally exciting and challenging. ●