

Barriers to prevocational placement programs in rural general practice

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THERE IS A SHORTAGE of medical practitioners in rural and remote Australia.¹⁻⁴ Because exposure to a rural setting is known to enhance rural recruitment,⁵⁻⁹ a number of initiatives introduced at the undergraduate level ensure that all students have some experience of rural general practice. However, there is a gap between the end of undergraduate education and the beginning of vocational general practice training. A major reason has been the 1996 Commonwealth Provider Number legislation,¹⁰ which precludes prevocational trainees (PVTs) from experiencing general practice unless they are in a recognised training program. This deficit was recognised by the 1998 Commonwealth Medical Training Review Panel,¹¹ which recommended that “all prevocational doctors receive clinical experience in rural and community practice within the first 2 years after qualification”. This recommendation resulted in several pilot programs aimed at providing PVTs with experience in rural general practice.¹²

We describe our 5-year experience of prevocational rural general practice placements in Western Australia, initially in Albany and then in Busselton (Box 1). In establishing and administering this program, we identified various barriers to widespread introduction of such placements.

Barriers

State and federal funding

General practice is funded substantially by the federal Medicare system, whereas hospital prevocational training is primarily funded by state governments. Placement of PVTs who provide rebatable Medicare services while receiving state hospital salaries has produced a hybrid funding system. This has caused conflict between medical service funding and the provision of prevocational training.

The rebatable medical service provided to the patients by the PVTs is bundled together with the training costs into the fixed federal funding component. Following the success of the pilot placements, the Rural and Remote Area Placement Program (RRAPP) in 2002 increased the number of sites nationally. As the total federal funding component was fixed, this required the funding per site to be capped. This cap, for one of our sites, limited the PVT to fewer than two patients per hour of Medicare-rebatable services in a 30-hour week. Such diminished patient contact reduces the PVTs' clinical experience in general practice.

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ABSTRACT

- Despite explicit support of the federal and state health departments, most prevocational trainees do not experience general practice or rural medicine.
- We have been running a program of prevocational placements of trainees working as rural general practitioners under supervision. From our experience, we have identified various barriers to implementation of such programs. These barriers include:
 - funding issues (trainees are providing federally funded Medicare-rebatable services, while receiving state-funded hospital salaries);
 - conflicts between the placement of trainees outside the hospital when hospitals are undergoing staffing crises;
 - difficulties in coordinating the many organisations (funding bodies, practices, hospitals) involved in providing the placement; and
 - the isolation experienced by trainees when they arrive in rural practice.
- Funding from a single administration and coordination by a locally appointed rural Director of Clinical Training are essential to overcome these barriers.

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Service versus training

In WA, there is a small pool of PVTs to fill the positions in teaching hospitals. There is tension between training and service expectation in the teaching hospital workforce. Hospital staffing crises impair secondment to community training positions by increasing the tension between placements outside the teaching hospitals and staffing of hospital “service” positions.

Currently, recruitment to rotations in the Rural and Remote Area Placement Program is restricted to Australian PVTs and excludes doctors employed under temporary work visas. Such temporarily registered doctors represent a substantial number of the PVTs employed by the teaching hospitals. If the Medical Training Review Panel recommendation “that all PVTs have clinical experience in rural and community practice”¹⁰ is implemented, the tension between external training placement and hospital service staffing is likely to increase.

Coordination of multiple stakeholders

The placements are supported by a consortium of funding bodies, the practices, and the teaching hospitals. There is need for external administrative and educational support. The Prevocational Training and Accreditation Committee

1: The prevocational rural general practice placement program in Albany and Busselton, Western Australia

The program

In 1998, we established a consortium to support a prevocational placement in general practice. The consortium comprised the Southern Regional Medical Group (Albany), Royal Perth Hospital, Royal Australian College of General Practitioners (RACGP) and the Western Australian Department of Health. The Albany pilot was the first prevocational placement program after the 1996 provider number legislation, to enable autonomous, supervised, general practice experience. The Busselton Medical Practice joined the consortium in 2000. Both locations qualify as rural (RRMA 4).¹³

Since mid-2000, support, administration and funding have been provided by cooperation between the Prevocational Training and Accreditation Committee of the Medical Board of Western Australia; the Rural and Remote Area Placement Program, Australian College of Rural and Remote Medicine; the WA Department of Health; the West Australian Centre for Rural and Remote Medicine and the participating general practices.

The program is overseen by the rural Director of Clinical Training (DCT). The DCT's responsibility is to maintain the support of the participating general practices and fulfil the training needs of the prevocational trainees (PVTs). The DCT appointment is administered by the Prevocational Training and Accreditation Committee of the Medical Board of Western Australia (the statutory body for registration of medical practitioners) and funded by the WA Department of Health.

The PVTs "learn to be a doctor by being a doctor". The PVTs have prescriber and provider numbers and autonomy in all components of consultation and management, without the requirement for input from a GP. However, they have immediate access to a GP supervisor.

Thirty-four PVTs participated in our program between January 1998 and December 2002. Twenty-three (68%) returned logbooks and evaluation questionnaires, and all were interviewed by the DCT before and after placement.

Trainees' assessment of the program

At interview, the PVTs unanimously nominated the placement as one of their best prevocational rotations for training and clinical experience. All were enthusiastic and supportive of the program. They all agreed that it would encourage recruitment into rural practice and help determine or confirm career decisions as well as provide valuable general practice and rural medicine experience. The logbooks kept by the PVTs showed that, among the patients they saw, there was a similar range of patient presentations and similar demographics to the patients seen by their GP supervisors.

The PVTs were asked to rate their current level of knowledge or skill in nine areas (Table) before and after their placement. Self-perception of knowledge and skills all either increased or remained the same during the term. Six of the nine areas assessed showed improvement in the levels of self-assessed knowledge or skill (Table). These were management of presenting problems; management of continuing or chronic problems without referring; opportunistic promotion of healthy behaviours (preventive health); modification of health-seeking behaviour in patients; assessing the contextual identity of the patient; and time management for 15-minute consultations.

The questionnaires received from GP supervisors also showed unanimous support for the program, even though PVTs required 50% more supervision than vocational training program registrars. GP supervisors enjoyed the professional and personal contact.

PVT responses to questionnaire on self-perception of knowledge or skills

Knowledge or skill (n=23)	Before placement*		After placement*		Z statistic†	P†
	Mean	Median (IQR)	Mean	Median (IQR)		
History taking	3.591	3.5 (3-4)	3.864	4.0 (4-4)	-1.897	0.058
Management of presenting problems	3.432	3.0 (3-4)	3.773	4.0 (3.75-4)	-2.385	0.017
Management of continuing or chronic problems without referring	2.614	3.0 (2-3)	3.386	3.0 (3-4)	-3.359	0.001
Opportunistic promotion of healthy behaviours (preventive health)	3.114	3.0 (2.75-4)	3.614	4.0 (3-4)	-2.801	0.005
Modification of health-seeking behaviour in patients	2.659	3.0 (2-3)	3.273	3.5 (2.75-4)	-3.213	0.001
Assessing the contextual identity of the patient	2.886	3.0 (2.75-4)	3.477	3.75 (3-4)	-2.474	0.013
Time management for 15-minute consultations	2.409	3.75 (3-4)	3.636	4.0 (3-4)	-3.234	0.001
Explain management to patients (so they will understand)	3.773	4.0 (3-4)	4.045	4.0 (4-4)	-1.604	0.109
Explanation of chronic or serious illness to patients	3.500	3.5 (3-4)	3.773	4.0 (3-4)	-1.255	0.210

* Mean/median values on a five-point Likert scale where 1 is inadequate and 5 is special expertise. † Wilcoxon signed rank test: Z statistic is "before placement" minus "after placement"; P value is two tailed. IQR = interquartile range.

has appointed a sessional GP (one of the authors, AWW) as the Director of Clinical Training (DCT). The DCT also has a separate appointment to one of the primary allocation hospitals. We consider that a rural DCT is essential for providing the management and pastoral support necessary for the continuation of these projects.

The DCT's role may include attention to:

- accommodation difficulties;
- social support and isolation from peers;
- easing the paperwork for practice principals, which is a disincentive to participating in this project; and
- dealing with indemnity issues and recruitment to the rural rotations from within the teaching hospitals. As an

example, providing medical indemnity for the PVTs and the GP supervisors has required careful negotiation, cooperation and support from a medical defence organisation and the WA Department of Health.

Rural resources

Funding is required for the rural DCT to identify and recruit appropriate training practices. The practices, for their part, make substantial financial and administrative commitment, including provision of facilities (consulting rooms, equipment, and additional support staff) and payment of accommodation costs.

2: Recommendations to help overcome barriers to prevocational placement in rural general practice

- Relevant bodies should agree on the appropriate level of clinical exposure for prevocational trainees (PVTs). Once the level is agreed, Medicare-rebatable services provided by the PVT should be fully funded to this level of experience.
- The hybrid funding system (in which trainees are providing federally funded Medicare-rebatable services, while receiving state-funded hospital salaries) should be simplified to a single funding body, to prevent conflicts of service and training responsibilities within the project, and bypass inter-sectoral administrative difficulties.
- Appointment of accredited practices and a rural Director of Clinical Training (DCT) to provide ongoing hands-on management should be made locally and with regard to local conditions.
- The DCT should report through the entity responsible for accreditation of prevocational training and education in each jurisdiction. If possible, the DCT should be a practising GP external to the participating practices. The conjunction of an appointment to a teaching hospital is also advantageous for local advocacy and for recruitment of PVTs.

Continuity of supply of PVTs is essential for the support and maintenance of prevocational rural general practice programs. However, external factors, such as personal problems of the PVT and recruitment difficulties at the primary allocation centre, may lead to uncertainty of supply, which adversely affects the goodwill of the participating general practice.

Personal and professional isolation from peers is frequently nominated by PVTs as a disincentive for recruitment. The emerging trend of graduates with considerable commitment to new families or with financial obligations or who are mature age discourages relocation to rural locations. Once the trainees arrive they frequently feel isolated, as there are few people of their own age and circumstances in the community. Our PVTs have reported less feelings of isolation since the provision of computer and Internet facilities and involvement of the Rural Medical Family Network.

Conclusion

Encouraging rural recruitment and providing experience in general practice during prevocational training requires a long-term strategy with broad support from all stakeholders. Despite a number of jurisdictional and financial hurdles, we have been able to establish a model that allows a small number of trainees to have autonomous, supervised, rural general practice experience. Most of the areas in which the PVTs considered they had improved their knowledge or skills were related to primary care, which they would be unlikely to have encountered in hospital practice. The placements improved the PVTs' self-assessment of skills relevant to primary care, and encouraged recruitment into rural and general practice. This program has also assisted with workforce in the rural practices. The participating practices have had a continuous supply of PVTs, who are willing to work for three months in a rural general practice

without having to commit themselves to a three-year vocational training program.

However, there are considerable barriers to the ongoing viability of this program. They include financial constraints, overlapping responsibility for health services between state and federal jurisdictions, and workforce shortages in urban and regional hospital health services. There is a need for careful coordination between the fund holders, the teaching hospital and the practices. Some suggestions for overcoming these barriers are presented in Box 2.

Ideally, a substantial proportion of prevocational doctors should be able to experience general practice and rural medicine. Removal of the barriers that we describe would make it possible for a larger proportion of prevocational doctors to have such experience. This would assist the desirable goal of vertical integration of medical education and facilitate a seamless transition between established undergraduate programs and vocational training.

Competing interests

None identified.

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