MEDICAL TRAINING REVIEW
PANEL GRANTS

Development of mentoring and supporting programs for junior doctors in rural settings to promote high quality education outcomes

FINAL REPORT
TO THE DEPARTMENT OF HEALTH AND AGEING

15 JUNE 2008

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The Project was undertaken between October 2007 and June 2008 by project staff of the Australian College of Rural and Remote Medicine with funding from the Australian Government Department of Health and Ageing, through a grant awarded by the Medical Training Review Panel.

MEDICAL TRAINING REVIEW PANEL GRANTS
PROJECT REPORT OCTOBER 2007 – JUNE 2008

EXECUTIVE SUMMARY

1. INTRODUCTION

The final report of activity for the period November 2007 –June 2008 outlines a range of issues that rural supervisors, mentors, junior doctors and their supporting organisations have identified as significant influences on the quality and sustainability of rural placements for junior doctors. It also refers to the outcomes of recent research and evaluation of junior doctor training and other documentation that respondents have cited as relevant sources of direction and support for supervisors, training sites and junior doctors and as useful components of a quality framework of teaching.

The report outlines the consultation process undertaken to fulfil the project objectives, details the strategic outcomes of the inquiry and lists any challenges or changes to implementation during the project timeline.

The material presented in the report is developed principally from consultation within the rural sector, however it is evident that many of the issues raised, can refer equally well to teaching and learning within regional and metropolitan settings and strategies for the support of rural supervisors and mentors are equally applicable across the board.

2. PROJECT AIMS AND OBJECTIVES

The project aims to enhance an understanding of expectations of junior doctors, prior to their placement in rural settings that might assist the development of support mechanisms for junior doctors by teachers, practices, hospitals and statutory bodies and also might improve the co-ordination of outcomes for existing partners and networks. The project aims for:

A. Clarification of the means to support the role of supervisor and mentor in rural placements.
B. Generation of a body of data to assist the roll-out of the Australian National Curriculum Framework and national planning by Postgraduate Councils for support of rurally delivered junior doctor training.
C. Enhanced understanding of the components of community placements that are seen as contributors to excellence by supervisors and junior doctors.
D. The development of a final report of activity and outputs with recommendations contributing to decision-making about:

    - Selection, establishment, management and evaluation of rural and remote terms/placements for junior doctors

- Engagement, orientation and support of supervisors and mentors for rural junior doctors.

Objective One:
To consult with a subset of rural practices delivering training to junior doctors in all States and Territories in Australia to develop a framework of issues and initiatives required to support their teaching role.

Objective Two:
To consult with regulatory and education bodies and organisations maintaining rural networks, on a framework of potential points of integration and support for practices delivering training for junior doctors in the community.

Objective Three
To draw on and extend existing data that indicate potential support issues for supervisors and junior doctors in community placements and seek validation and/or prioritisation of these items through the consultation process.

Objective Four:
To draw on and extend existing data that identify a framework of components of community placements that support excellence in education, clinical skills development, professional and personal growth and seek validation and/or prioritisation of these items through the consultation process.

3. STRATEGIC OUTCOMES OF THE CONSULTATION

The issues raised in consultation show considerable similarities across rural organisations, between private practice and hospital teaching settings and between junior doctors and their teachers. The challenge is to develop a framework of issues, in useful categories that provide support for teachers and mentors of junior doctors and which promotes the delivery of high quality teaching in rural placements and fulfils the expectations of learners.

It must be emphasised that the Postgraduate Councils in each State already have arrangements and programs in place that address many of the issues raised by respondents. However, placing the items within the framework indicates the importance of these current supports, to both teachers and learners. It also provides an opportunity for regional development of support that may currently be available in a more centralised form. The issues in common across training settings, disciplines and geographical regional relate to:

- The essential link between workforce shortage and teaching capacity
- The need to look more widely for teachers and mentors, including support of junior staff and students
- The extent of a common definition across disciplines and professional levels of what constitutes a good teaching and learning environment
- A genuine willingness to extend rural partnerships in the service of a vertical integration of education and training and retaining good doctors within the learning region

Table One: FRAMEWORK OF ISSUES INFLUENCING SUPERVISION AND MENTORING FOR JUNIOR DOCTORS IN RURAL TERMS AND PLACEMENTS

Category	Strategic issues influencing training quality
Identifying and expanding the private practice and small rural hospital teaching cohort	That private practices are best positioned to self determine their engagement, level and degree of involvement in teaching and nominate the form of their involvement, consistent with current personnel, resources and small business considerations Recognition that Rural Hospital personnel may be best placed to identify the elements of the National Curriculum that can be accommodated at particular small hospitals in terms of clinical throughput and teaching capacity

	That particular involvement and support of procedural rural practices, would substantially increase the community placements for junior doctors with undifferentiated generalist requirements That training terms be of adequate length to cover the clinical and cultural learning inherent to rural practice That rural regions could be supported to trial different forms of regional engagement, including multi site training and hub and spoke patterns that may cross current District boundaries, in order to take maximum advantage of scarce rural resources and teaching capacity That the moves to broaden the range of teachers and mentors through the inclusion of regional partners, administrative staff, junior staff, community members and forms of regional co-ordination, is an important determinant of rural capacity
A well informed and enthusiastic junior doctor cohort	Where possible, for junior doctors in rural placements should have voluntary access to rural terms That Postgraduate Councils continue to support priority arrangements for junior doctors who are alumni of Rural Clinical Schools and wish to remain in the same/similar regions That further opportunities are developed, pre-placement for teachers to understand the expectations of the rural term by junior doctors and to permit joint negotiation of objectives That a greater proportion of rurally produced information and orientation be provided at the point of choice for intern training or for senior medical students to facilitate an informed choice of hospital, terms and rurality That there are greater opportunities to use web based and multi media orientation material, accessible by junior doctors, to contribute to their making good choices about rural community options That priority is given to the inclusion of advice regarding family supports, including strategies that would assist the factoring in of partner and family plans, schooling, holiday arrangements for families including: Payment and other industrial arrangements while on practice Gaining correct indemnity/registration status Insurance: clinical and professional arrangements, personal and family cover while on placement That term organisers provide assurances of high quality family accommodation That there is greater understanding of the additional costs of a rural community term to junior doctors and their families Support for the development and use of a structured orientation to community practice by the feeder hospital team, prior to placement including easily distributable DVDs on the training experience in rural community placements, practice operations and culture That there is more ready access by rural hospitals and regional organisations to University and State Health websites, in collaboration with the Postgraduate Councils, for the posting of information That early access is arranged, for junior doctors, to regional professional supports eg Regional Training Provider Programs and Divisional membership That importance be attached to assisting students to feel positive and secure in their choice of rural terms though:

	Co-ordinating quality accommodation and safe working and living conditions for learners Making emergency support, conflict resolution and debriefing policies and processes clear Development and delivery of orientation to rural practice and rural communities, including oversight of the effectiveness of specific local orientation to hospital or practice Working with rural communities to engage and support community mentors and interested stakeholders to support doctors in training and their families Using the above to develop social and family support networks that extend beyond the teaching situation Co-ordination of students' transit within the rural regional setting and between learning venues and general discipline areas in the rural setting – hospital, practice, allied health settings Oversighting the roll out of the relevant University Medical Curriculum Developing and using quality forms of evaluation and ensuring that feedback is seen to be actioned
Well informed and supported rural teaching sites	Provision of a carefully targeted and well maintained series of resources for the training practice that enable all the partners to commit to the decision to train, as a cost-effective part of the practice business plan Development and distribution of material that provides a clear definition and illustration of the components of quality training and practice - to enable practices to clarify their capacity to achieve recognition Opportunities for the collaborative setting of objectives for the term by junior doctor and supervisor and better understanding of how to integrate these goals with the pre and post learning of the junior doctor Useful regulatory and administrative supports, in place prior to the commencement of training, that enable safe, well informed, and educationally sound models of training and practice that include: A standard approach to indemnity arrangements for junior doctors in community placements A model for an educational agreement between the practice and the junior doctors with agreed objectives and preferred outcomes A checklist of items defining the characteristics of an effective junior doctor training practice, to ensure good choices and assist training site development A framework for a Training and Service agreement between the feeder hospital and the training practice Guidelines for supervision of junior doctors, approved by the Postgraduate Councils; A teaching framework for supervisors of junior doctors including recommended schedules and teaching/learning strategies Regionally available training on supervision and mentorship techniques for the teachers of junior doctors – with options provided by Divisions of General Practice, Regional Training Providers and Rural Clinical Schools
Resources for rural teaching	Extension of capital works support in junior doctor training to increase the clinical and teaching space in community practices and to increase teaching room options in rural hospitals and assist the creation of a culture of training for junior doctors Examination of a sustainable system of financial recognition for rural teachers A more integrated approach to training, that extends the use of existing teaching resources currently in place for students and/or Registrars, to junior doctor training Greater online access to learning resources for the junior doctor while on placement

	including in accommodation, for clinical learning and contact feeder hospital, family and peers Enhanced availability of training and resources for practice administrative and management staff to assist in the orientation of junior doctors to the operational aspects of private practice Resources and acknowledgement for rural hospital staff assisting with community based training Financial support for a fractional appointment for a practice staff member (eg practice nurse, administrator) to co-ordinate the learning and outreach program for the junior doctor Creation of the Rural Co-ordinator/ Rural DCT function to free teaching time for current supervisors and thus to improve teaching quality and the access for supervisors to junior doctors, development time for teaching resources and local CPD
Broader training options within the hospital and private practice setting	Access to regional support that removes some of the non-educational care of the junior doctor from the role of the supervisor A practice management and administrative training package, suitably resourced, to allow supervisors to devolve training on the business, accreditation and regulatory aspects of private practice – including Medicare, Veterans Affairs, medical records. Teaching rewards consistent with a small business plan, that enables practice staff and supervisors to commit as a team, to spread the teaching and mentorship roles, and to take fullest advantage of the range of special interests and clinical roles available within the teaching setting Promotion of a local model of involvement across the practice and hospital setting that mirrors the roles of local practitioners eg Involvement and support of visiting specialist and other hospital based staff in the teaching models and the provision of resources for this role to small rural hospitals Resources and acknowledgement for rural doctors' time spent teaching in the hospital setting via practitioners VMO arrangements Encouragement for Registrars, Residents, Interns and Students to take up a teaching and mentorship role and for Postgraduate Councils to continue development of a training role for junior staff Encouraging Registrars to provide mentorship which is close to the junior doctor's stage of development and also to support access to a mentor who is not immediately responsible for assessment, grading or further professional recommendations Recognition of the value placed by Junior doctors on being asked to mentor and assist peer and junior colleagues and having that role recognised and supported Creation of a regional/local educational co-ordination capacity (eg a Rural DCT Model) located at regional and/or rural teaching hospitals to co-ordinate training within the region for junior doctors and to maintain strong teaching and informational links with larger feeder bases. Greater use of part-time and retired medical staff within the regions in funded co-ordination, mentorship and supporting roles for junior doctor training
Expanded options for rural partnerships across the levels of training	A recommended strategy for the achievement of the greater coordination and use of regional resources across the levels of training by development of a series of regional conjoint appointments of managers, administrators and junior/senior teachers, including

	for: Promotion to Postgraduate Councils by the Universities of arrangements that rural organisations deliver services to teachers and medical students in the rural setting, that are capable of reinforcement for junior doctors The potential for rural networks, local knowledge and support mechanisms to operate across the point of Graduation, particularly when a proportion of final year medical students from Rural Clinical Schools, opt to take an internship in the same region Potential for activities and support networks to blend more effectively into Registrar training in rural settings The further enhancement of an academic/teaching culture in rural hospitals through the gazetting of rural hospitals as Teaching Hospitals and the creation of further academic links/ academic titles for rural hospital teachers through the related Rural Clinical Schools of Universities Recognition of the importance of local partnerships in supervisor support – particularly the work done by the Rural Clinical Schools in: The recognition of the rural teacher in terms of links with academic institutions, clinical titles, access to academic resources, inclusion in broader medical school programs Knowledge of the region and its teaching resources Current programs of supervisor and mentor recruitment and orientation Support of supervisors by access to local programs of development Recognition of the immediate usefulness of Regional Training Providers and Divisions of General Practice in their provision of collegial support and professional advice to junior doctors in rural placements
Opportunities to address some challenges to teaching quality in rural settings	Redress of perceptions by metropolitan medical students and interns that a rural choice would involve a reduced access to: Central education resources Education networks Training co-ordination services and Personal contact with specialty colleagues influencing opportunities for selection to specialist training lists Recognition of the challenge to teaching quality of cultural variations within the hospital setting and the pressure of meeting the differential learning needs and timeframes of the current junior doctor cohort in small rural hospitals Acknowledgement of the forthcoming challenges to the teaching load of rural hospitals related to increasing numbers of Bonded and other Scholarship candidates selecting rural terms, from PGY2 onwards, in fulfilment of their bond and the further resourcing of mentoring and supervision related to this For terms in rural hospitals to be of a suitable length to enable junior doctors to experience adequate exposure to clinical material for the procedural skills and to accommodate different degrees of confidence and rates of learning of the junior doctor Creation of consistent IT policies, procedures and integration between rural hospitals, regional feeders and State-based junior doctor training networks that facilitates and not impedes cross communications Recognition of the challenges of the supervisory load inherent to mixing accredited and experiential terms and that the pressures on supervisors of junior doctors with a broad range of learning rates, styles and cultures requires further review and support Further recognition of the current limitations to teaching capacity in rural hospitals owing to the competing administrative and co-ordination roles of supervisors, irrespective of clinical workload

4. DIFFICULTIES ENCOUNTERED

There have been relatively few difficulties throughout the project however the issues emerging and the strategies to overcome problems are listed below:

1. Relatively slow start to NAC meetings owing to some organisations not being able to nominate representatives until the post Christmas period.

The project manager continued to consult the Department representative as issues arose and convened the first NAC meeting in February 2008.

2. Relative difficulty of convening meetings with large groups of interns owing to service obligations.

Consultation and validation rounds have included more detailed case-study opportunities in locations where focus groups of interns and residents were readily available, hospital and practice settings were in close proximity and regional affiliations were well defined with the local support networks (Rural Clinical Schools, University Departments of Rural Health, Regional Training Providers) already forming strong working models, capable of replication.

3. The shortening of the original project timeline from 12 months to 7 months.

Consultation has been tailored to both timeline and budget, using mainly east coast locations for face to face meetings and remote interview and survey where possible. Literature, reports and evaluations of programs when fewer face to face visits were possible, have been accessed.

MEDICAL TRAINING REVIEW PANEL GRANTS

DEVELOPMENT OF MENTORING AND SUPPORTING PROGRAMS FOR JUNIOR DOCTORS IN RURAL SETTINGS TO PROMOTE HIGH QUALITY EDUCATION OUTCOMES

FINAL REPORT: JUNE 2008

1 INTRODUCTION

The final report of activity for the period October 2007-June 2008 outlines a range of issues that rural supervisors, mentors, junior doctors and their supporting organisations have identified as significant influences on the quality and sustainability of rural placements for junior doctors. It also provides a reference to research and other documentation that respondents have cited as relevant sources of direction and support for their current activity and as useful components of a quality framework of teaching. The report outlines the methodology and consultation process undertaken to fulfil the project objectives and lists any changes made to the process during the project timeline.

It is evident from national audit data [1] that the number of placements for junior doctors in rural and remote Australia is limited in numbers, compared to those in metropolitan settings and also that the numbers of teaching terms located in hospitals exceeds those undertaken in community/private practice. The principal direction of the consultation process has been to gather the views of both teachers and learners from the rural setting as to how rural terms and placements might be supported and expanded while maintaining a high quality training outcome.

2. SCOPE AND OBJECTIVES OF THE PROJECT

The Commonwealth provided funding to the Australian College of Rural and Remote Medicine, in October 2007, to undertake an investigation of the issues relating to the supervision, mentoring and support of junior doctors in rural community settings that may contribute to the promotion of high quality educational outcomes. The project aims to enhance an understanding of expectations of junior doctors, prior to their placement in rural settings that might assist the development of support mechanisms for junior doctors and teachers and also improve co-ordination and outcomes for existing partners and networks. The project aims for:

A Clarification of the means to support the role of supervisor and mentor in rural placements.
B Generation of a body of data to assist the roll-out of the Australian Curriculum Framework and national planning by Postgraduate Councils for support of rurally delivered junior doctor training.
C Enhanced understanding of the components of community placements that are seen as contributors to excellence by supervisors and junior doctors.
D The development of a final report of activity and outputs with recommendations contributing to decision-making about:

- Selection, establishment, management and evaluation of rural and remote terms/placements for junior doctors
- Engagement, orientation and support of supervisors and mentors for rural junior doctors.

[1] Commonwealth of Australia. Medical Training Review Panel, Eleventh Report, Canberra 2007

The four project objectives are:

1. To consult with a subset of rural practices delivering training to junior doctors in all States and Territories in Australia to develop a framework of issues and initiatives required to support their teaching role.

2. To consult with regulatory and education bodies and organisations maintaining rural networks, on a framework of potential points of integration and support for practices delivering training for junior doctors in the community.

3. To draw on and extend existing data that indicate potential support issues for supervisors and junior doctors in community placements and seek validation and/or prioritisation of these items through the consultation process.

4. To draw on and extend existing data that identifies a framework of components of community placements that support excellence in education, clinical skills development, professional and personal growth and seek validation and/or prioritisation of these items through the consultation process.

Minor difficulties

There have been relatively few difficulties throughout the project however the issues emerging and the strategies to overcome problems are listed below:

1. Relatively slow start to NAC meetings owing to some organisations not being able to nominate representatives until the post Christmas period. *The project manager continued to consult the Department representative as issues arose. First NAC meeting in February 2008.*
2. Relative difficulty of convening meetings with large groups of interns owing to service obligations. *Consultation and validation rounds have included more detailed case-study opportunities in locations where focus groups of interns and residents were readily available, hospital and practice settings were in close proximity and regional affiliations were well defined with the local support networks (Rural Clinical Schools, University Departments of Rural Health, Regional Training Providers) already forming strong working models, capable of replication.*
3. The shortening of the original project timeline from 12 months to 7 months. *Consultation has been tailored to both timeline and budget, using mainly east coast locations for face to face meetings and remote interview and survey where possible. Literature, reports and evaluations of programs when fewer face to face visits were possible, have been accessed.*

3. METHODOLOGY

3.1 Summary

The project methodology was based on three major components:

1. A preliminary series of field visits to rural training locations, together with interview and survey administration with existing rural training networks.

2. Re-analysis of existing data sets as listed including:
- The education and training literature
- Exit data from rurally placed junior doctors 2005-7
- Rural supervisor support preference data
- Training effectiveness data in rural settings

3, A further series of field visits, plus circulation of issues for comment, used as a validation round of outcomes sent to relevant groups undertaking particular stages of support.

Details of activity are contained in the Project Work Plan (Attachment One) and the Consultation Framework (Attachment Two)

3.2 Supervision and review

1. Project outcomes were overseen by an Advisory Committee, meeting monthly or two monthly throughout the project, and representing the following organisations or groups:

- The Department of Health and Ageing
- The AMA Doctors in Training Committee
- Practice Managers and Administrators
- The Confederation of Postgraduate Councils
- The Supervisors Association
- The Federation of Rural Medical Educators (FRAME)
- The Australian College of Rural and Remote Medicine

2. Outputs and process of the project have been referred to the Research Committee of the Australian College of Rural and Remote Medicine, for review.

3. In addition to data collected through the consultation rounds, some reliance was placed on the quantitative data collected through the Prevocational General Practice Placement Program 2005-8 evaluations. The reliability of these data was based on the following protocols:

- Surveys for junior doctors, supervisors and hospital personnel submitted for iteration and approval by the Internal Evaluation Working Group and the RACGP Ethics Committee.

- Ethical approval of the objectives, methodology and management was obtained through the Ethics Committee arrangements of the RACGP.

4. The Project Officer is also required to consult with, and provide documentation to Confederation of Postgraduate Medical Education Councils (CPMEC) team working on the implementation of the Australian Curriculum Framework for Junior Doctors, for distribution as required, to its three National Working Groups. Material has been forwarded as drafts were prepared, to the nominated officer of the CPMEC project, for further distribution and meetings arranged with project staff.

3.3 Data management

Primary data was collected using both survey and interview by the Project Manager. Data was collected according to ACRRM standard research protocols. Confidentiality and risk management for data collection and management were supported by the following strategies:

- Requests for participation were accompanied by an information disclosure about the intention of the inquiry, management of the data and options for refusal to participate
- Storage and management of data in secure circumstances and the provision of only de-identified aggregate data in reports
- Hard copy data was kept securely in locked filing cabinets with access limited to investigators and electronic data stored on a secure server and password protected
- Provision of a secure postal location for the return of questionnaires was used to ensure the confidentiality of returns. The provision of email addresses on password protected online services to ensure the confidentiality of data and comments provided online
- Use of code numbers and not names on questionnaires with the code list being held only by investigators in secure storage locations
- Removal of names and in the case of small samples (Directors of Clinical Training and Supervisors in PGPPP data) the removal of identifying locations
- Respondents had access to transcripts and data summaries for amendment, confirmation or withdrawal from the research process.

- Participating organisations received a copy of the relevant data summary for circulation across their membership for the purposes of validation and comment.
- Participants had access project staff for de-briefing or the provision of additional information relating to the project or to access a designated member of the Advisory Committee as an alternate in special circumstances.

Secondary data used in the project was analysed using the Statistical Package for Social Sciences (SPSS v13)[2].

Minimisation of interviewer bias was achieved through the use of recent secondary data collected by a range of project staff and the return of all issues analyses to providers, for review and comment.

3.4 Consultation processes

Objective One:
To consult with a subset of rural practices delivering training to junior doctors in all States and Territories in Australia to develop a framework of issues and initiatives required to support their teaching role.

Outputs:

To June 2008, all rural and remote practices delivering community based training to junior doctors have been visited and/or surveyed about the forms of support required by supervisors and teachers. The items emerging from this consultation have formed the basis of a survey, administered in March 2008 (Attachment Three), wherein supervisors in practices delivering junior doctor training could rank their preferred components of support. A parallel sample of 60 non-teaching practices in all States and Territories was surveyed about the usefulness of a similar range of support items in assisting practices to consider becoming involved in the training of interns and residents in community practice. (Attachment Four)

Face to face consultations were also undertaken with supervisors and practice staff in practices teaching more than one junior doctor, in order to investigate the special needs of teachers in these circumstances and their views on the potential for expansion of this teaching model.

Teaching staff in locations engaged in the new dual model of parallel practice and hospital terms for junior doctors were also consulted about effective support. The evaluation reports of the Western Australian Community residencies were accessed and field visits made to the hospitals and private practices involved in the Riverland (SA) and South Gippsland (Vic) teaching sites.

Objective Two:
To consult with regulatory and education bodies and organisations maintaining rural networks, on a framework of potential points of integration and support for practices delivering training for junior doctors in the community.

Outputs

One of the outputs of the project has been to understand the current and potential role in training of existing organisations and regional networks. Documentation produced by the Postgraduate Councils formed a substantial part of a review of the literature. Prior to the start of survey activity, face to face visits were made to staff and training locations of three Rural Clinical Schools:

- Monash Rural Clinical School – Traralgon, Bairnsdale and Sale
- Flinders University Rural Clinical School – Mt Gambier and the Riverland project
- Centre for Rural Health – Alice Springs

[2] http://www.spss.com/au/, accessed 10 November 2006.

Issues emerging from these visits formed the basis for an in-depth interview schedule with Rural Clinical School senior personnel in each State and Territory (Attachment Five) and a survey of all University Departments of Rural Health (Attachment Six), regarding their existing roles and perceived potential for expansion of programs of support to junior doctor levels. Regional Training Providers in each State have also been consulted as part of the PGPPP evaluation, either face to face or by phone interview with regard to their role in supporting interns and residents in rural generalist practice.

Interview data gathered by the PGPPP between 2005-8 with administrative and educational staff of Regional Training Providers has also been accessed, including intern orientation (Sturt Fleurieu and Adelaide to Outback); Supervisor support and junior doctor inclusion in the Registrar Training Program (GetGP); Supervisor recruitment (VicFelix); Links with Rural Clinical Schools (TMT); Teaching models, Teaching on the Run (WAGPET), Support of the remote area teacher (NTGPE).

Interview data held by ACRRM with a subset of Directors of Clinical Training and management in a number of large feeder hospitals was also accessed regarding their role in orientation of junior doctors for rural placements and the degree of promotion of rural placements currently available in the larger training settings. Flinders Medical Centre, Royal Adelaide Hospital, Charles Gairdner Hospital (Perth) and the Gold Coast and Royal Brisbane Women's' Hospitals were used. The objective was to examine current barriers to promotion, the potential for greater orientation of junior doctors prior to placement and the maintenance of stronger links between the feeder hospitals and regional outreach.

Objective Three
To draw on and extend existing data that indicate potential support issues for supervisors and junior doctors in community placements and seek validation and/or prioritisation of these items through the consultation process.
And
Objective Four:
To draw on and extend existing data that identifies a framework of components of community placements that support excellence in education, clinical skills development, professional and personal growth and seek validation and/or prioritisation of these items through the consultation process.

Outputs

Secondary data: Existing quantitative and qualitative data was accessed through the following:

1. A review of the literature
2. A review of policies, positions and documentation in the public domain, from each Postgraduate Council
3. Material developed by project personnel of the Australian Curriculum Framework Project and posted on their website
4. Reports of Medical Training Review Panel projects 2001-7
5. Interview data with existing junior doctors from PGPPP rural community placements 2005-8, accessed and re-analysed
6. Satisfaction surveys of junior doctors exiting PGPPP community placements, accessed in aggregate and de-identified form only
7. Aggregate and de-identified PGPPP data on supervisor satisfaction and resource requirements in community placements
8. Review of aggregate and de-identified survey data from Directors of Clinical Training of the feeder hospitals currently supplying junior doctors to rural community placements.
9. Analysis of the exit interviews of 250 PGPPP junior doctors undertaken between 2005 and 2007, and records of face to face and focus group data from junior doctors in tertiary hospital settings recorded between 2004 -5 dealing with pre-conceptions of rural placements and how expectations were met.

Primary data: The project has drawn on a number of data sources in this regard. A series of field visits and face to face interviews with junior doctors on placement October- December 2007 and March/April 2008 in Victoria, Tasmania and Queensland was undertaken. In terms of validating and augmenting the framework of issues emerging from the above, a series of interviews with junior doctors in their training settings was undertaken in March/April 2008 and a circulation of the framework of issues for comment by junior doctor and other training organisations in May 2008. Items emerging from the inquiries above were circulated for validation and prioritisation via:

1. Submission for comment by the Working Groups of the Australian Curriculum Framework Implementation project team (via the Project Manager)
2. A prioritisation survey to all current PGPPP supervisors (n60 79% response) and control survey of doctors in current locations not engaged in junior doctor training (n 60 50% response).
3. A series of phone and face to face meetings/focus groups with rural interns, residents and PGY3 doctors in three States
4. A series of face to face meetings and phone interviews with supervisors, practice staff and health district managers

Locations visited for face to face lead-up and final round consultations comprised:

- ANZMet Conference: attendance at the Junior House Officer and Directors of Clinical Training Forum events, Sydney
- Private practices and rural hospitals in Bundaberg, Gladstone, The Royal Brisbane and Women's Hospital, Cairns Base Hospital, and the Gold Coast Hospital, Queensland
- The rural training hospital and Rural Clinical School of James Cook University, at Atherton, North Queensland
- The integrated rural training model of the University of Tasmania Rural Clinical School and Burnie Regional Hospital, private practices at Longford and New Norfolk, Tasmania
- The Centre for Rural Health, Alice Springs and junior doctor training practices in Aboriginal Health, Alice Springs NT
- The Rural Clinical School of Flinders University at Mt Gambier and Renmark
- Flinders University Medical Centre, Hawkins Medical Centre and the rural hospital at Mt Gambier SA. Private practices and rural hospitals in Berri, Waikerie, Loxton, Barmera and Renmark, Riverland SA
- Private Practices and rural hospitals at Bairnsdale, Lakes Entrance and Camperdown. The pilot community based intern training posts at Heyfield (Vic) The combined rural hospital and community training model in South Gippsland (Vic) Rural training hospitals at Traralgon, Leongatha and Wonthaggi (Vic)

3.5 Dissemination of results

Reports have been submitted to the Department of Health and Ageing in May and June 2008 together with scheduled reporting to the Department and Advisory Committee. Outcomes reports have been sent to the CPMEC Australian Curriculum Project management for dissemination to the Working Groups and PMC members as required. Circulation of relevant issues for comment of the final framework issues has been completed with all participants in the consultation rounds, FRAME, the Australian Rural Health Education Network (ARHEN), the Supervisors Association, the Australian Medical Students Association, the AMA Doctors in Training Group, The Rural Clinical Schools, the GP Registrars Association, contributing CEOs of rurally based Regional Training Providers.

An abstract has been submitted to the National Prevocational Medical Education Forum, November 2008.

4. SUMMARY OF ISSUES IN THE LITERATURE

4.1 INTRODUCTION

The forecast increase in graduates from Medical Schools places pressure on the traditional points of training for Interns and Residents within the Australian system that are only lately coming to terms with the challenges of providing clear outcomes and consistent, high quality supervision for junior doctors. [3]

The increase in numbers is likely to be expressed in the next 2-5 years, by the need to locate a greater proportion of training places in community settings, rural hospital settings and a combination of both – as new training models emerge. [4] [5]

To date there has been relatively little training of junior doctors in rural and remote locations, (RRRMA Classifications 4-7). However two of Stephen Leeder's ten challenges [6] included the expansion of the home of intern education to remote general and community practice and securing an equitable educational experience across Australia.

The expansion of training experience in rural practice cannot be separated from the current issues in medical workforce. The teaching cohort in rural Australia is determined both by workforce numbers and by the workforce mix that influences the sustainable teaching/service balance that can be achieved in particular rural hospitals and practices. [7] However, Walters and Worley [8] link the expansion of postgraduate rural training to potential for future workforce and stress the immediate need for moves to more sustainable models of practice and workforce targets.

The Australian Curriculum Framework for Junior Doctors [9] and the State versions it has inspired [10] has greatly clarified the scope of training preferable for their development. In order to promote the implementation of the Curriculum Framework in all training settings, the specific issues that relate to rurally based teaching and support warrant further investigation. The development of the Curriculum Framework brings the potential for a consistency of educational approach for junior doctors for the first time in Australia. Its implementation provides a further opportunity to make an assessment of the roles of existing rural organisations and regional arrangements in their support of junior doctors in particular, and of the training continuum in general. [11] [12]

In addition to greater integration of effort by Australian accrediting and education bodies [13] and by multiple rural organisations, studies in the UK conclude that future models of junior doctor training may include more complementary work between hospital and generalist practice settings and that the need for new models of collaboration for supervisors in these settings can be facilitated by a curriculum framework. [14]

In terms of the training offered in rural Australia, practitioners, teachers and managers are already exploring forms of regional collaboration that enhance both the quality and the sustainability of regional training capacity.

4.2 PARTICULAR CHALLENGES IN THE RURAL SETTING

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[3] Lake,FR. Landau,L. Training our prevocational doctors, *MJA* **2007**; 186(3): 112-113.

[4] Postgraduate Medical Council of NSW. Community and Rural terms for Junior Doctors in Australia: A National Review. Commonwealth Department of Health and Ageing, March 2002.

[5] Medical Training Review Panel (MTRP) Eleventh Report. Commonwealth Government, Canberra, December 2007.

[6] Leeder, SR.. Preparing interns for practice in the 21st Century. *MJA* 2007; **186:** S6-8.

[7] Downton SB. Imperatives in medical education and training in response to demands for a sustainable workforce. *MJA* 2005; **183:** 595-598.

[8] Walters, L. and Worley PS. Always one doctor away from a crisis! *Rural and Remote Health* 2004; **4 (**online): 317**.**

[9] Confederation of Postgraduate Medical Education Councils. *Australian Curriculum Framework for Junior Doctors,* Version 2.1, November 2006.

[10] PMCWA, *Western Australian Junior Doctor Curriculum*, Perth: WA Department of Health, 2006.

[11] Beaton, NS. Nichols, A. McLellan, A. Cameron, B. and SenGupta, T. Regionalisation of rural medical training in Far North Queensland: a learning experience for medical educators and managers. *Australian Journal of Rural Health* 2001; **9:** S32-S38.

[12] Paltridge,D. Prevocational medical training in Australia: where does it need to go? *MJA 2006*; **184:** 349-352.

[13] McGrath BP. et al. Lack of integration of medical education in Australia: the need for change. *MJA* 2006; **184:** 346-348.

[14] Williams,C. Cantillon, P. and Cochrane, M. The clinical and educational experiences of pre-registration house officers in general practice. *Medical Education 2001;* **35:** 774-781.

Edmonds and Everett [15] state that *rural and remote positions are prone to a lack of support mechanisms for JMO welfare …and unique solutions are required to give a satisfactory standard for accreditation.* The MTRP Eleventh report notes the difficulties of rural areas in providing accreditable specialty posts in some disciplines owing to lack of specialist teachers, lack of patient throughput and catchments that are too small to support a specialist workforce.[16]

Both junior doctors and their teachers find that placements in rural and regional Australia involve disruption to the doctor and their family. Not all partners have transportable careers and children have both school and social commitments. Many doctors have cultural networks in larger cities that are difficult to leave and most junior doctors leave behind some social and emotional support networks that are integral to their perceptions of safety and wellbeing. Kramer notes the additional requirements on practice staff and supervisors in the development of a new support network for young doctors and their involvement in the larger community setting. [17]

Today's junior doctors have clear requirements for a flexible work schedule and work/life balance and the organisers of rural training terms face particular challenges in accommodating such requirements at some distance from traditional support bases. [18] However, future uptake of such placements is essential, as the pressure on current training locations increases.

A further challenge to the promulgation of rural training terms arises from the perception that rurally based training is not of as high a quality as metropolitan terms and that subsequent rating of junior doctors will be influenced by these terms. Work in Canada [19] and Australia [20] indicates that, with the selection of appropriately sited and resourced training terms and the capacity to recruit committed and enthusiastic candidates, the quality of teaching is directly comparable and training outputs indicate no differences in the final ratings.

Exposure to rural practice appears to be limited during internship and also to some extent during the second postgraduate year and therefore the orientation and preparation mechanisms in the feeder hospitals have not been viewed as a matter of priority. In terms of those junior doctors required to undertake rural relieving or the increasing numbers of rural bonded doctors, an adequate preparation for rural practice is essential. Respondents to a 2005 Queensland study [21] indicated that inadequate orientation and uninformed expectations were two significant challenges to junior doctors undertaking rural placements and that provision of more information and support while in the preceding hospital terms would assist junior doctors in their preparation for country relieving, rural terms and longer placements.

The need for greater collaboration and for a strong regional coordination role is identified by a Western Australian study of rural community placements for junior doctors. [22] Particularly cited are the systemic issues in blending State based and Commonwealth funding in such joint arrangements; conflicting demands of rural placements and hospital service requirements at a time of workforce shortage; and the challenges of co-ordinating the many organisations with an interest in rural training placements (funding bodies, practices and hospitals).

Their recommendations for simplification of the roll out of rural community terms include some streamlining of the governance of such placements and the appointment of dedicated regional coordination for their implementation. Similar comments from South Australia support the need to simplify the financial arrangements and administration of the multiplicity of training grants and forms of payment for teachers. [23]

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[15] Edmonds, MJR. And Everett, DS. Prevocational medical education at the coalface: Report from the 2006 National Junior Doctor and Director of Clinical Training/Registrar Forums. *MJA* 2007; **186(7):** S20-21.

[16] MTRP 2007 op. cit.

[17] Kramer J. Teaching and learning in rural general practice. *Australian Family Physician* 2004; **33(9):** 737.

[18] AMA Work-Life Flexibility Survey, 19 June 2007: Report of Findings.

[19] McKendry, RJ et. al. Does the site of postgraduate family medicine training predict performance on summative examinations? A comparison of urban and remote programs. *JAMC* 2000; **163(6):** 708-711.

[20] Worley, PS. et al. Why we should teach undergraduate medical students in rural practice? *MJA* 2000; **172:** 165-167.

[21] Smith, DM. Barriers facing junior doctors in rural practice. *The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy 2005;* ***27 October:*** *1-8.*

[22] Vickery, AW. Tarala, R. Barriers to prevocational placement programs in rural general practice. *MJA* 2003; **179(July):** 19-21.

[23] Walters L. et al (2006) op cit.

4.3 DETERMINANTS OF TEACHING AND LEARNING QUALITY

4.3.1 Support for training sites

The achievement of collaboration is cited as a positive determinant of training quality in rural practice. The need for rural practices, health services and practitioners to develop educational models that are sustainable in rural settings and attractive to learners is viewed as important, as is the need to adapt to variations in the needs and life/learning stages of trainees. [24]

While there are term characteristics and preceptor behaviours that are valued by almost all learners, studies of over 3000 junior doctors in hospital terms in Canada found distinct differences in learning requirements over the stages of training in terms of the forms of supervision preferred, the balance between clinical and professional teaching, the dependence on resources, relationships with patients, degrees of autonomy and access to knowledge about regulations and systems. [25]

The task of maintaining a high quality teaching and learning setting for junior doctors within rural generalist practice can be addressed by consideration of innovative models of teaching and support. A South Australian study [26] indicates the benefits of working to a set curriculum, which enables managers to broaden the range of teachers involved, the advantages of pooling resources to service a rural training area and to make better use of the whole practice staff as teachers.

In addition, the current trend to recognise the benefits of using registrars, junior doctors and students as teachers and mentors is being expanded and its value is well documented. [27] [28] The benefits of new teaching models are also being explored with the Postgraduate Medical Council of Western Australia (PMCWA) Teaching on the Run, [29] DeWitt's service learning models [30] and the hub and spoke models of teaching practice coordination [31] being cited as practical and sustainable models capable of implementation across the vertical integration of training.

Significant structural arrangements have been identified and/or addressed through the work of the Postgraduate Councils, recognising the ongoing complexity of systems of delivery of junior doctor training in a broad range of settings. [32] The PMCWA Strategic Plan also notes the challenge of delivering training in a context of increasing global recruitment competition and supply issues. [33]

The NSW Institute of Medical Education and Training (IMET) identifies current imbalances in structure through which prevocational training is managed and examines mechanisms for the distribution of the junior doctor workforce to its service (and hence training) locations throughout NSW. The management of training by current organisations and the degree of choice and input available to junior doctors has also been examined, in addition to the recruitment processes. IMET's review examines the extent to which traditional approaches and former cultures contribute to the current workforce and training imperatives and investigates the means to instigate change. [34]

4.3.2 Support for teachers

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[24] Wlalters L. et al (2006) op cit.

[25] Howe,A. Teaching in practice: a qualitative factor analysis of community-based teaching. *Medical Education* 2003; 34: 762-768.

[26] Pearce,R. Laurence, CO. Black, LE. Stocks N. The challenges of teaching in a general practice setting. *MJA* 2007; **187(2):** 129-132.

[27] Cate, OT and During, S. Peer teaching in medical education: twelve reasons to move from theory to practice. *Medical Teacher* 2007; online accessed October 2007

[28] PMCV op cit.

[29] Postgraduate Medical Council of Western Australia, *Teaching on the Run*, 2004, Commonwealth Department of Health and Ageing.

[30] DeWitt,D. Incorporating medical students into your practice. *Australian Family Physician* 2006; **35:** 24-26.

[31] Commonwealth Department of Health and Family Services. General practice education: the way forward. *Final report of the Ministerial Review of General Practice Training,* Canberra: Commonwealth Department of Health and Family Services, 1998.

[32] Dahlenburg,GW. Medical education in Australia: changes are needed. *MJA* 2006; **184(7):** 319-320.

[33] PMCWA, *Strategic Directions of Postgraduate Medical Education in Western Australia: 2004-8,* Perth, PMCWA.

[34] NSW Institute of Medical Education and Training (IMET). *NSW prevocational training and workforce project,* September 2006

Currently 34% of all Australian general practices are involved in training [35] and those that do, have made organisational changes to the practice in order to provide both the training and the patient load to sustain teaching. However there is potential for the expansion of participation of rural practices and other rural community settings, particularly if the infrastructure is provided to sustain a quality term and to meet the dual demands on teachers of clinical and educational work.

The provision of infrastructure support, accommodation, technology and teaching space is advocated. In addition, support for human resources is required, including essential administrative support for teaching staff, a broadening of the definition of teachers within the practice setting, regional co-ordination of training initiatives and a re-considered financial model to reward teaching activity. In terms of succession planning, note is made of the effectiveness of the Australian Curriculum Framework in terms of its validation of teaching activity for registrars and junior doctors and the inclusion of teaching support for doctors and students in the junior ranks to be teachers and mentors. [36] [37] It further develops the opportunity for teaching practices to confirm that they have the capacity, clinical mix and patient load to satisfy the larger educational requirements of the junior doctor and to access a ready check list of recommended outcomes of the rural term. [38] [39] Greater access to such confirmatory information is a recommend outcome of the current project.

Supervisors have stressed the importance of having junior doctors who are committed and enthusiastic and who want to be in rural areas. The rural preferential recruitment initiatives of Postgraduate Councils are highly important in maintaining a committed rural training cohort that is appreciative of their teaching component and of their rural community settings. Initiatives such as the IMET recommendations on Rural Preferential Policy, [40] the work of Rural Clinical Schools in retaining their alumni in the same regions as junior doctors and the maintenance of programs such as PGPPP as voluntary participation projects are all important to the culture of the rural training term.

Teachers feel that the ability to deliver a curriculum in the primary care setting can be challenging but very much depends on student motivation as well as on practice characteristics and readiness. Issues were raised about conflicting views by junior doctors about training in the primary care setting which, to some extent, supervisors felt undermined the respect learners held for their discipline and capacity to teach.

Supervisors also stress the importance to their support of readily available professional development and the opportunities to demonstrate readiness to undertake a training role. Rural practices also rate the importance of being able to determine, at their own rate, their capacity for teaching. Many practices do not accurately recognise their own potential as a teaching practice and assistance with the formulation of characteristics of good teachers and teaching sites would considerably add to recruitment potential. [41] These include practices with a history of participation in other programs that have good relationships with jurisdictions/colleges/faculties in their regions and discipline.

Good supervisor support and training would be in place or in development and teaching viewed as a creative opportunity for doctors. Teaching would be shared across practice partnerships with a joint sense of responsibility in the creation of rural role models a positive image for the rural clinician. Effective teaching practices are interested in self development, positive teaching experiences, empowering and involving patients and promoting the values of generalist practice and primary care in private practice and in the small rural hospital. [42] [43] [44]

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[35] Pearce,R. (2007) op.cit.

[36] Thistlethwaite,JE. Kidd, MR. Hudson, JN. General practice: a leading provider of medical student education in the 21st century? *MJA* 2007; **187(2):** 124-128.

[37] Postgraduate Medical Council of Victoria (PMCV). Profesisonal development of registrars supervising junior medical staff. *Final project Report to the Australian Department of Health and Ageing,* October 2004.

[38] Australian Government, *Rural and Community Terms for Junior Doctors in Australia – A National Review*: http://www.health.gove.au/workforce/pdf.report.pdf Accessed January 2008.

[39] Commonwealth Department of Health and Ageing. *National Training and Assessment Guidelines for Junior Medical Doctors PGY1 and 2.* Canberra, July 2003.

[40] IMET (2007) op cit.

[41] Howe, A. (2003) op cit.

[42] Kilminster,SM and Jolly,B. Effective supervision in clinical practice settings: a literature review. *Medical Education* 2000; **34:** 827-840.

4.3.3 Support for junior doctors

There are multiple studies published in the past decade that note the relative lack of national consistency for junior doctor training, compared to the more structured development of the medical student and Registrar levels.

Particular items for review have included the need for a differential approach to training for junior doctors at different levels of confidence and competence and doctors from a broad range of cultural and linguistic backgrounds. [45] The PMCV report includes in its terms of reference, a review of junior doctors' perceptions of their educational needs and the current deficiencies in postgraduate training. The degree to which teachers and training managers understand, and respond to, the expectations of junior doctors (in both metropolitan and rural settings) and allow them to have a much more significant input to the planning and roll out of their training, is noted by teachers and learners as one of the key determinants of a high quality educational output. [46]

Junior doctors have clear ideas on their preferred forms of training and interaction with teachers. [47] Closer contact with current supervisors and registrars for formal and opportunistic teaching is preferred and the opportunity to give and receive feedback. Interns particularly appreciate access to advice (particularly in community practice) at points during each practice day, to receive clinical advice, but, more regularly, confirmation of good practice. Junior doctors requirements for training which equips them to cover an emergency situation and raise levels of clinical skills [48]

Dent (2006) recognises the need for junior doctors to have access to other forms of information, in addition to clinical items. Junior doctors are at the point of making key decisions about subsequent training pathways and career. Several studies recommend that this advice be more readily available, together with the time to make a considered decision. The issues raises the question of access to a broader range of mentors and advisors for junior doctors and the importance placed on advice from the levels immediately succeeding prevocational training. [49] [50]

In remote teaching settings, the relationship between trainees and supervisors assumed particular importance, although the item rates highly throughout the cohort. A supervisor, who is interested, enthusiastic, well informed and (most importantly) available, is rated highly by learners. Maintaining the balance for learners in rural and remote practice between educational, service and workforce needs determines the quality of the placement to a great extent. [51] Junior doctors need to be able to view a supervisor as a role model, a viable clinician and community member and with limited choice of teachers, perceptions and relationships assume a greater significance to training quality.

Preceptors need to be aware of, and make available, teaching strategies such as feedback and clinical reasoning that learners have identified as helpful. If strategies that prove unhelpful, such as teaching in the presence of the patient are to continue then it is important to review the means of delivery and the motive for continuance. Although what all learners want appears to be similar, supervisors should be aware of the significant differences in many categories between the levels of training and in different specialties, particularly in the practice and clinical setting.

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[43] Mann, KV et al. Community family medicine: teachers' perceptions of their teaching role. *Medical Education* 2001; **35:** 278-285.

[44] Kilminster, S. Cottrell, D. Grant,J. Jolly, B. *AMEE Guide No 27: Effective educational and clinical supervision*. http://dx.doi.org/10.1080/0142159901210907 Accessed January 2008.

[45] Postgraduate Medical Council of Victoria. Assessment of learning needs in postgraduate medical trainees: a learning needs analysis. *A Report to the Australian Government Department of Health and Ageing,* June 2005.

[46] Gleason, AJ. Daly, JO. Blackham, RE. Prevocational medical training and the Australian Curriculum Framework for junior doctors: a junior doctor perspective. *MJA* 2006; **186 3):** 114-116.

[47] Schultz, KW et al. medical students' and residents' preferred site characteristics and preceptor behaviours for learning in the ambulatory setting: a cross sectional survey. *BMC Medical Education* 2004. http//www.biomedcentral.com/1472-6920/4/12 Accessed October 2007.

[48] Dent,AW. Crotty B. et al. Learning opportunities for Australian prevocational hospital doctors: exposure, perceived quality and desired methods of learning. *MJA* 2006; **184(9):** 440.

[49] Dent (2006) op cit.

[50] Nichols, A. Worley, PS, Toms, LM, Johnston-Smith, PR. Change of place, change of pace, change of status: rural community training for junior doctors, does it influence choices of training and career. *Rural and Remote Health* 2004; Online May 24 2004.

[51] Wearne,S.M. Pilot study on the factors that influence learning by GP registrars in central Australia. *Rural and Remote Health* 2003; **3 (223):** (online).

In a review of the learning preferences of 3000 residents across Canada, junior doctors identified a number of preferred characteristics of learning. These include, having an adequate number and variety of patients while being supervised by enthusiastic preceptors who give feedback and are willing to discuss their reasoning processes and delegate responsibility. In common with many of their Australian and UK counterparts, Canadian junior doctors rank the following as priority items in their determination of a quality term. Effective teachers; the opportunity to see patients independently; the opportunity to see a large variety of patients; the opportunity to see an adequate number of patients; having preceptors readily available; the opportunity to do procedures; a readily available examination room; the opportunity to see patients in follow-up visits; the opportunity to observe preceptor if desired ; the opportunity to interact with consultants and/or referring doctors; setting and meeting jointly agreed objectives. [52]

Issues raised in the consultation round of the current study are substantially representative of the key issues mentioned in the literature regarding the challenges of establishing and maintaining high quality training terms in rural and remote Australia, in providing support for the current cohort, enlarging the teaching network and meeting the expectations of a broadly undifferentiated group of junior doctors.

5. RESULTS

The following issues were developed from the series of surveys, interviews and field visits with organisations and personnel as outlined in the Consultation Framework (Attachment Two). The issues have been referred back to respondents for validation and also to the Advisory Committee for further review and comment. The results form the basis for the framework of support for supervision and mentoring in rural placements that is outlined in Section Five.

Respondents note that many of the issues refer equally to metropolitan settings and also that the list does not represent a “to do” approach, noting that many of the items listed as important components of support, are currently in place, have been in operation for some years and are worthy of further support and extension. Each Postgraduate Council, University and rural educational organisation will be able to recognise strategic supports that they already provide in the States and regions. Their inclusion on the lists of issues acknowledges the importance placed upon those initiatives by respondents.

Results are presented in three sections:

4.1 Supporting Supervisors and Mentors
4.2 Supporting junior doctors
4.3 Rural partnerships

5.1 SUPPORTING SUPERVISORS AND MENTORS

Supervisors in both the private practice and hospital settings identify some key challenges of junior doctor training that are not experienced in the training stages on either side:

- Students are also time intensive, however with their limited capacity to practice, the issues of supervision vs clinical responsibly are somewhat different

- Registrars are 2/3 years more experienced and their capacity for autonomy in practice is much greater and they are destined for a GP career

- Junior doctors present with a wide range of interests in various clinical disciplines, an un-defined career path and a range of capacity levels, confidence and skills base. In terms of their need for careful and structured supervision and their need for a realistic and challenging medical service framework, interns and residents are the most demanding in terms of supervision.

[52] Schultz, K. (2004) op cit.

Supervisors and mentors of junior doctors in both rural community placements and in rural hospital terms have identified issues of importance and potential solutions to their current limitations and challenges. Teaching is seen as a highly important activity by senior doctors in rural areas and respondents uniformly agree that the greatest challenges to their participation are:

The rural workforce shortage, which lowers the numbers of potential teachers and relief teachers
The lack of time for teaching, considering the competing service and administrative roles
The lack of a teaching culture in some organisations – demonstrated by lack of educational space, resources and sheltered time

5.1.1 Issues in community practice terms

Levels of understanding between partners

There is a high level of experience and understanding in rural practices of the regulations relating to Registrar training. Most practices are well informed about the pathway to accreditation for general practice training by the RACGP and ACRRM and the items that need to be in place within the practice to gain such accreditation.

Similarly, the Universities have been very effective in the last decade in recruiting, informing, and resourcing practices to teach medical students for the standard 8 week terms or for longer experiential periods through the Rural Clinical Schools or the Parallel Rural Community Curriculum (PRCC).

Practices of this type, visited during the project, have a mandate for training from the University, subsidised training rooms which clearly identify the practice as an educational unit and strong linkages to the Rural Clinical School and its regional officers for advice, training and resources. Furthermore, strong allegiances are built with the Universities though the award of Clinical Titles and/or adjunct teaching appointments.

Until recently, junior doctors have not been trained in the community practice setting and there is naturally, relatively little historical or operational linkage/ knowledge base between the private practice and either the Postgraduate Medical Councils or the public hospitals. Except in the small group of PGPPP practices, the requirements of a training term for junior doctors in the community setting in terms of outputs are untested. Even current PGPPP practices record limited experience of a Postgraduate Medical Council accreditation process, few direct links with the Directors of Clinical Training of feeder hospitals, knowledge of relevant Guidelines for Supervisors of junior doctors or the means to develop a clear Service/Training Agreement. Each of these factors is likely to limit the rate of engagement of teaching practices.[53]

There is a real opportunity for organisations at the student and the junior doctor levels to further co-ordinate the destinations to which interns are sent, to provide continuity of hospital and district to junior doctors who have been involved in those areas through their Rural Clinical School education and for further co-ordination of these roles by fractional and joint appointments of personnel between university, hospital and Postgraduate Medical Council. The Regional Director of Clinical Training function is one example of a working model.

Supervisors in private practices therefore recommend:

- A greater involvement and continuity of Rural Clinical School expertise and resources in the community training of interns, especially alumni from the RCS cohorts

[53] Australian College of Rural and Remote Medicine, Evaluation Reports of the Rural and Remote Area Placement Program and the Prevocational General Practice Placement Program, 2000-2007

- The extension of some of the successful elements of student support to the junior doctor levels – including capital infrastructure in developing training space and a clear culture of education and training within working practices
- The provision of additional teaching support and resources to assist IMG doctors with cultural, medical and linguistic adaptation to Australian General Practice including the use of resources that may currently be available in the hospital setting.

Selection and orientation

Selection is an important determinant of placement quality. In a similar way to which supervisors believe that private practices should self select as training sites, they also note the benefits of selecting enthusiastic and committed junior doctors for rural training posts.

Issues including junior doctors who are disinterested in rural options; have conflicting family and social commitments; cultural challenges; and general absence of motivation to include a rural term; are identified by supervisors as:

- Disincentives for practices to continue training
- A major component in reducing morale at the practice and with patients
- A drain on already fragile training and working conditions

Supervisors state that one of the principal forms of support for the mentoring and teaching role is the initial selection of junior doctors who are interested in trying a rural term or who have volunteered for a set of terms with a rural option. The current success of the RCS initiatives in rural communities has been linked in part with the cohort of enthusiastic and rurally interested students on placement. Therefore recommendations include:

- A greater proportion of rurally produced information and orientation at the point of choice for intern training or for senior medical students to facilitate an informed choice of hospital, terms and rurality
- Opportunities for rural personnel to brief metropolitan junior doctors to ensure realistic expectation of the term and more informed choices, especially using web based and DVD media

The selection of supervisors is equally crucial to training quality. When asked how supervisor selection was undertaken within the partners in a community practice, respondents to the PGPPP evaluations indicated that the key determinants should be, in rank order:

- The personal characteristics of the supervisor, particularly a high level of interest and enthusiasm for teaching
- The availability and time to provide high quality and safe supervision and teaching
- Demonstrated teaching experience and qualifications – eg through teaching history at student and registrar levels
- Experience in generalist practice and rural medicine and understanding of practice in the rural community
- Broad generalist clinical experience and knowledge base, procedural practice experience or special interest areas

Foundations of rural teaching

Responding supervisors also state that successful and sustainable teaching in private practice requires a good foundation and that there are several basic tenets to both identifying and enlarging the private practice teaching cohort. These comprise:

- The need for private practices to self determine their engagement, level and degree of involvement in teaching and to nominate the form of their involvement, consistent with current personnel, resources and small business considerations
- Support to ensure the ongoing involvement of procedural rural practices as amongst the most effective private teaching placements for junior doctors with undifferentiated requirements

- Some useful regulatory and administrative supports, in place prior to the commencement of training, that enable safe, well informed, and educationally sound models of training and practice

- Access to regional support that removes some of the non-educational care of the junior doctor from the role of the supervisor

- A practice management and administrative training package, suitably resourced, that allows supervisors to devolve training on the business, accreditation and regulatory aspects of private practice – including Medicare, Veterans affairs

- An opportunity for portions of the above to be provided pre-placement

- Provision of a carefully targeted and well maintained series of resources for the training practice that enable all the partners to commit to the decision to train, as a cost-effective part of the practice business plan

- The need for the practice staff and supervisors to commit as a team, to spread the teaching and mentorship roles and to take fullest advantage of the range of special interests and clinical roles available within the teaching setting

- The need to foster a local model of involvement across the practice and hospital setting that mirrors the roles of local practitioners, especially with VMO rights

- The involvement and support of visiting specialist and other hospital based staff in the teaching models and the provision of resources for this role to small rural hospitals

Supervisors were surveyed to ascertain the most useful foundation initiatives to support their teaching roles in private practice. A 79% response was obtained. A corresponding sample of non-teaching practices was also surveyed (55% response) with regard to items of support that might influence their decisions to teach. The two rankings corresponded closely in terms of doctors' perception of the usefulness of support items. All the items listed received scores of "useful and above" however, in rank order, current supervisors rated the most useful supports as follows:

Table One: Priority support items for rural supervisors

1. A standard approach to indemnity arrangements for junior doctors in community placements;

2. Resources for dedicated teaching and learning space for junior doctors while on placement; and
A more integrated approach to training, with the capacity to use existing teaching resources that are currently in place for students and/or Registrars; and

4. A checklist for practice partners outlining the requirements for supervision and mentorship of a junior doctor;

5. Resources for greater online access to learning resources for the junior doctor while on placement

6. The availability of training and resources for practice administrative and management staff to assist the orientation of junior doctors to the operational aspects of private practice and
Resources and acknowledgement for hospital staff assisting with community based training

8. A model for an educational agreement between the practice and the junior doctors with agreed objectives and preferred outcomes; and
A checklist of items defining the characteristics of an effective junior doctor training practice, to ensure good choices and assist training site development; and
Regionally available training on supervision and mentorship techniques for the teachers of junior doctors;

11. A framework for a Training and Service agreement between the feeder hospital and the training practice;

12. The development and use of a structured orientation to community practice by the feeder hospital team, prior to placement;

13. The development and use of a DVD for the feeder hospital, outlining the training experience in rural community placements;

14. The development and use of a DVD on practice operations and culture to assist the orientation of junior doctors with clinical care and relationships with patients;

15. Guidelines for supervision of junior doctors, approved by the Postgraduate Councils;

16. A teaching framework for supervisors of junior doctors including recommended schedules and teaching/learning strategies;

17. Resources and acknowledgement for time spent teaching in the hospital setting.

In addition to the above priorities, supervisors identify the following support requirements:

- Time to teach amongst increasing workforce demands
- Teaching space
- The minimisation of paper work to undertake training
- A guaranteed supply of junior doctors to ensure continuity for the practice
- Time to orientate the junior doctors and to keep resources and information up to date
- Closer and more collaborative relationships between practice and feeder hospitals
- More streamlined arrangements for junior doctors' attainment of a provider number for private practice work
- Greater proportion of online resources and access being integral to taking junior doctor placements
- Integrated teacher training and supervisor support by regional organisations RCS, RTPs Divisions
- Financial support for a fractional appointment for a practice staff member (eg practice nurse, administrator) to co-ordinate the learning and outreach program for the junior doctor

Both senior and junior doctors recognised the increasing importance of encouraging Registrars, Residents, Interns and Students to take up a teaching and mentorship role and to be resourced and recognised for that role. Postgraduate Councils have been involved in the development of a training role for junior staff and this was acknowledged, together with current supervisors' recognition that an increased teaching load in rural settings may be unsustainable without an enhanced role for registrars in teaching.

5.1.2 Issues from small rural hospitals

A cross section of small rural hospitals was visited to consult with teachers, PGY 1-3 medical officers, administrative staff and regional partners. These field visits allowed an observation over several days of the systems and supports in rural districts and particular hospitals, the gathering of relevant local data and validation of issues raised in other sections of the consultation.

The following series of issues has emerged from the consultation rounds and is presented for further consideration and comment. Results comprise a list of principal challenges identified by respondents to the development and enlargement of quality training opportunities in rural and remote medical placements and a further list that respondents view as important to a quality teaching and learning model. Respondents also made reference to models and working arrangements that they view as potential solutions to issues raised.

Challenges to teaching and learning in the rural hospital

- Further recognition of the current limitations to teaching capacity in rural hospitals owing to the competing administrative and co-ordination roles of supervisors, irrespective of clinical workload

- The need to develop more accredited, (as opposed to experiential), terms in rural hospitals, and the need to examine the different logistical requirements of both and the effect on supervisor workload

- Recognition of the challenge to teaching quality of cultural variations within the hospital setting and the pressure of meeting the differential learning needs and timeframes of the current junior doctor cohort in small rural hospitals

- Acknowledgement of the forthcoming challenges to the teaching load of rural hospitals related to increasing numbers of Bonded and other Scholarship candidates selecting rural terms, from PGY2 onwards, in fulfilment of their bond and the further resourcing of mentoring and supervision related to this

- A perceived lack of accurate information for medical students at the point of selection of the intern training locations (and the suite of terms available), that would promote regional and rural choices by a greater proportion of quality candidates

- Redress of perceptions by metropolitan medical students and interns that a rural choice would involve a reduced access to:
    - central education resources
    - education networks
    - training co-ordination services and
    - personal contact with specialty colleagues influencing opportunities for selection to specialist training lists

Factors influencing support of quality training and teaching personnel

The rural teaching setting

- For State Health jurisdictions to appreciate that an effective regional and rural teaching framework may cut across current health District boundaries and that learning opportunities and programs of support for rural teachers may require consideration of this

- Through the Postgraduate Councils and State jurisdictions - support and recognition of the rural teaching hospital in terms of its capacity to deliver a balanced generalist training during the first two postgraduate years and ensure sufficient direct clinical contact with patients to provide adequate training opportunities for clinical and diagnostic skills development, confidence and responsibility

- Rural hospital personnel consider that they are best placed to identify the elements of the National Curriculum that can be accommodated at particular small hospitals in terms of clinical throughput and teaching capacity

- Ahead of increased demands on rural training, hospital personnel suggest that there are benefits in conducting a regional inventory of training locations and their capacity to deliver either a broad generalist training and/or rural specialist training opportunities in particular disciplines

- Creation of a regional/local educational co-ordination capacity (eg a Rural DCT Model) located at regional and/or rural teaching hospitals to co-ordinate training within the region for junior doctors and to maintain strong teaching and informational links with larger feeder bases

- Further support of flexible teaching and learning for junior doctors within the teaching region using a rural co-ordinator, to enable combined training of junior doctors between rural hospitals and Advanced Rural Skills Posts at Regional hospitals

- Clear definition and illustration of the components of quality training and practice - to enable teaching models/terms to achieve recognition – including the collaborative setting of objectives for the term by junior doctor and supervisor

- For terms in rural hospitals to be of a suitable length to enable junior doctors to experience adequate exposure to clinical material for the procedural skills and to accommodate different degrees of confidence and rates of learning of the junior doctor

- A review of the financial framework for rural supervisors and mentors and the remuneration for the service element in rural hospitals by junior doctors in terms of parity with larger sites

- A clear and consistent reference point for standards and assessment

Orientation and Information technology

- Support for rural teaching organisations to develop and deliver promotional and orientation information to metropolitan sites – either medical schools or hospitals - to ensure the best possible basis for choice of rural terms by junior doctors (eg Item below)

- Funding and support for the further development and maintenance of the Websites of rural teaching Hospitals as a means to orientate and support rural choices by final year medical students and inclusion of direct links to rural hospital websites on State health junior doctor Websites and networks.

- The creation of dedicated administrative support for the organisation and delivery of training in small rural hospitals

- Support of the capacity for rural hospitals to review and report on the helpfulness to teaching, learning and communication of current software systems

- Creation of consistent IT policies, procedures and integration between rural hospitals, regional feeders and State-based junior doctor training networks

Practical support of supervisors

- Creation of the Rural Co-ordinator/ Rural DCT function to free teaching time for current supervisors and thus to improve teaching quality and the access for supervisors to junior doctors, development time for teaching resources and local CPD

- The further enhancement of an academic/teaching culture in rural hospitals through the gazetting of rural hospitals as Teaching Hospitals and the creation of further academic links/ academic titles for rural hospital teachers through the related Rural Clinical Schools of Universities

- Further development of service arrangements that enable backfilling of teachers to allow weekly medical sessions and grand rounds where all teachers can attend - eg greater flexibility to use available local and district workforce, further development of the teaching role of local procedural GPs in rural communities that currently assist visiting specialists via their VMO role

- Use of the above, in the short and mid-term to create a critical mass of teachers and supporters that limits burn-out and allow time for supervisors to offer opportunistic learning, immediate feedback and periodic confidential review of aspects of performance

- Greater use of part-time and retired medical staff within the regions in funded co-ordination, mentorship and supporting roles for junior doctor training

- Continued support for the access by junior doctors to clinical protocols via Palm Pilots

- Development of dedicated teaching rooms in the rural hospitals including private break-out space for the supervisor and learner on the ward. This encourages service downtime to be more effectively used for teaching

- Further recognition of the role of teaching in the rural hospital by the inclusion of teaching and mentorship strategies and roles in the assessment of registrars and junior medical staff

- While the current teaching load of Consultants and Senior Medical Officers forms the core component of teaching and supervision, further emphasis is suggested on the development of mentoring and supervision roles by junior staff, particularly registrars (consistent with the 2006 MTRP Report) but also by interns and Junior House Officers. Their role as support and mentors for medical students should not be underestimated

- Regionally and locally available programs of up-skilling and peer development for rural supervisors should be promoted and expanded

- The use of clinical backfilling strategies to create the time and capacity for current supervisors to enlist and encourage colleagues who are presently not engaged in formal teaching

- The importance of local partnerships in supervisor support – particularly the work done by the Rural Clinical Schools in:

    - Knowledge of the region and its teaching resources;
    - Current programs of supervisor and mentor recruitment and orientation
    - Support of supervisors by access to local programs of development
    - The recognition of the rural teacher in terms of links with academic institutions, clinical titles, access to academic resources, inclusion in broader medical school programs;
    - Ongoing recognition and support in the local community

- It is suggested that an extended role for the Rural Clinical School would be the support of teachers, particularly at the intern level – recognising that their requirement for support and feedback continues to have greatest similarity to final year medical school models

- Similar feedback is provided on more innovative use of Rural Divisions of General practice in support of rural training and CPD to develop supervision and mentoring roles.

5.2 SUPPORTING JUNIOR DOCTORS

5.2.1 Introduction

While junior doctors, tracking from the John Flynn Placement Program, Rural Scholarship Schemes and Rural Clinical School placements, have a good understanding of the educational and social benefits/deficits of rural placements, there is a general lack of accurate, well illustrated material that can be

readily circulated to final year medical students and junior doctors regarding their placement options. There was considerable similarity between the issues raised by junior doctors in the community practice setting to those emerging from interviews and focus meetings in small rural hospitals.

Both junior doctors and their supervisors have requested:

- Greater opportunities to use web based and multi medical orientation material for junior doctors to influence their making good choices about rural community options
- The inclusion of advice regarding family supports, including strategies that would assist the factoring in of partner and family plans, schooling, holiday arrangements for families
- Assurances of high quality family accommodation
- Greater understanding of the additional costs of a rural community term

Irrespective of the quality of the teaching situation, junior doctors in community terms have consistently required: [54] [55]

- Good quality and safe accommodation
- A sense of safety in both practice and social settings while on placement
- Being treated like a colleague
- Having some clear determination of the formulation of their term and the capacity to give feedback which is heard and actioned
- Consideration of family circumstances – flexible working roster, recognition of factors of isolation, provision of mechanisms to stay in touch eg technology, broadband access, compatible software between rural and metropolitan learning sites
- Leave arrangements that allow for family holidays and school terms
- A healthy and sustainable work/life balance

5.2.2. Challenges

Junior doctors also note some limitations of the rural setting, real or perceived, that influence decision-making about undertaking rural terms and strongly influence expectations of the term. A greater understanding by both teachers and junior doctors of these perceptions and expectations will contribute to a quality training outcome. Junior doctors note the following limitations:

- Gaining sufficient information about rural options at a time when choices are made
- Perceived limits on training terms and learning opportunities is smaller hospitals
- Perceived limitations on staff numbers in rural hospitals that might limit learning opportunities and a favourable training/service mix
- Making and maintaining rural based learning choices with family and social connections and commitments in metropolitan centres
- The connected challenges for partner and family in terms of employment and schooling
- Perceived disadvantages of a rural choice with regard to links with educational support and the capacity to influence further training options and career information
- Learning across a range of circumstances in the service area – including:
    - accredited and non accredited (experiential) terms operating within the same junior doctor environment;
    - fitting in with the different learning rates and requirements of the intern group and the different time tracks to AMC registration – including special needs of International Medical Graduates and doctors joining the junior doctor cohort laterally through immigration in various years
    - morale issues of placement in terms that are currently not accreditable nor unable to attract recognition of prior learning by particular Colleges.

[54] AMA Work-Life Flexibility Survey 2007 op cit.
[55] PGPPP Internal Evaluation Report, ACRRM 2007.

5.2.3 Requirements in the service/teaching environment

- Enthusiastic, committed teachers with time to give to the junior medical staff
- A comprehensive orientation to the rural hospital and community, including particularly key local contacts and protocols, emergency management and local industrial, public health priorities
- Demonstration of a strong teaching culture in the hospital including provision of teaching rooms and resources, access to IT and locations on the ward where immediate and opportunistic mentoring can be provided
- A clear weekly program of education and training, using sheltered time from service obligations and routine attendance expected of supervisors and junior doctors
- Interns particularly value a supervision and mentoring schedule that permits ready and regular access to supervisors for checking, confirmation of good practice and reassurance/guidance at the early stages of complex situations
- Recognition and appropriate response by supervisors of the range of knowledge, experience and confidence of an intern in the early terms
- A regime that supports continuity of knowledge across shifts – this includes clear, simple and available hospital safety procedures, immediate support staff phone contacts, a handover protocol (eg Safe Handover- Safe Patients, AMA) in daily use and developed by ward staff, a term handover and analysis document that covers routine, local protocols, shift operation etc (eg Atherton model)
- The opportunity to give and receive feedback on the job in confidential circumstances
- Supervisors who are regionally recognised teachers and role models – see item on clinical titles and academic partnerships
- Greater flexibility by supervisors and consultants who may be slow to adapt to the learning styles of current junior doctors and some means to broker some changes by hospital and clinical staff as required
- Support for the ongoing work of JMO groups to provide advocacy for junior doctors – and identification of the need for confirmed support and resources for junior doctors to maintain peer discussion in their hospital and to lobby for change
- Access to education and training resources on line in or near the ward location and access after hours through the learning centre or development of adequate online capacity in accommodation
- Acknowledgement of the particular service and learning requirements of female doctors
- Having a mentor who is close to the junior doctor's stage of development eg one year above and also having access to a mentor who is not immediately responsible for assessment, grading or further professional recommendations
- Being asked to mentor and assist peer and junior colleagues and having that role recognised and supported
- A training location with a broad range of clinical experience that enables direct interaction with patients and a reduced service hierarchy in terms of sufficient numbers of cases to develop clinical skills and medical confidence

- A supervision and service mix that develops structured autonomy over the period of the term

- The capacity to access and deliver feedback to teachers by junior doctors on a shift, weekly and term basis, including evaluation of the term that is comprehensive in format, demonstrably valued and actioned by hospital administration and teaching staff

5.2.4 Meeting expectations

Both supervisors and junior doctors have a vision of what a rural term can provide in terms of educational outcomes and a quality experience. Both groups agree that a better understanding of these expectations would be helpful and might be achieved though:

- An early and accurate orientation to the term for junior doctors
- The opportunity for the rural sector to develop these orientations
- Clear processes of discussion and joint setting of goals at the start of each term
- Better understanding of how to integrate these goals with pre and post learning of the junior doctor

These issues among others allow for a clearer understanding of the conditions to be encountered in rural community placements and a better appreciation by program planners and supervisors of the expectations (and misconceptions) of rural training by junior doctors, and how these might be met.

Junior doctors undertaking the RRAPP and PGPPP programs since 2000 clearly identify the effective elements of their community based training and these could usefully form the basis of a framework of information, promotion and orientation programs about the opportunities available for the private practice setting.

PGPPP community placement data identify that the capacity to meet expectations contributes substantially to junior doctor satisfaction with the placements and that this often hinges on issues not directly related to the learning program. Supervisors likewise note that well informed junior doctors, with a realistic expectation of rural community practice and culture provide the practice with a more positive and worthwhile experience of teaching

In terms of community placements, a framework of categories has been developed and refined over time [56] that junior doctors have identified as important to the quality of teaching and learning, clinical experience, practice and work environment, key relationships and support mechanisms. These are used periodically to test the effectiveness of placements by junior doctors and to provide feedback to supervisors on the degree to which they are meeting the expectations of their trainees.

5.2.5 Work to be done

There are items on the list that junior doctors consider are being less well addressed at this time and these comprise:

- The provision of adequate publicity and information at the hospital of where community placements are available, how to apply and what form and quality of training to expect
- Provision of, and access to, online learning and support programs – comprising current texts and clinical protocols, entry to local training supports (Registrar arrangements), strong online linkages back to peer training at the feeder hospital, facilitation of entry to RCS, Divisions of GP and regional hospital resources through temporary membership, password access and compatible software
- Recognition of gender differences in training requirements, and social/family circumstances through the tailoring of teaching styles and approaches and flexible daily/weekly rostering

[56] RAPPP Evaluation Framework 2000-2004 and PGPPP Evaluation Framework 2005-7

- The provision of both resources and protected time for supplementary study and research
- Factoring family and partner issues to training regimes – a reference to the family, carer requirements of both genders
- Acknowledgement of, and support for, the additional costs to junior doctors and their families of participation in a rural community or hospital term
- Hospital based doctors state the need for further teaching opportunities in which all their supervisors are available for teaching rounds – this accords with the preferences of IMGs who have preferences for more formal training events

Junior doctors also stated that their role in mentoring and teaching could be more formally supported, through recognition of their potential role with medical students and peers, a teaching pathway that progressed with seniority of clinical experience and recognition of the teaching role through assessment. Junior doctors found their mentorship role with medical students and the reinforcement received was supportive of their own confidence and professional development.

Junior doctors require an appropriate orientation to community placements and strong, ongoing linkages to their feeder hospital and its support services. One of the principal supports is access to advice, mediation and conflict resolution in case of adverse events. Junior doctors require a clear pathway of support in this regard. Their data indicate that the quality of placements could be enhanced by significant orientation/access, prior to the placement on:

- The needs of private practice, including Medical Director Software, Medicare Australia protocols and schedules, Veterans' Affairs and Social Service protocols for patients, EPC arrangements, individual professional charters of practices, local administration and recording systems of practices
- Payment and other industrial arrangements while on practice
- Gaining correct indemnity/registration status
- Insurance: clinical and professional arrangements, personal and family cover while on placement
- Input to a training plan with the practice and joint establishment of learning objectives and expected outcomes

Junior doctors indicate the degree to which participation in the Registrar Training Program through the Regional Training Provider (RTP) contributes to knowledge of the above – however they state that these programs often come late in the placement and arrangements with Regional Training Providers for an early introductory program would be of significant assistance.

5.2.6. Equivalence with the metropolitan hospital setting

One of the frequently raised issues by junior doctors is that of income. While rural community placements provide a change of pace which is appreciated, the unintended effect of this is a reduction of income in terms of overtime and additional shifts, which is a routine part of hospital practice. Doctors with families, funding dual residence and support costs while in community practice, raise this as an unexpected item that requires consideration. Supervisors note that while community placements rank well with junior doctors in terms of:

- A satisfactory number of working hours
- A fair working schedule
- A reasonable pace of work; and
- Appropriate and not excessive administration and paperwork

The issue of income equivalence continues to be raised as a disincentive.

Categories of community training that meet junior doctor expectations

Junior doctors in community placements consider that the following items constitute a good teaching and learning environment. Their priority items comprise:

- Models of good practice being demonstrated in the teaching situation
- The provision of role models
- Absence of a marked training hierarchy
- Resources/ time for supplementary study and research

5.2.7 Relationships with teachers and colleagues

Having a personal supervisor, a one on one teaching situation and the capacity to receive feedback in a timely manner form the basis of effective teaching support as reported by junior doctors in the PGPPP. Interns particularly appreciate the availability of supervisors at the close of a patient consultation to check clinical and safety processes and to confirm good practice.

The junior doctor groups in the hospital setting report similar requirements in terms of enthusiastic and committed teachers with the time to give them feedback as required. The proportions of supervision events during the typical week in community practice are developed to suit junior doctor confidence and clinical readiness, with some broad variation being reported as dependant on:

- Personal characteristics
- Lateness of term in each year
- Progression of key terms delivered prior to the community placement – paediatrics and surgery being particularly important

Professional and community relationships that junior doctors consider contribute to the quality of the term comprise:

- Knowledgeable and interested supervision
- Feedback from supervisors on performance
- Appropriate access to expert advice
- The opportunity to debrief and discuss problems
- Good professional relationships with colleagues – practitioners
- Good professional relationships with colleagues – consultants/specialists
- Capacity to factor partner and family issues into training regimes
- The capacity to belong to a community and learn more about the culture of rural life
- Being known by patients

5.2.8 Clinical experience

Most junior doctors state that prior to the placement, their detailed knowledge of the type of clinical experience that they would encounter was somewhat limited, but the exceptions were alumni of former placements in the senior years of Medical Schools through the RCS programs.

However, at the close of placements, the majority of junior doctors were highly supportive of the use of rural placements for clinical training, having found that they had attained a greater sense of autonomy in practice and attainment of a broad range of clinical skills related to their experience with a different spectrum of illness than that in metropolitan hospital terms, plus:

- Good ‘hands on’ experience
- A satisfactory level of medical and professional responsibility to treat patients
- The capacity to practice continuity of care and treating people in context
- The attainment of procedural skills and the capacity to engage in procedural medicine
- Greater self-sufficiency in clinical management and emergency procedures

- The opportunity to practice preventive care at the community level

The deficit in quick access to a broad range of investigations and test results is noted. However, junior doctors rate the following as benefits of the community terms and contributors to their overall confidence as practitioners:

- the opportunity to develop greater confidence in clinical diagnostic skills,
- to manage limited resources well,
- to engage with the full range of community resources and services and
- to enhance both referral skills and the opportunity to manage post operative care.

Junior doctors also rate highly – being known by patients, being thanked and being useful.

5.2.9 Teachers' expectations of the rural term

Do junior doctors and supervisors have equal expectations of a rural term? We asked both groups about the aspects of teaching and learning in rural practice that were deemed most effective, as a means to develop a framework of teaching and learning objectives.

It is evident that junior doctors think on a more immediate scale about skills enhancement and patient encounters, while supervisors tend to rate the whole outcome of the terms and the development of the junior doctor. As professionals living long-term in the rural community, their comments refer more to meeting community health needs and the broad spectrum of rural medicine.

The PGPPP evaluation data indicate that teachers regard the following as the ten most effective aspects of training in the rural private practice setting:

- Increasing the confidence of junior doctors in relationships with patients
- Increasing confidence of junior doctors in their clinical decision-making skills
- Increasing self sufficiency in clinical management
- Demonstrating an effective practice of continuity of care and preventive care at the community level
- Managing a different spectrum of illness and injury to that routinely seen in the teaching hospital
- Increasing capacity to access and use a range of equipment typical of community based medical care
- Gaining a positive experience of working in the community setting
- Demonstrating the ability to use clinical knowledge in diagnosis and seeking further investigations when appropriate
- Appreciation of the difference in structure and organisation of community health service support
- Demonstrating an appreciation of different patterns of investigative medicine than that used in the teaching hospital

Several weeks after the return of the junior doctor to the hospital, Directors of Clinical Training were surveyed [57] regarding their rating of changes to performance. Hospital based teachers noted the benefits of rural community based teaching on:

- Increasing junior doctor confidence in clinical management
- A greater tendency towards autonomy
- Enhanced decision-making skills
- Better communication with patients
- Improved consideration of discharge issues.

[57] PGPPP Evaluation Data: DCT Survey Results, 2006

5.3. RURAL PARTNERSHIPS

5.3.1 Introduction

A series of interviews, surveys and analysis of existing data sets has been undertaken to identify potential partnership activity and extended support roles for organisations that already hold a substantive brief in rurally-based education, training and support. These data also include issues raised in the exit interviews of junior doctors in rural community placements who have particular instances of support and mentorship while in rural placements, that are capable of more general application.

Main concepts:

1. There are functions of rural organisations that deliver services to teachers and learners in the rural setting that are capable of reinforcement for junior doctors.
2. There is potential for rural networks, local knowledge and support mechanisms to operate across the point of Graduation, particularly when a proportion of final year medical students from Rural Clinical Schools, opt to take an internship in the same region.
3. There is potential for activities and support networks to blend more effectively into registrar training

Respondents note that a number of rural organisations hold resources for rural teaching and have broad experience in the delivery of education and training on several levels. Strong collaborations have developed in States and regions which continue to provide:

- Smooth transitions for students, junior doctors and registrars who wish to remain within the same region
- Opportunities for joint appointments of rural teachers that further enhances work across the vertical integration of training
- Opportunities for clearer identification of regional training capacity
- Opportunities for joint use of scarce resources for rural teaching

Respondents from the Rural Clinical Schools, University Departments of Rural Health, Rural Divisions of General Practice and Regional Training Providers have identified roles within their terms of reference that could be further developed in support of high quality rural teaching across the board. Many of the issues raised represent work that is firmly in place and considered essential to the overall sustainability of regional training initiatives and preservation of a teaching workforce which is viewed as relatively fragile at this time.

5.3.2 Regional Training Providers and Rural Divisions of General Practice

It is likely that interns in rural placements will not have decided on their future careers [58] and basically want a sound, generalist experience in rural medicine, there is an increasing proportion of doctors in PGY2 who will have elected for a general practice career and may already have a linkage with a college and/or Regional Training Provider. The provision of an orientation to general practice for junior doctors in their hospital year of training is viewed by respondents as a significant contribution to quality and certainty by junior doctors in terms of:

- Becoming part of a professional community
- Early orientation to the administrative bases of general practice
- Opportunities for junior doctors and registrars to be inducted as teachers and mentors

And for supervisors:

- A regionally accessible source of supervisor training and support
- Regional access to CPD
- Collegial and peer support

[58] Pearce, R. 2007 op cit.

The exit interviews with 250 junior doctors in the PGPPP contain a series of references to the support and assistance gained from their local Division of General Practice and Regional Training Provider that played a role in the quality of the placement. Both junior doctors and Divisions have highlighted the usefulness of a partnership which enables a supported introduction to general practice and the opportunity, for the period of the placement to become part of the larger medical community as a professional equal. The detailed suggestions raised are listed below, together with suggestions for greater involvement of these organisations in developing quality components of rural placements.

5.3.3 Issues raised by junior doctors

Junior doctors have identified a number of items of importance to them while in a community placement that have been supplied through contacts and mentorship outside the clinical teaching setting. These comprise:

- The importance to the quality of the term of feeling like a colleague
- Feeling like a member of the community
- Having access to some advice and support beyond the practice setting
- Access to information and advice that enables junior doctors to "look ahead" in terms of more senior levels of general/rural medical practice
- Being part of the senior doctor CPD network, attending workshops and having young doctors' views sought and actioned
- The influence of the above on junior doctors' decision-making about trying a rural medical career and belonging to a rural medical community

Junior doctors in the PGPPP also raised a number of local supports delivered by RTPs and Divisions which comprise:

- That RTPs and Divisions provide a local cohort of doctors that give essential mentorship (outside the supervisor relationship) at a time of key career decision-making for junior doctors

- That temporary membership of a Division or RTP Registrar program provides, in the view of junior doctors, a feeling of belonging and collegiality which they rate as highly important to the quality of the placement

- Access to local and regional CPD programs, through Divisions, provides insight to skills development for junior doctors beyond their current knowledge base

- Divisional and local supervisor groups provide a mentor base for the industrial, business and regulatory context of rural practice that may not be adequately covered in the clinical practice setting owing to time constraints

- Divisional and RTP groups form a medical family with direct links, though partners and children to professional /community members able to broaden the social base of junior doctors while on placement and to "sponsor' newcomers into established rural networks that are traditionally difficult to enter

Divisions have the capacity to enhance placement quality through extension of the experience beyond the clinical setting, broadening the inquiry and opinion base for junior doctors and increase exposure to successful role models of rural practice and practitioners.

Junior doctors report that Division meetings and the connections made through the supervisor network provide social and family support for their partners and families who were either visiting or taking the placement time in the community. They also report that the Division and RTP contacts provided one of the broadest sources of information about family prospects for employment, schools, quality of life, regional opportunities, remuneration and lifestyle.

Recommended strategies for Regional Training Providers (RTP) and Divisions of General Practice

- Establish a link for their CEO to the PMCs, supplying feeder hospitals, Universities or other program management networks to ascertain the numbers, names, locations and further details of trainees in the district at any point in time

- Provide a series of key local contacts, other than the supervisor, to support the placement and the clinical teacher, including temporary membership to be actioned in the first week of terms and placements

- Provide opportunities at meetings, regional events and national conferences for input by junior doctors, design and deliver CPD for local supervisors of junior doctors and include the junior doctors in that role

- Request logistical support and funding from the home Universities and State jurisdictions for these tasks

- Combine with Rural Clinical Schools in their regional mapping activities, to identify medical families, mentors and community sponsors recruited and supported by their local RTP and Division of General Practice

5.3.4 Rural Clinical Schools (RCS) and University Departments of Rural Health (UDRH)

Respondents were asked to identify the support for supervisors and learners that is done well by RCS and UDRH, in the opinion of respondents and is capable to transfer to other layers of training and suggest options for further partnership activities and support between the RCS/UDRH and other organisations (Postgraduate Councils, Rural Divisions of GP, Regional Training Providers, University Departments of Rural Health)

Meeting the challenges of establishing and maintaining high quality rural teaching places is not solely the province of medicine. Scarce regional training places and resources must be spread between multiple health disciplines. In view of the likely impact of this demand on medical teaching places in the community, UDRH in each State were surveyed regarding their views on the components necessary to ensure a quality training placement and the factors necessary for ongoing support and growth.

UDRH opt for greater consultation between rural partners regarding the use and overlap of training placement sites. Allied Health, nursing and medical students/ trainees are in direct competition for the same placements in rural areas. Private practitioners report an increasing need to make choices between disciplines and levels of training accepted in the practice. It is evident from the majority of respondent comments, that greater collaboration and joint support of existing training points will assist rural communities, hospitals and practices to maintain their training capacity.

Effective University based activities highlighted for application at other levels of training:

- Creation of a culture where rurally based training is viewed as advantageous and/or preferable

- Making positive steps to bridge the graduation point and build a role for RCS in supporting junior doctors – starting with students graduating from the regional universities and staying within the region

- Capitalising further on RCS capacity to recruit, engage and support training locations and staff with the potential to operate beyond Graduation

- Working closely with organisations competing for similar placements in areas where the training workforce is limited

- Active regional planning to accommodate the increased numbers including co-consultation with regional hospital management and regional training providers

- Consideration of the time required to complete capital works and increase the base of involved private practices

- Recognising the effectiveness of RCS use of infrastructure and resource support for creating a culture of learning within practices and health facilities and providing forms of teaching infrastructure in practices and hospitals that create the "teaching footprint"

- Noting the degree to which the RCS have influenced the extension of rural teaching models to the mainstream of university Medical School teaching - not limited to rural placements or specific years

- Recognition of the mutual benefit of the co-location of different levels of training especially senior students and junior doctors

- Recognition of the additional cost to students of undertaking rural terms and the additional cost factors for training organisations to roll out rural terms well

- Developing clear jointly agreed learning objectives for students and creation of a regional training network within which students can move to points where certain skills can best be acquired and their learning objectives met

- Planning to ensure that the final year University programs blend with the National Curriculum Framework and for RCS/PMC/State Health collaboration in "intern ready" graduates

- Developing the base level for a regional teaching network including:

    - Capitalising on the capacity of RCS funding models to develop training infrastructure – especially teaching room in practices and hospitals
    - Ensuring the use of University resources to maintain training infrastructure over time
    - Forging and maintaining closer links (and supports for) rural hospital Medical Superintendents that determine the quality of, and commitment to, training for students in small rural hospitals
    - Developing fractional teaching appointments to create further teaching time within the hospital setting
    - Recruiting and supporting teachers in private practice including support of extended mentoring roles for junior doctors and Registrars

- Monitoring the sustainability of teaching posts in the region and recruiting for the future via:

    - Recognising the importance of recruitment in generating a reserve capacity in rural regions, enabling structured downtime for training posts and allowing for high percentages of personnel changes
    - Maintaining a detailed knowledge of the training region including current and potential training sites, changing hospital teaching capacity, staff changes in general practice and health disciplines
    - Identifying and specially targeting Medical Superintendents who wish to expand the clinical teaching capacity of small hospitals beyond the current point
    - Working with private practitioners and regional health staff to expand the forms of accepted teaching locations
    - Respecting cultural limitations on remote training sites

- Assisting students to feel positive and secure in their choice of rural terms though:

- Co-ordinating quality accommodation and safe working and living conditions for learners
- Making emergency support, conflict resolution and debriefing policies and processes clear
- Development and delivery of orientation to rural practice and rural communities, including oversight of the effectiveness of specific local orientation to hospital or practice
- Working with rural communities to engage and support community mentors and interested stakeholders to support doctors in training and their families
- Using the above the develop social and family support networks that extend beyond the teaching situation
- Co-ordination of students' transit within the rural regional setting and between learning venues and general discipline areas in the rural setting – hospital, practice, allied health settings
- Oversighting the roll out of the relevant University Medical Curriculum
- Making final year assessment processes similar to intern models within the State
- Developing and using quality forms of evaluation and ensuring that feedback is seen to be actioned

- Helping both supervisors and learners develop a high quality placement by:

    - Taking central responsibility for program development that ensures a well organised and comprehensive placement
    - Involving regional academic liaison staff to support supervisors and teaching terms
    - Close co-ordination of regional activities for learners and their supervisors
    - Provision of administrative services to cover the rostering of student education and support programs
    - Making the University a single point of overview for implementation of the curriculum across the area served by particular Universities/ accrediting bodies
    - Demonstrating support of supervisors by recognition and inclusion in the arrangements of an academic faculty
    - Having a clear point of contact and a point of strategic organisation/action for distant and devolved points of training
    - Using web and phone based meetings to support remote preceptors and a regular program of consultation
    - Maintaining an informational and advisory link for supervisors between training delivery and assessment outcomes that permits an ongoing review of training quality
    - Guaranteeing the delivery of professional development for faculty members that is capable of accreditation for CPD, RPL etc as required
    - Creation and oversight of specific teaching and support models for remote training placements and in Aboriginal health
    - Appreciation of the differentials in support for remote supervisors as opposed to rural hospital and community locations
    - Provision of mechanisms for maintenance of strong links with central teaching and peer groups for learners in rural placements
    - Defining and developing models of training for implementation in rural and remote settings including the proportions of clinical and academic work, the degree of service involvement for learners and the proportions of on-site and remote training
    - Providing a common framework for assessment of progress against objectives and benchmarks and enabling direct comparison with learners in alternative settings within the medical school
    - Oversighting provision of IT hardware and compatible IT for on-site work and links with feeder Universities
    - Developing and providing tailored teaching programs, online resources, simulation arrangements and equipment for rural training sites
    - Contributing by these means to the co-location of different levels of training

- Making rural teaching a prestigious activity by:

    - Inclusion of all levels of students in the mentoring and orientation roles for the years below – making mentoring and teaching a preferred activity for students
    - Access to academic qualifications for supervisors eg Masters in Medical Education, masters in Remote Medicine and Certificate of Clinical Teaching (proposed)
    - Providing a policy framework through the University that includes teacher recognition, professional support, remuneration, conflict resolution and indemnity
    - Providing CPD programs for supervisors and ensuring recognition of these for professional accreditation
    - Reviewing the financial structure for teachers and recognition via allowances

The issues raised in the consultation round, show considerable similarities across rural organisations, between private practice and hospital teaching settings and between junior doctors and their teachers. The challenge is now to develop a simple framework of support for teachers and mentors of junior doctors which enables the delivery of high quality teaching in rural placements and fulfils the expectations of learners.

6. DISCUSSION

6.1 Introduction

Supervisors of junior doctors in rural Australia generally consider that they fulfil the key parameters of quality teaching outlined by junior doctors. The smaller size of rural hospitals, practices and communities enables the one-on-one relationship with teachers and mentors to develop easily and for junior doctors to feel that, however far from home they may be, they are not lost in the crowd.

Quality in rural teaching and learning is more dependent on factors of time, space, resources and information. All of these contribute to the capacity of the supervisor to provide accessible, well structured teaching and support, a safe teaching and learning environment and the time to respond to opportunistic requests for clinical information, confirmation of practice and personal/professional mentorship.

It must be emphasised that the Postgraduate Councils in each State already have arrangements and programs in place that address many of the issues raised by respondents. However, placing the items in the framework indicates the importance of these current supports, to both teachers and learners. It also provides an opportunity for regional development of support that may currently be only available in a more centralised form.

The issues in common across the rural training settings, disciplines and geographical regions appear to relate to:

- The essential link between workforce shortage and teaching capacity
- The need to look more widely for teachers and mentors, including support of junior staff and students in teaching roles
- The general agreement across disciplines and professional levels of what constitutes a good teaching and learning environment
- A genuine willingness to extend rural partnerships in the service of a vertical integration of education and training and retaining good doctors within the learning region

Table Two: FRAMEWORK OF ISSUES INFLUENCING SUPERVISION AND MENTORING FOR JUNIOR DOCTORS IN RURAL TERMS AND PLACEMENTS

Category	Strategic issues influencing training quality
Identifying and expanding the private practice and small rural hospital teaching cohort	That private practices are best positioned to self determine their engagement, level and degree of involvement in teaching and nominate the form of their involvement, consistent with current personnel, resources and small business considerations Recognition that Rural Hospital personnel may be best placed to identify the elements of the National Curriculum that can be accommodated at particular small hospitals in terms of clinical throughput and teaching capacity That particular involvement and support of procedural rural practices, would substantially increase the community placements for junior doctors with undifferentiated generalist requirements That training terms be of adequate length to cover the clinical and cultural learning inherent to rural practice That rural regions could be supported to trial different forms of regional engagement, including multi site training and hub and spoke patterns that may cross current District boundaries, in order to take maximum advantage of scarce rural resources and teaching capacity That the moves to broaden the range of teachers and mentors through the inclusion of regional partners, administrative staff, junior staff, community members and forms of regional co-ordination, is an important determinant of rural capacity
A well informed and enthusiastic junior doctor cohort	Where possible, for junior doctors in rural placements should have voluntary access to rural terms That Postgraduate Councils continue to support priority arrangements for junior doctors who are alumni of Rural Clinical Schools and wish to remain in the same/similar regions That further opportunities are developed, pre-placement for teachers to understand the expectations of the rural term by junior doctors and to permit joint negotiation of objectives That a greater proportion of rurally produced information and orientation be provided at the point of choice for intern training or for senior medical students to facilitate an informed choice of hospital, terms and rurality That there are greater opportunities to use web based and multi media orientation material, accessible by junior doctors, to contribute to their making good choices about rural community options That priority is given to the inclusion of advice regarding family supports, including strategies that would assist the factoring in of partner and family plans, schooling, holiday arrangements for families including: Payment and other industrial arrangements while on practice Gaining correct indemnity/registration status Insurance: clinical and professional arrangements, personal and family cover while on placement That term organisers provide assurances of high quality family accommodation That there is greater understanding of the additional costs of a rural community term to junior doctors and their families Support for the development and use of a structured orientation to community practice by the feeder hospital team, prior to placement including easily distributable DVDs on the training experience in rural community placements, practice operations and culture

	That there is more ready access by rural hospitals and regional organisations to University and State Health websites, in collaboration with the Postgraduate Councils, for the posting of information That early access is arranged, for junior doctors, to regional professional supports eg Regional Training Provider Programs and Divisional membership That importance be attached to assisting students to feel positive and secure in their choice of rural terms though: Co-ordinating quality accommodation and safe working and living conditions for learners Making emergency support, conflict resolution and debriefing policies and processes clear Development and delivery of orientation to rural practice and rural communities, including oversight of the effectiveness of specific local orientation to hospital or practice Working with rural communities to engage and support community mentors and interested stakeholders to support doctors in training and their families Using the above to develop social and family support networks that extend beyond the teaching situation Co-ordination of students' transit within the rural regional setting and between learning venues and general discipline areas in the rural setting – hospital, practice, allied health settings Oversighting the roll out of the relevant University Medical Curriculum Developing and using quality forms of evaluation and ensuring that feedback is seen to be actioned
Well informed and supported rural teaching sites	Provision of a carefully targeted and well maintained series of resources for the training practice that enable all the partners to commit to the decision to train, as a cost-effective part of the practice business plan Development and distribution of material that provides a clear definition and illustration of the components of quality training and practice - to enable practices to clarify their capacity to achieve recognition Opportunities for the collaborative setting of objectives for the term by junior doctor and supervisor and better understanding of how to integrate these goals with the pre and post learning of the junior doctor Useful regulatory and administrative supports, in place prior to the commencement of training, that enable safe, well informed, and educationally sound models of training and practice that include: A standard approach to indemnity arrangements for junior doctors in community placements A model for an educational agreement between the practice and the junior doctors with agreed objectives and preferred outcomes A checklist of items defining the characteristics of an effective junior doctor training practice, to ensure good choices and assist training site development A framework for a Training and Service agreement between the feeder hospital and the training practice Guidelines for supervision of junior doctors, approved by the Postgraduate Councils; A teaching framework for supervisors of junior doctors including recommended schedules and teaching/learning strategies Regionally available training on supervision and mentorship techniques for the teachers of junior doctors – with options provided by Divisions of General Practice, Regional Training Providers and Rural Clinical Schools
Resources for rural teaching	Extension of capital works support in junior doctor training to increase the clinical and teaching space in community practices and to increase teaching room options in rural

	hospitals and assist the creation of a culture of training for junior doctors Examination of a sustainable system of financial recognition for rural teachers A more integrated approach to training, that extends the use of existing teaching resources currently in place for students and/or Registrars, to junior doctor training Greater online access to learning resources for the junior doctor while on placement including in accommodation, for clinical learning and contact feeder hospital, family and peers Enhanced availability of training and resources for practice administrative and management staff to assist in the orientation of junior doctors to the operational aspects of private practice Resources and acknowledgement for rural hospital staff assisting with community based training Financial support for a fractional appointment for a practice staff member (eg practice nurse, administrator) to co-ordinate the learning and outreach program for the junior doctor Creation of the Rural Co-ordinator/ Rural DCT function to free teaching time for current supervisors and thus to improve teaching quality and the access for supervisors to junior doctors, development time for teaching resources and local CPD
Broader training options within the hospital and private practice setting	Access to regional support that removes some of the non-educational care of the junior doctor from the role of the supervisor A practice management and administrative training package, suitably resourced, to allow supervisors to devolve training on the business, accreditation and regulatory aspects of private practice – including Medicare, Veterans Affairs, medical records. Teaching rewards consistent with a small business plan, that enables practice staff and supervisors to commit as a team, to spread the teaching and mentorship roles, and to take fullest advantage of the range of special interests and clinical roles available within the teaching setting Promotion of a local model of involvement across the practice and hospital setting that mirrors the roles of local practitioners ie Involvement and support of visiting specialist and other hospital based staff in the teaching models and the provision of resources for this role to small rural hospitals Resources and acknowledgement for rural doctors' time spent teaching in the hospital setting via practitioners VMO arrangements Encouragement for Registrars, Residents, Interns and Students to take up a teaching and mentorship role and for Postgraduate Councils to continue development of a training role for junior staff Encouraging Registrars to provide mentorship which is close to the junior doctor's stage of development and also to support access to a mentor who is not immediately responsible for assessment, grading or further professional recommendations Recognition of the value placed by Junior doctors on being asked to mentor and assist peer and junior colleagues and having that role recognised and supported Creation of a regional/local educational co-ordination capacity (eg a Rural DCT Model) located at regional and/or rural teaching hospitals to co-ordinate training within the region for junior doctors and to maintain strong teaching and informational links with larger feeder bases.

	Greater use of part-time and retired medical staff within the regions in funded co-ordination, mentorship and supporting roles for junior doctor training
Expanded options for rural partnerships across the levels of training	A recommended strategy for the achievement of the greater coordination and use of regional resources across the levels of training by development of a series of regional conjoint appointments of managers, administrators and junior/senior teachers, including for: Promotion to Postgraduate Councils by the Universities of arrangements that rural organisations deliver services to teachers and medical students in the rural setting, that are capable of reinforcement for junior doctors The potential for rural networks, local knowledge and support mechanisms to operate across the point of Graduation, particularly when a proportion of final year medical students from Rural Clinical Schools, opt to take an internship in the same region Potential for activities and support networks to blend more effectively into Registrar training in rural settings The further enhancement of an academic/teaching culture in rural hospitals through the gazetting of rural hospitals as Teaching Hospitals and the creation of further academic links/ academic titles for rural hospital teachers through the related Rural Clinical Schools of Universities Recognition of the importance of local partnerships in supervisor support – particularly the work done by the Rural Clinical Schools in: The recognition of the rural teacher in terms of links with academic institutions, clinical titles, access to academic resources, inclusion in broader medical school programs Knowledge of the region and its teaching resources Current programs of supervisor and mentor recruitment and orientation Support of supervisors by access to local programs of development Recognition of the immediate usefulness of Regional Training Providers and Divisions of General Practice in their provision of collegial support and professional advice to junior doctors in rural placements
Opportunities to address some challenges to teaching quality in rural settings	Redress of perceptions by metropolitan medical students and interns that a rural choice would involve a reduced access to: Central education resources Education networks Training co-ordination services and Personal contact with specialty colleagues influencing opportunities for selection to specialist training lists Recognition of the challenge to teaching quality of cultural variations within the hospital setting and the pressure of meeting the differential learning needs and timeframes of the current junior doctor cohort in small rural hospitals Acknowledgement of the forthcoming challenges to the teaching load of rural hospitals related to increasing numbers of Bonded and other Scholarship candidates selecting rural terms, from PGY2 onwards, in fulfilment of their bond and the further resourcing of mentoring and supervision related to this For terms in rural hospitals to be of a suitable length to enable junior doctors to experience adequate exposure to clinical material for the procedural skills and to accommodate different degrees of confidence and rates of learning of the junior doctor Creation of consistent IT policies, procedures and integration between rural hospitals, regional feeders and State-based junior doctor training networks that facilitates and not impedes cross communications

	Recognition of the challenges of the supervisory load inherent to mixing accredited and experiential terms and that the pressures on supervisors of junior doctors with a broad range of learning rates, styles and cultures requires further review and support Further recognition of the current limitations to teaching capacity in rural hospitals owing to the competing administrative and co-ordination roles of supervisors, irrespective of clinical workload

Acknowledgements

The Project was undertaken between October 2007 and June 2008 by project staff of the Australian College of Rural and Remote Medicine with funding from the Australian Government Department of Health and Ageing, through a grant awarded by the Medical Training Review Panel.

The Project Manager would like to thank the contributors to surveys and interviews across Australia for their contribution to the results and conclusions and also to members of the Project Advisory Committee for advice and support received.

ATTACHMENTS

ATTACHMENT ONE: Project Work Plan and Outputs

ATTACHMENT TWO: Consultation Framework

ATTACHMENT THREE: Survey of existing national community practices training junior doctors

ATTACHMENT FOUR: Matching survey of 60 non training practices

ATTACHMENT FIVE: Interview schedule for Rural Clinical Schools

ATTACHMENT SIX: Survey of University Departments of Rural Health

ATTACHMENT ONE

Development of Mentoring and Support Programs for Junior Doctors in Rural Settings
Report of progress against the Project Delivery Plan: June 13 2008

Project phase	Activity	Time	Program Outcomes
1. Establishment	Engage and brief appropriate project staff.	November 2007	Staff member engaged and briefed
	Establish the membership of a project Advisory Committee and confirm a meeting schedule and develop draft terms of reference for presentation at the first meeting.	November – January 2007	Committee membership submitted to Department and approved. Approved organisations contacted to provide a nominee. Nominees approached to arrange a first meeting date in February 2008 to hear progress report. NAC Terms of Reference completed and approved by the Department and the NAC.
2. Implementation	Develop and document a methodology that supports strategic inquiry and the development of consensus	November/December 2007	Methodology developed, documented and approved. A consultation framework developed and submitted for approval by the Department. This working document amended for each NAC meeting and finalised June 13 2008
	Review the literature on support, supervision and mentorship including the Australian Junior Doctor Curriculum Framework.	November 2007 to January 2008	Literature search undertaken on components of excellence in supervision, mentorship and training and on specific rural issues. Literature analysed to provide a basis of items for surveys and interviews. Components of the Australian Junior Doctor Curriculum Framework included.
	Review current statutory positions on supervision and support by regulatory bodies, including the Postgraduate Councils, Supervisors Association, AMA Doctors in Training.	November/December 2007	Documented positions of training by Postgraduate Councils obtained and reviewed, with issues being included in

			the framework developed for the Interview schedule with junior doctors and supervisors.
	Conduct a pilot consultation with up to 4 Rural Clinical Schools to obtain an issues schedule for integration and support of junior doctor training by these institutions, to underpin the consultation framework	November/December 2007	Four clinical school locations/staff visited – Alice Springs (NT), Monash (Vic), Flinders (SA), UTAS Burnie (Tas) and issues listed.
	Review current research data available on components of excellence in support of junior doctor training in the community	November 2007 and ongoing	PGPPP and other junior doctor placement research outcomes obtained, being reviewed and included in the framework. Outcomes of the 2008 evaluation of training excellence obtained and re-analysed. Transcripts of interviews with 250 junior doctors, post rural placement being analysed. Survey and interview material with 35 rural supervisors of junior doctors analysed.
	Develop an issues framework to underpin the qualitative and quantitative inquiry	November 2007/January 2008	Issues framework developed and used in consultations from February –May 2008. Framework issues submitted periodically to NAC and CPMEC Curriculum project manager
	Develop a draft consultation framework of personnel and organizations to be used in months 3 and 4 of the project.	November/December 2007	Draft consultation framework submitted to Dept and approved December 2007. Final consultation framework includes NAC advice and a training practice/location list for interview and visits. Interview list of relevant organizations and personnel developed for use in 2008. UDRH and Rural Clinical School consultation list developed and administered

	Implementation of the consultation rounds Re-circulation of issues for validation	Jan-April 2008 To May 30 2008	Consultation round completed May 2008 including interviews, focus groups, face to face visits and remote inquiries. Completed framework available for report May 15 2008. Interviews transcribed and submitted for validation. Issues recorded and recirculated to respondents for validation and further comment. University Department of Rural Health Survey completed distributed and analysed. Outcomes summaries developed for consideration by the NAC at each meeting. Contact continuing regarding outcomes with the CPMEC Group working on the Australian National Curriculum Framework. Surveys administered in April on support issues and initiatives, to a group of practices currently training junior doctors and a control group of practices have been received and analysed. Field interviews with teaching staff, hospital junior doctor liaison officers and junior doctor training practices being conducted in three states during April – complete and issues circulated to Postgraduate Councils in each state, for comment.. Interim report written for May 15 2008.
3. Finance	Ensure financial reporting from ACRRM to the Commonwealth is in line with the terms of the agreement between the Department and ACRRM.	Reporting period 1 July 2007 – 30 June 2008	ACRRM Financial Officer preparing financial reports as required by contract.

	Ensure arrangements for the presentation of invoices for the MTRP Project as outlined in the contract between the Department and ACRRM Undertake and deliver the agreed audit arrangements	Report due June 15 2008	
4. Monitoring and evaluation	Development an evaluation framework for the Mentoring and Support project to include: • Program arrangements and processes • Contact with organizations and individuals on the consultation schedule • Outputs and times achieved according to contract • Difficulties and unintended effects and outcomes Collate and report evaluation data to Department and feedback summary to participants	November 2007 May/June 2008	Evaluation framework developed and approved by Dept. in November 2007. Arrangements for internal evaluation in progress and implemented June 20 2008 reporting to Dept and Advisory Committee prior to June 30. Issues summaries and evaluation outcomes to be circulated to responding organisations and individuals as detailed in Consultation Framework prior to June 30 2008
5. Reporting	Provision of reports to The Dept of Health and Ageing against the Project Plan in line with contract schedule comprising: 1. Development and submission of the Project Plan and report as designated in the contract 2. Project Report including outcomes of the consultation round 3. Delivered outcomes against expectations and recommendations Ensure forwarding of these reports to the CPMEC Assessment Steering Group Ensure provision of project material and data to the Department Two monthly summary reports to the MTRP Advisory Committee	November 30 2007 May 15 2008 June 15 2008 As above following Department approval June 15 2008 End of November 2007; March 2008, May 2008	Completed November 30 report submitted and approved. Activity report Feb. 2008 developed and submitted to Dept. March report to NAC prepared and delivered. Interim activity report to the Department prepared for May 15 2008. Report for NAC completed and presented May 29 Discussion draft of final report distributed June 10 2008 Final report submitted June 13 2008

ATTACHMENT TWO

MTRP CONSULTATION FRAMEWORK

List of personnel and organisations included in consultation via survey and/or interview, field visits, circulation of documents for comment

CATEGORY	NOMINATED CONTACT	CONSULTATION
Department of Health and Ageing and project National Advisory Committee – representatives of: • The Department of Health and Ageing • The AMA Doctors in Training Committee • Practice Managers and Administrators • The Confederation of Postgraduate Councils • The Supervisors Association • The Rural Clinical Schools The Australian College of Rural and Remote Medicine	NAC members	Monthly meeting from February 2008 and with Dept officers from October 2007. Presentation of issues for feedback.
CPMEC Australian National Curriculum Framework project team, PMCQ Offices, Chermside, Brisbane.	Debbie Paltridge on behalf of Dr Jagdishwar Singh	Provision of reports as scheduled for the Dept of Health and Ageing and written briefing on issues emerging from the consultation – ongoing.
Offices of Rural Health, State Government Departments of Health	List	Circulation of general issues and specific State related items as required and in May 2008 for comment.
Department of Human Services, Victoria, Southern Health region, Leongatha Hospital, Leongatha, Vic and Wonthaggi Hospital CEO and supervisor support team.	Dr Gary Templeton and Dr Lea Pope Directors of Medical Services	Interviews regarding the support needs of junior doctors and teachers in the South Gippsland integrated training model, April 2008.
Royal Brisbane and Women's Hospital, Brisbane	Dr Graham Steele	Interns and Resident supply and teaching support. Orientation of interns and promotion of rural terms in metropolitan hospitals
Cairns Base Hospital, PO Box 902 The Esplanade, Cairns North Queensland, Cairns and Hinterland Health Service District Phone: 07 40506357 Email: Kathleen_Atkinson@health.gov.qld.au	Dr Kathleen Atkinson , Director of Medical Services	Development of models of regional co-ordinators to assist the supervision of junior doctors in small hospitals. Development of linkages between rural and regional hospitals. Creation of rural DCT functions and means to free supervisors for teaching.
University Dept and Rural Health, Northern Rivers NSW	CEO	Field visit to consult on regional role and potential for district and regional integration in the Northern Rivers region.
Western Australian General Practice Education and Training Alliance (WAGPET) WAGPET PO Box 1233, Bentley DC WA 6983 Phone: (08) 9473 8200 Email: admin@wagpet.com.au	Dr Janice Bell (CEO)	Review of WAGPET programs, Teaching on the Run and supervisor support programs in WA. Review of planning and evaluation of the Community Residencies program. Issues list circulated for comment, May 2008.
Rural and Regional QLD Consortium PO Box 2076 Annand Street Toowoomba QLD 4350 Phone: 07 4638 7999	Ms Jennifer Bundy (CEO)	Visit to regional offices in Toowoomba and review of supervisor support for PGPPP practices at Goondiwindi, Oakey, Roma and Mitchell October 2007.

Gippsland Education and Training for General Practice (GETGP) Suite B2 Green Inc. Building 50 Northways Road Churchill Victoria 3842 Phone: 03 5132 3100 Email: admin@getgp.net.au	Dr Rod Wellard (CEO)	Consultation regarding supervisor and junior doctor support for double intern placements at Heyfield, the South Gippsland Hospital/Private practice model and the PGPPP standard placements at Lakes Entrance. April 2008.
North Coast GP Training PO Box 1497 Ballina NSW 2478 Phone: 02 6681 5711 Email: info@ncgpt.org.au	Mr John Langill (CEO)	Request for comments on Supervisor Support Framework May 2008
Bogong Regional Training Network PO Box 165 Wodonga VIC 3689 Phone: (02) 6057 8600 Email: bogong@bogong.org.au	Ms Nicki Melville (CEO)	Request for comments on Supervisor Support Framework May 2008.
New England Area Training Service PO Box 838 Moree NSW 2400 Phone: 02 6752 7354 Email: ceo@neats.com.au	Mr Marc Prospero (CEO)	Request for comments on Supervisor Support Framework May 2008. Interview 2007 on development of community training in rural NSW.
Sturt Fleurieu Po Box 877 Strathalbyn SA 5255 Phone: 08 8536 5000 Email: sturt.fleurieu@sfgpet.com.au	Mr Ken Redford (CEO)	Field visit including review of intern orientation meeting and intern support.
Victoria Felix Medical Education PO Box 2177 Bendigo Delivery Centre (DC) Victoria 3554 Phone: 03 5441 9300 Email: jtogno@vicfelix.com.au	Dr John Togno (CEO)	Field visits and interviews on junior doctor training delivery at Stawell and survey of priority support areas for supervisors March 2008.
NTGPE PO Box u179, CDU Casuarina NT 0815 Phone: 08 8946 7079 Email: admin@ntgpe.org	Dr Michael Wilson (Executive Director)	Field visit 2007 and follow up survey March 2008. Orientation DVD for remote area practices in development.
GGT PO Box 5010, Warrnambool VIC 3280 Phone: 03) 5562 0051 Email: gmcmeel@ggtgpet.com.au	Me Greg McMeel (CEO)	Field visit 2007 regarding the RTP's organisation of regional junior doctor training across State boundaries – Hamilton, Warrnambool, Naracoorte.
CoastCityCountry Training PO Box 5242 Wagga Wagga NSW 2650 Phone: 02 6923 5400 Email: enquiries@ccctraining.org	Dr Sharon Flynn	Discussions and work regarding establishment of community based training in NSW for junior doctors.
The Rural Clinical School of Western Australia (Kalgoorlie) PO Box 1654 Kalgoorlie Western Australia 6433 Phone: 08 9722 1883 or 08 9021 5366 Email: rcsadmin@rcs.uwa.edu.au	Professor Campbell Murdoch (Head of RCS)	Initial interview regarding currently and potential new roles for Rural Clinical Schools in support of the teachers of junior doctors and orientation to the rural community.
The James Cook University Rural Clinical School (Atherton) Atherton Hospital, Louise Street Atherton North Queensland Email: Neil_Beaton@health.gov.qld.au	Assoc Prof Neil Beaton	Three day field visit to a rural hospital and connected JCU Rural Clinical School to observe accredited rural hospital posts being conducted. Interviews with interns and supervisors.
The James Cook University Rural Clinical School (Townsville) James Cook University Townsville QLD 4811 Phone: 07 4781 6232 Email: medicine@jcu.edu.au	Prof Tarun Sen Gupta	Initial interview regarding currently and potential new roles for Rural Clinical Schools in support of the teachers of junior doctors and orientation to the rural community.

The Australian National University Rural Clinical School Rural Clinical School, Medical School Frank Fenner Building 42 The Australian National University CANBERRA ACT 0200 Phone: 2 6125 7657 Email: rhu@anu.edu.au	Ass Prof Amanda Barnard	NAC member and representative of FRAME. Briefing and consultation.
The University of Queensland Rural Clinical Division (Toowoomba) Phone: 07 4616 6670 Email: rcdswq@som.uq.edu.au	Assoc Prof Peter Baker Assoc Prof Bruce Chater	Initial interview regarding currently and potential new roles for Rural Clinical Schools in support of the teachers of junior doctors and orientation to the rural community.
The University of Queensland Rural Clinical Division (Bundaberg) Phone: 07 4150 2205 Email: rcdcq@som.uq.edu.au	Dr Denise Powell	Field visit to observe preparation for the first multi-intern site in private practice and the links with the RCS. Model for mentoring and oversight of training also investigated.
University of Tasmania - Rural Clinical School Private Bag 3513 Burnie TAS 7320 Phone: 03 6430 4561 Email: judith.walker@utas.edu.au	Professor Judi Walker (Chief Executive)	Initial interview regarding currently and potential new roles for Rural Clinical Schools in support of the teachers of junior doctors and orientation to the rural community. Plus field visit in May 2008 to the RCS Burnie and associated training hospital.
Flinders Rural Clinical School (Mt Gambier) GGT PRCC, PO Box 3570 Mount Gambier SA 5290 Phone: 08 8726 3999 Email: ggt.prcc@flinders.edu.au	Assoc Prof Lucie Walters	Field visit to Mt Gambier RCS site to observe teaching program and facilities for intern and supervisor support. Training practice at My Gambier and hospital included.
Flinders University Rural Clinical School (Renmark) PO Box 852 Renmark SA 5341 Phone: 08 8586 1000 Email: rural@flinders.edu.au	Assoc Prof Lucie Walters Dr Pam Stagg	Field visit to rural practices and hospital sites in the Riverland regarding the proposed mixed model of training organised by the RCS Renmark. Meeting with full RCS Staff re teaching support and rural orientation of junior doctors.
Northern Territory Clinical School Alice Springs Hospital PO Box 2234 Alice Springs NT 0871 Phone: 08 8951 7982 Email: alice.ntcs@flinders.edu.au	Prof. John Wakerman	Field visit to Alice Springs to consult on the current and proposed role for the UDRH and RCS networks in remote settings. Meetings with junior doctors and supervisors at Congress re teaching and learning in Aboriginal health settings.
Gippsland Regional Clinical School (Traralgon and Warragul) PO Box 424 Traralgon, Victoria 3844 Phone: 3 5173 8181 Email: daryl.pedler@med.monash.edu.au PO Box 723 Warragul, Victoria 3820 Phone: 03 5622 6418	Associate Professor Daryl Peddler (Director)	Visit to the Monash RCS at Traralgon regarding PGPPP sites in the region and rural orientation and teaching of students and junior doctors at the Latrobe Regional Hospital.
East Gippsland Regional Clinical School (Bairnsdale and Sale) PO Box 1497 Bairnsdale, Victoria 3875 Phone: 3 5150 3613 Email: david.campbell@med.monash.edu.au PO Box 9159 Sale, Victoria 3850 Phone: 03 5143 8500	Dr David Campbell (Director)	Field visit to the Monash RCS at Bairnsdale regarding teacher and junior doctor support. In particular, the support needed by small rural hospitals where private practitioners teach in both settings using their VMO capacity. Observation of the teaching model in small hospitals with no resident specialists but range of Visiting Consultants with rural procedural doctor support.
PGPPP Practices in all States and Territories (60)	Survey list	Survey requesting prioritisation of items listed as key supports for private practices teaching junior doctors.
Non PGPPP Practices in all States and Territories (60)	Survey list	Survey requesting prioritisation of items listed as key supports for private practices teaching junior doctors.

ATTACHMENT THREE

SUPPORT FOR CURRENT SUPERVISORS AND MENTORS OF JUNIOR DOCTORS

ACRRM has been awarded a grant by the Commonwealth Government Medical Training Review Panel to investigate the items of support most helpful to supervisors of Interns and Residents in community placements. The outcomes will contribute to establishment of support mechanisms for teachers and teaching practices ahead of the increased demand for community training places for junior doctors.

Your assistance in completing this short survey would be most appreciated.

Please rate the usefulness of the following items to your supervision of junior doctors as follows:
5. Essential 4. Highly useful 3. Useful 2. Of little use 1. Not relevant

Issue	Rating
Guidelines for supervision of junior doctors, approved by the Postgraduate Councils	
A framework for a Training and Service agreement between the feeder hospital and the training practice	
A standard approach to indemnity arrangements for junior doctors in community placements	
A model for an educational agreement between the practice and the junior doctors with agreed objectives and preferred outcomes	
A checklist of items defining the characteristics of an effective junior doctor training practice, to ensure good choices and assist training site development	
The development and use of a structured orientation to community practice by the feeder hospital team, prior to placement	
The development and use of a DVD for the feeder hospital, outlining the training experience in rural community placements	
The development and use of a DVD on practice operations and culture to assist the orientation of junior doctors with clinical care and relationships with patients	
A checklist for practice partners outlining the requirements for supervision and mentorship of a junior doctor	
Resources for dedicated teaching and learning space for junior doctors while on placement	
Resources for greater online access to learning resources for the junior doctor while on placement	

A more integrated approach to training, with the capacity to use existing teaching resources that are currently in place for students and/or Registrars	
Regionally available training on supervision and mentorship techniques for the teachers of junior doctors	
The availability of training and resources for practice administrative and management staff to assist the orientation of junior doctors to the operational aspects of private practice	
A teaching framework for supervisors of junior doctors including recommended schedules and teaching/learning strategies	
Resources and acknowledgement for time spent teaching in the hospital setting	
Resources and acknowledgement for hospital staff assisting with community based training	

Your three major support requirements as supervisor of junior doctors

1 ……

2 ……

3 ……..

Your three current main difficulties/discouragements as a supervisor of junior doctors

1 ……

2 ……

3 ……..

Thank you for taking the time to complete this survey.
Please Fax to ACRRM at 07 3105 8299

The MTRP Project Officer Anna Nichols would be happy to answer any questions about the survey.
Contact 0407 138 972 or 07 3105 8200 or email a.nichols@acrrm.org.au

ATTACHMENT FOUR

SUPPORT FOR THE RURAL DOCTORS' ROLE IN SUPERVISION OF JUNIOR DOCTORS

ACRRM has been awarded a grant by the Commonwealth Government Medical Training Review Panel to investigate the items of support most helpful to supervisors of Interns and Residents in community placements. The outcomes will contribute to establishment of support mechanisms for teachers and teaching practices ahead of the increased demand for community training places for junior doctors.

How helpful would you find the following items in terms of considering or establishing a placement for junior doctors in rural practice? Your assistance in completing this short survey would be most appreciated.

Please rate the usefulness of the following items to your supervision of junior doctors as follows:
5. Essential 4. Highly useful 3. Useful 2. Of little use 1. Not relevant

Issue	Rating
Guidelines for supervision of junior doctors, approved by the Postgraduate Councils	
A framework for a Training and Service agreement between the feeder hospital and the training practice	
A standard approach to indemnity arrangements for junior doctors in community placements	
A model for an educational agreement between the practice and the junior doctors with agreed objectives and preferred outcomes	
A checklist of items defining the characteristics of an effective junior doctor training practice, to ensure good choices and assist training site development	
The development and use of a structured orientation to community practice by the feeder hospital team, prior to placement	
The development and use of a DVD for the feeder hospital, outlining the training experience in rural community placements	
The development and use of a DVD on practice operations and culture to assist the orientation of junior doctors with clinical care and relationships with patients	
A checklist for practice partners outlining the requirements for supervision and mentorship of a junior doctor	
Resources for dedicated teaching and learning space for junior doctors while on placement	
Resources for greater online access to learning resources for the junior doctor while on placement	
A more integrated approach to training, with the capacity to use existing teaching	

resources that are currently in place for students and/or Registrars	
Regionally available training on supervision and mentorship techniques for the teachers of junior doctors	
The availability of training and resources for practice administrative and management staff to assist the orientation of junior doctors to the operational aspects of private practice	
A teaching framework for supervisors of junior doctors including recommended schedules and teaching/learning strategies	
Resources and acknowledgement for time spent teaching in the hospital setting	
Resources and acknowledgement for hospital staff assisting with community based training	

Your three major support requirements as supervisor of junior doctors would be:

1 ……

2 ……

3 ……..

Your three current main difficulties/discouragements as a supervisor of junior doctors would be:

1 ……

2 ……

3 ……..

Thank you for taking the time to complete this survey.

Please Fax to ACRRM at 07 3105 8299

The MTRP Project Officer Anna Nichols would be happy to answer any questions about the survey. Contact 0407 138 972 or 07 3105 8200 or email to a.nichols@acrrm.org.au

ATTACHMENT FIVE

MEDICAL TRAINING REVIEW PANEL (MTRP)
NATIONAL PROJECTS IN PREVOCATIONAL MEDICAL EDUCATION AND TRAINING

DEVELOPMENT OF MENTORING AND SUPPORT PROGRAMS FOR JUNIOR DOCTORS IN RURAL SETTINGS TO PROMOTE HIGH QUALITY EDUCATION OUTCOMES

SEMI STRUCTURED INTERVIEW SCHEDULE

To assist Rural Clinical School (RCS) representatives being interviewed for the above project, a short list of questions is provided below. Interviews should take around twenty minutes and will be recorded unless otherwise requested. A transcription of the interview will be provided to participants for their review and feedback to researchers. Themed analysis of the transcripts will be undertaken and no data will be able to be attributed to individual respondents.

QUESTIONS

1. **What involvement does the Rural Clinical School (RCS) currently have in regard to placements undertaken in the community?**

2. **What are the key areas of interface between student and junior doctor community placements?**

3. **What is the preferred role of the RCS in terms of support and contributions to junior doctor training in the community?**

4. **In regard to the above role, what are the chief support requirements for the RCS in terms of:**

    a) **Linkages with existing junior doctor training providers?**

    b) **Coordination of placements and the effective use of placement opportunities?**

    c) **Use of vertical integration in the training experiences of students and junior doctors?**

    d) **Future and / or ongoing support requirements from Government, Learned Colleges, feeder hospitals and universities?**

Thank you for being available to respond to these questions. We look forward to speaking with you in the following weeks.

ATTACHMENT SIX

MEDICAL TRAINING REVIEW PANEL GRANTS (MTRP)

Identification of quality frameworks for rural and remote clinical placements

As part of the 2007-8 MTRP Grants program funded by the Commonwealth Government, ACRRM has been commissioned to inquire about the components necessary to ensure a quality training experience in rural and remote placements and the items necessary for their ongoing support and growth. We invite you to contribute to this research by completing this survey.

ACRRM would value your input and return of the survey by FAX to 07 3105 8299 or my mail to GPO Box 2507, Brisbane 4001 by January 30 2008

1. What do you consider are the 5 main issues that determine a quality training placement in rural and remote Australia?

a)

b)

c)

d)

e)

2. What are the 3 main benefits for students attending a rural clinical placement?

a)

b)

c)

3. What form of preparation do you consider is essential for students prior to their placement?

a)

b)

c)

4. What are the 3 principal challenges to developing and supporting a rural training placement?

a)

b)

c)

5. What support do you currently provide for your supervisors and mentors in terms of:

a) Training

b) Logistical support

c) Payment

d) Links to the University

e) Other

6. Are you currently able to recruit enough training placements to fulfil your student requirements?

YES / NO

7. How do you currently recruit new sites for training?

a)

b)

c)

8. How do you rate the current supply of rural clinical placements to meet demand?

SUFFICIENT MINOR SHORTAGES SERIOUS SHORTFALLS

9. What do you consider are the best strategies for ensuring a future supply of clinical training places?

a)

b)

c)

Thank you for completing the survey. Your responses will contribute to our recommendations for support of rural clinical placements and the maintenance of quality teaching and learning.

If you have further questions, please contact Anna Nichols on 0407 138 972 or at a.nichols@acrrm.org.au