Doctors in Rural Training Policy Position

Policy Position

The Rural Doctors Association of Queensland (RDAQ) asserts that Doctors in Rural Training must be afforded professional, quality education and training opportunities which build upon those received by their city counterparts for the duration of their training across the variety of rural/remote contexts.
Training experiences for Doctors in Rural Training in Queensland must demonstrate clear standardised prioritisation of educational and supervision experiences regardless of location or workforce limitations. These formative training experiences will encourage and promote remote and rural practice and increase the likelihood that a trainee will commit to providing service to that community beyond their training time, thereby strengthening services in rural locations.

RDAQ's position on Doctors in Rural Training supports the endeavours of the Australian College of Rural and Remote Medicine (ACRRM), Royal Australian College of General Practice (RACGP), Queensland Rural Generalist Pathway (QRGP) and the work of Health Workforce Queensland in widening positive rural training opportunities for pre-vocational doctors in Queensland in line with the recently released Australian Medical Council (AMC) national pre-vocational training framework.

Remote and rural medical services in Queensland, should be delivered to individuals and families as close to home as is safe and possible by a collaborative team with strong governance structures.

Remote and rural medical services in Queensland are faced with declining viability, requiring urgent additional incentives and support to ensure ongoing stability and sustainability. Doctors in Rural Training is a key focal point through which positive training, educational and supervision experiences are a key part of laying the foundation to continuing interest and commitment from our trainees in serving the communities they trained in beyond fellowship.

RDAQ identifies key enablers which enhance the training journey of prevocational doctors in rural and remote settings.

Strategies to Address the Unique Challenges in Rural Training for Doctors

RDAQ calls for the following strategies to address challenges for doctors training in rural medicine:

- Ensure access/prioritisation of protected teaching time on rural/remote terms.
- Guarantee continuity of supervision on rural rotations/relieving terms.
- Maximise opportunities for face-to-face training and preparatory workshops.
- Work on future proofing training and workshops in the event of future barriers such as the COVID 19 pandemic to prevent similar disruption in training.
- Provide allocated/rostered study time and exam leave for RG/GP registrars, ensuring parity with city-based speciality training programs.
- Provide adequate support and relief to protect against burnout and mental ill health compounded by demands of workforce shortages.
- Ensure doctors in training have a training journey that provides for their learning needs and overshadowed by workforce demands.
- Ensure Professional Development leave for Doctors In Rural Training is prioritised to meet the trainees learning needs.

The case for acting on these strategies is time critical. The underpinning issues have impacted doctors progressing in rural training to the detriment of their own experiences and workforce outcomes.

Education, training, supervision and access to professional development leave have been identified as vitally important factors in the work satisfaction and retention of rural doctors, who have the right skills and knowledge to best meet the needs of our rural and remote communities.

RDAQ, on behalf of our Doctors in Training Network encourages employers, supervisors, administrators and the colleges to reflect on the educational opportunities currently available within their rural facilities and to take steps to optimise these opportunities and to address any issues arising.

Key Principles

Access to Training

All Doctors in Training, but particularly those who have selected a rural pathway should be able to access rural/remote placements across hospital and primary care contexts throughout their training. Those hospitals who do not currently have rural facilities attached for placements are encouraged to facilitate ties to expand exposure and access to rural/remote training opportunities.

The AMC National Pre-vocational Framework offers an opportunity for rural facilities in collaboration with larger tertiary hospitals to expand their training portfolios and expand training into primary care contexts. The framework clearly outlines expectations in terms of learning outcomes for trainees and the responsibilities of the training facility and supervisors.

Rural training facilities for doctors, need to collect, listen to, reflect and act upon feedback. This can be done via on-going check-ins, collaboration with college and other academic staff, exit surveys, trainee satisfaction audits, and ideally should be de-identified so that trainees feel comfortable providing honest feedback that will not affect their term reports.

RDAQ will continue to offer reflective practice opportunities for all members through their Connect & Reflect Program and continue to provide a forum for Doctors in Rural Training to provide their feedback about collective training experiences, points of difference and opportunities for improvement so these can be raised with relevant stakeholders by RDAQ.

Supervision

Doctors in Training need to feel well supported in their practice, with access to reliable supervision. Localised leadership needs to be foundational with adequate opportunity for reflection, debriefing and in-action learning.
Individual Doctors in Rural Training need observation and support to ensure they are working with healthy boundaries associated with the demands of placement and study. This is a critical responsibility of the rural facility and supervisor, whilst the Doctor develops further skills in managing their time and commitments.

Protected Teaching Time during Rural Placements and Rural Relieving Terms

Prioritisation of protected teaching time on remote and rural placements/relieving terms should be written into the facility roster and ideally include time where phones/pagers are held by an alternative staff member for the duration of the education/training (if applicable). If there is no one on

site that is able to provide the teaching/training then tele-links to alternative educational sources (eg. tertiary hospital grand rounds/intern teaching/EMET etc.) should be arranged to fill this gap.

Localised issues including such things as inadequate and stretched workforce demands, need to be acknowledged and mitigated collaboratively, before and during placements.

Fellowship Training

Doctors undertaking fellowship training in rural/remote locations should be able to access study leave in the lead up to their exams in line with the entitlements afforded to city-based specialty pathway trainees.

Fellowship training for rural/remote medicine currently requires significant commitment/study time outside of rostered work hours and it would be ideal if some of that study time could be incorporated into work time as it currently is with certain specialty training pathways. This would require rostering to allow for allocated study time for registrars similar to that undertaken by most tertiary hospital based specialty training programs.

Professional Development Leave

Wherever possible, Professional Development for Doctors in Rural Training should be prioritised, and barriers to access such leave minimised, to ensure trainees have the same opportunities as their city counterparts and are enabled to gain the best possible skill set in the service of their community.
For this reason, rostering of professional development leave should be included in the total worked hours for the individual pay period. Doctors in Rural Training should not be expected to attend professional development training above and beyond the usual required included hours in a normal pay period.

Strong Workforce

Whilst filling gaps in the inadequate workforce facing many rural medical services provide new and solid training opportunities, care must be afforded to ensure doctors in training are adequately and consistently supervised. Those in training need to feel well supported in their practice, with training as the priority.
Highly skilled multi-disciplinary teams are essential in securing and preserving remote and rural access to health care. A multidisciplinary approach should be fostered, which is continuous and supports best practice care for consumers. Doctors in rural training need opportunities to connect with the wider team including theatre staff, pathology services, medical imaging, registered nurses and extended specialist support.
Doctors in rural training need to be aware of and witness, vocational pathways and associated programs for the maintenance of skills, in order to maintain and develop the standards of the clinical workforce of rural medical services. These pathways and programs must be supported by government, professional colleges and referral specialist centres.

Collaboration

RDAQ will work closely with the Australian College of Rural and Remote Medicine, Royal Australian College of General Practice and Health Workforce Queensland to advocate in alignment with this Policy Statement.