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Medical Board of Australia

To Whom it may concern,

Re: Response to the Medical Board of Australia request for feedback on the application of the RACGP and ACRRM for approval of the Rural Generalist specialty

We are pleased to provide some thoughts in relation to the above application for recognition. This is presented from our perspective working in the Northern Territory in roles to increase the medical training pathways in the NT. The NT is a geographically and culturally diverse region, with a significant population living in remote and rural areas. The delivery of a health service in the NT is very challenging as a result. The experience allows reflection of the importance of the generalist who can provide a breadth of service and work collaboratively with communities and others in the health service to respond effectively to the challenges of the context. The expertise of the generalist is not removed from the need to adapt from one context to the other and to be guided by the professional ability to monitor their limitations.

1.
Has the claim that regulatory action is necessary to recognise Rural Generalist Medicine as a field of specialty practice been substantiated?

It is reasonable that the training required to reach a standard of practice is set and measured. This should recognise the requirement for maintenance of knowledge, skills and competence and that this is regulated appropriately. It is essential that this regulation is guided from the lens of generalism as the foundation, recognizing that the assessment of competence is not measurable in the same way we measure knowledge and skills. Generalists should have a role in validating core aspects of their specialism. Where a set of skills and knowledge overlaps between generalism and specialism, it is reasonable that there be clarity of what these are and how standards are set and maintained. Competence in generalism develops over time and experience and the maintenance of skill occurs with peer review, feedback and reflective professionalism. These may need to be defined differently for each specialty lens.

2.
Have the positive consequences of recognition of Rural Generalist Medicine as a field of specialty practice under the National Law been stated? Are there additional positive consequences that should be considered?

The positive consequences have probably been overstated. To a large extent, the problems that exist are:

- a mal-distribution of workforce and services with a lack of access to health care in rural and remote Australia
- the undeniable socio-geographical context of Australia where the vast majority of the population live in or within a short distance of very large metropolitan centres and a minority is distributed sparsely over a very large area.
- a need for there to be integrated, coordinated care for remote patients that recognises the burden of time and travel to attend diagnostic and management-planning consultations, not just travel to receive treatment.
- a dissatisfaction with conventional rural general practice as a career choice
- a disparity of income between specialists and general practitioners
- an increasing propensity for trainees and specialist and general practice doctors to work part time.

The benefits of identifying a general practitioner as a Rural Generalist should be defined from a patient's point of view and in terms of the value added to health care available in rural and remote areas. This should be related to reducing the burden of disease management which comes from living away from integrated specialist services and not merely the provision of procedural services in those areas.

3.
Have the potentially negative consequences of recognition of Rural Generalist Medicine as a field of specialty practice under the National Law been stated? Are there additional negative consequences that should be considered?

The governance relationship between specialist colleges and the new Rural Generalist Medicine has not been well described. In particular, it appears that it is planned that the two primary care colleges take on the responsibility for setting the scope of practice and skill standards (including those subsets which overlap with other specialist colleges). This has the potential to generate two levels of quality standards for procedures usually undertaken by specific specialists. As well, there is potential for there to be conflicts in the workplace where there is a formal or informal supervisory relationship between a specialist providing services and a Rural Generalist. There may also be tensions between Rural generalist and General Practitioner covering the same roles with appropriate competence and the distinction between salaries may be unwarranted.

4.
Are there specific issues or claims in the application that should be the focus of the AMC assessment of the application?

The recognition of Rural Generalist Medicine and provision of specialist services in areas where these are not well represented may have unintended consequences. It is possible that outreach regional specialists may reduce their service levels and, consequently, an increased, even unsustainable workload fall on rural generalists. This is also likely to have knock-on effects and reduce the quality of training in regional areas.

5.

In the application for the recognition of Rural Generalist Medicine as a new field of specialty practice are there any impacts for patients and consumers, particularly vulnerable members of the community, that have not been considered or need more detailed consideration?

By definition, Rural Generalist Medicine practitioners will have a different scope of practice than specific discipline specialists. Rural and remote practice is characterised by lower case-exposure, a wider variety of presentations and a need for more independent practice. The key service to the community is the expertise of diagnosis from undifferentiated case presentation, with expertise to manage within limitations of individual experience and context. Referral to specific discipline specialty may also be necessary. It is not clear how this is to be addressed. One consequence is that a two-tier quality standard develops. There needs to be continuing consultation and collaboration with all specialist colleges to enable the Rural Generalist to be the point through which patient care is managed so that the complexity of medical, social and family geography is understood. Sometimes the individual care requires specific expertise that would be referred to specific discipline specialist.

6.
In the application for the recognition of Rural Generalist Medicine as a new field of specialty practice, are there any impacts for Aboriginal and/or Torres Strait Islander People that have not been considered or need more detailed consideration?

As First Nations people are disproportionally represented in rural and remote areas of Australia, they are consequently more likely to experience the specialist care from Rural Generalists. This outcome needs to be considered in terms of training.

7.
Are there specific stakeholder groups that should be consulted further as the application is assessed and what would they add to understanding of the application? (please see Attachment B for the stakeholder groups for this consultation)

“Stakeholders” affected by this proposal are those who provide services in rural and remote Australia. These doctors may be less engaged across multiple college committees and other national bodies, and at present are more likely to have been trained abroad. They are therefore less likely to take part in stakeholder consultations such as this one. An active process is required, otherwise there is a risk of this development being driven by those with vested interests and particular enthusiasm.

8.
What are the interactions now between Rural Generalists and other medical and health practitioners including other General Practitioners? How are these likely to change if Rural Generalist Medicine is recognised as a field of specialty practice?

RG in regional hospitals working with specific discipline specialists.
There is a relatively large number of Rural Generalists who provide anaesthetic services at regional hospitals. There is a smaller number of those who work in Emergency

Departments, Obstetrics and Gynaecology and an even smaller number who are GP surgeons. Many have been trained in rural hospitals and may have transferred from specialist training pathways in Australia and abroad. Most work under direct or indirect supervision of specific discipline specialists and, in many ways, fulfil the role of a middle grade or senior registrar in the field. For this reason, although they reduce the intensity of on-call and emergency work they do not reduce the frequency and may, in some cases, increase it. Anecdotally, increasing involvement in providing part-time, hospital-based specialist services, reduces the availability of the doctors to work in primary care. The point of Rural Generalism is to match the medical needs of patients who are rurally-based to practical service delivery. This is not the role of a senior registrar equivalent but the tailored rural generalist who ensures comprehensive management of the patient's presentation with specific skills for management that are required for a rural context. A specialist skill should be complementary to the specialist knowledge and skills needed for primary care in this context, not a substitute for an absence of specialist procedural skills.

9.
Your views on how the recognition of Rural Generalist Medicine will impact on the following:

• disincentives/incentives for General Practitioners to undertake rural practice resulting from additional training requirements

• unnecessary deskilling or restrictions in the scope of practice of other practitioners who practise in rural environments.

No comment.

10. Have all economic impacts for governments, businesses and consumers been identified? Should further economic analysis be undertaken during the AMC assessment to assess the claims of minimal costs impact of recognition, and if yes, what should be the focus of the analysis?

It is unlikely that the full impact of a change to recognition of Rural Generalist Medicine can be predicted. Perhaps, the most likely one is that pressure for specialist colleges to genuinely address the mal-distribution of services will be reduced without justification. The danger is that the real need to develop the complex set of skills required to provide high-quality primary care designed for rural and remote communities is neglected as attention is placed on procedural skills. Funding that becomes focused on remuneration for procedures should not distract from a recognition of the added value of that a Rural Generalist brings to a consultation - but it may.
The discussion should be driven by the primary need for a generalist skills-set in a community to address greater scope of diagnosis and informed management planning (shared decision making in particular). Specific discipline specialists are also important and may be visiting at regular intervals to assist at more complex diagnostic or management decisions. The specific specialist also offers support online and patient care improves with a better coordination of access to the expertise needed.

Yours sincerely,

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