Submission to Queensland Health: August 2012

Evaluation of the Queensland Rural Generalist Program

The Australasian College for Emergency Medicine (ACEM – the College) welcomes the opportunity to provide comment to Queensland Health regarding our views on the Queensland Rural Generalist Program (QRGP), as input to the current evaluation of this program.

ACEM is a not-for-profit institution whose prime objective is the training and credentialing of medical specialists in the practice of emergency medicine in Australia and New Zealand. The College has a vital interest in improving the quality of training and clinical supervision while ensuring the highest standards of emergency medical care are maintained for all patients across Australasia, including in regional, rural and remote locations.

ACEM understands that the QRGP was established and funded by Queensland Health as a strategy to ensure a future supply of rural doctors able to meet the Queensland’s workforce and clinical service needs. In context of QRGP a ‘rural generalist’ - while typically referring to a rural located doctor providing a broad range of services including specialised services such as emergency medicine, obstetrics, or anaesthesia - has a specific meaning and implications within Queensland Health, according to the Roma Agreement. In particular, Queensland Health has introduced the concept of a Senior Medical Officer (Rural Generalist), as an industrially defined ‘specialist’ classification, which has a remuneration advantage in a subset of hospital positions in rural Queensland hospitals.

In considering the merits of the QRGP, ACEM strongly supports the general principle of high-quality training pathways and practice incentives to meet the primary and secondary care needs in rural and remote communities. In advocating for sustainable solutions to the current medical workforce shortages in these regions, ACEM is particularly keen to ensure the quality and safety of clinical care provided to patients is of high standard regardless of location. In terms of the current evaluation of the QRGP, comments provided by ACEM relate primarily to the discipline ‘Rural Generalist Emergency Medicine’, rather than to any of the other ‘rural generalist’ disciplines.

While unreservedly supporting the spread of specialist emergency medical services to regional and rural areas, ACEM acknowledges the valuable role played in the provision of emergency care in these locations by doctors who are not Fellows of ACEM (FACEMs). Furthermore, where remote communities may not be able to sustain full-time FACEMs, the College contends that doctors in such areas should have access to advice, educational opportunities and clinical support from FACEMs within their rural emergency medicine network.

ACEM believes that appropriate advanced training and credentialing is required for non-specialists (general practitioners and rural generalists) who undertake aspects of emergency medicine practice. Emergency medicine is somewhat unique in that, no matter the location - from a remote nursing outpost to a major metropolitan referral hospital - any medical condition can present, at any time,

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and the general public has a reasonable expectation that appropriate high standards of care and treatment will be immediately available. In rural and remote settings this can be particularly challenging as medical practitioners attempt to deliver a high standard of emergency medical care, to meet the immediate patient care needs, often with limited resources and with back-up being a distant flight away. In this context, inexperienced practitioners or practitioners with limited scopes of practice are arguably inadequate to meet the broad range of acute patient care needs in these settings. Practitioners must develop, and commit to ongoing maintenance of, emergency medicine knowledge and skills as a fundamental for the provision of optimal and safe care to the community.

ACEM acknowledges that the establishment of the rural generalist classification through the QRGP was driven by workforce needs in rural Queensland. At present, Senior Medical Officer (Rural Generalist) (Emergency Medicine) positions with Queensland Health require competence and capability in primary rural medical practice, particularly hospital based practice – demonstrated through Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) or Fellowship in Advanced Rural General Practice (FARGP)/Graduate Diploma in Rural General Practice (Grad Dip Rural) of the Royal Australian College of General Practitioners – along with successful completion of advanced skills training in Emergency Medicine.

ACEM would expect that any program of advanced skills training in emergency medicine must involve

- a formalised curriculum,
- a transparent process of supervised clinical training,
- demonstration of clinical competency and formal credentialing, and
- formalised continuing professional developments program.

ACEM is aware that the Generalist Emergency Medicine (GEM) post-Fellowship program offered by the Australian College of Rural and Remote Medicine (ACRRM) is recognised as ‘specialist qualification’ in terms of salary classification within Queensland Health facilities. While individual FACEMs may have assisted ACRRM in developing the GEM curriculum, ACEM has not been asked to formally review, nor has the College endorsed, this training program. In addition ACEM, despite its recognised role in training and standard setting in the practice of emergency medicine, has not subsequently been approached to nominate FACEMs, or provide any other advice or support, for the provision of clinical training or assessment of trainees undertaking the GEM program.

Furthermore, ACRRM Fellows who were determined, through a ‘grandfathering’ process, to have sufficient emergency medicine experience were initially awarded the GEM qualification. ACEM has significant concerns regarding the rigour and transparency of this process for recognition of prior experience, which was based on interview only with no apparent requirement to demonstrate or verify clinical competency in terms of emergency medicine practice. This is a vital patient safety issue in terms of practitioner competency to deliver appropriate, high-quality clinical care. An associated issue with this grandfathering process was back-pay (accrued from 2006) salary incentives offered by Queensland Health to candidates awarded the GEM qualification. A resultant distortion has been observed in that some recently qualified FACEMs applied for, and successfully achieved, GEM status in order to receive this back-pay. This clearly did not result in any expansion to the emergency medicine workforce.

Therefore, ACEM is concerned that the credentialing process for the ‘rural generalists in emergency medicine’, through the QRGP, may have been less robust than would be expected for doctors who are expected to be working independently in emergency medicine. ACEM considers that is a fundamental flaw that doctors in one discipline (general practice) are able to assess and credential the expertise of a doctor seeking to practice in another discipline (emergency medicine). ACEM contends that a candidate applying for recognition of competency in emergency medicine practice
should be assessed by an ACEM-appointed emergency medicine panel, not a general practitioner panel.

ACEM contends that, as the relevant specialist college, it has an important collaborative role in establishing the standards of training and criteria by which trainees are assessed in advanced skills in emergency medicine, through the QRGP. This is consistent with the principles of the Roma Agreement, in particular:

“iii. The educational standards of the training program will be set externally by the appropriate College.”

The College strongly asserts that completion of advanced skills training in emergency medicine (or any other specialty discipline) associated with the QRGP cannot be considered equivalent or near-equivalent to a specialist level qualification in that discipline (e.g. FACEM). Furthermore, ACEM considers that advanced skills training in emergency medicine for rural doctors is best met through the ACEM Emergency Medicine Certificate and Emergency Medicine Diploma programs. These programs have been specifically developed for generalist medical officers and general practitioners, who do not want to pursue a specialist Fellowship training pathway, to obtain high-quality advanced training in emergency medicine. Therefore these Certificate and Diploma programs administered by the ACEM, as the appropriate credentialing body for emergency medicine, should represent the expected minimum standard of training for any rural generalist practising in this discipline.

The Emergency Medicine Certificate, a program of at least six months supervised clinical practice in an approved emergency department, provides participants with a broad range of knowledge and skills for basic emergency medicine practice, beyond the junior post-graduate experience (i.e. candidates are required to be PGY3 or greater to be eligible to undertake the Certificate program). The Emergency Medicine Diploma requires a further twelve months of supervised training in an approved emergency department along with additional anaesthetics training and/or intensive care training, builds on the skills gained in the Certificate and provides more advanced knowledge in the areas of leadership, management, teaching and the clinical practice of emergency medicine. Both these Certificate and Diploma programs include workplace-based and online learning modules, participant e-portfolio requirements, attendance at external workshops (Emergency Life Support course for Certificate / Advanced Paediatric Life Support and Early Management of Severe Trauma courses for Diploma) and formal assessment processes. ACEM is pleased to note that the Certificate and Diploma programs have had a successful uptake in Queensland. In 2011, 16 candidates commenced the Certificate program and a further 10 candidates have enrolled, as at September 2012. Also one candidate has enrolled in the Diploma program, which was introduced in 2012.

As FACEMs currently provide significant support and training to the emergency medicine workforce, the College sees its Certificate and Diploma programs as an opportunity to support and significantly enhance current arrangements, whilst providing specific training for the trainers, standardised course content and assessment processes, and ongoing co-ordination and resource development. The College’s longer term approach to sustainability of these programs is to enable and encourage Emergency Medicine Diploma graduates to undertake supervisor training and subsequently supervise the Certificate and Diploma programs in approved emergency departments. ACEM also welcomes those who have completed both the Certificate and Diploma into the College as Associate Members and this provides them with the opportunity to take part in the ACEM Continuing Professional Development (CPD) program. ACEM maintains that all rural generalists who undertake extended-scope service provision should be required to participate in a CPD program relevant to the

3 Queensland Health (2007) A brief history of the rural generalist pathway
discipline in which they are practising. For Senior Medical Officer (Rural Generalist) (Emergency Medicine), ACEM has a well-established non-specialist doctor CPD program\textsuperscript{5} suitable for this purpose.

A number of regional and rural emergency departments across Australia have been approved by ACEM to deliver the Certificate and Diploma programs, and training has been provided to clinical supervisors in these departments. ACEM has also developed e-learning resources to complement the supervised workplace-based training experience. In addition, with Federal Government support, 20 Emergency Medicine Education Officers are being installed in outer metropolitan and regional hospitals to provide a network of support for these Certificate and Diploma training programs. At present, there is capacity to up-skill around 400 non-specialist doctors per annum, across Australia, through the Certificate and Diploma programs supported through 23 training network hubs, seven of which are located in Queensland.

ACEM, while supportive of incentives to promote and support rural practice, is concerned that salary structures associated with the QRGP may have resulted in unintended distortions and inequities in medical workforce remuneration. Incentive payments should be structured and targeted so as to avoid the situation where recipients are routinely working side-by-side with other doctors who are not receiving incentives but are undertaking similar types of clinical work. This may occur, particularly in larger rural towns and regional cities, if appropriate service-based and patient-based targeting mechanisms are not developed. In terms of emergency medicine, ACEM is aware of generalists working in Senior Medical Officer (Rural Generalist) (Emergency Medicine) salaried positions in urban (outer metropolitan Brisbane) and some regional areas\textsuperscript{6} alongside specialist emergency physicians (FACEMs). These generalist doctors are receiving significant salary incentives in settings where there is ample specialist (FACEM) support. This anomaly is clearly at odds with the intended aims of QRGP in addressing rural and remote service delivery and workforce issues, according to the stated goals described in the Roma Agreement, in particular:

\textit{“c) The training program has a jurisdictional focus – supplying rural generalist to both public and private sectors of the bush”}\textsuperscript{7}.

If doctors are to receive salary incentives as ‘rural generalists’, then one precondition must be that they are not paid at this higher level when practicing in an urban area or region where there is an adequate specialist or vocational trainee workforce.

The stated goals of the QRGP, to provide well-trained rural generalists to undertake extended-scope service provision in rural and regional areas of Queensland, clearly should be implemented. The future of health in the non-metropolitan areas of the state will rely on rural generalists working collaboratively with, and with appropriate levels of support from, specialists. ACEM believes that network models provide an efficient and effective mechanism to develop collaboration between emergency medicine specialists and rural generalists, ensure appropriate clinical governance, and promote quality patient care in rural settings. A ‘hub and spoke’-type of approach operating from Bundaberg Hospital is one example of such a model. The implementation is successful, not necessarily due to the QRGP but, because of rigorous training, supervision and credentialing offered by the FACEM team in Bundaberg and the ongoing support and networking relationships provided to the rural generalists working in this region.

\textsuperscript{5} Continuing Professional Development for Non-Specialist Doctors Working in Emergency Departments (CPDNSD) Overview \url{http://acem.org.au/education.aspx?docId=91}


Another important factor contributing to the successful implementation of network models is the support Queensland Health has provided to their FACEM specialist workforce, in terms of improved recruitment and retention mechanisms. The resulting increased emergency medicine specialist numbers have enabled the accreditation of many rural and regional emergency departments for ACEM training for the next generation of emergency specialists in Queensland, along with increased capacity for supervisory support to generalists training through the ACEM Certificate and Diploma programs.

Both generalist and specialist should be rigorously and reputably trained and assessed by the appropriate college according to their practice discipline area. ACEM supports high-quality reputable processes for training and credentialing, with the ACEM Certificate and Diploma programs providing the benchmark standard, for generalists wanting to practice in emergency medicine. ACEM recommends that Queensland Health consider a more comprehensive and well-resourced approach to developing rural emergency care networks that will improve clinical governance and quality of patient care by facilitating emergency medicine specialist input to the training, clinical support and ongoing credentialing of their rural generalist colleagues. This will ensure that the highest standard of emergency medical care is available to all Australians, regardless of presenting condition or location.

Thank you again for the opportunity to provide comments on the Queensland Rural Generalist Program, as input to the current evaluation of this program. If you require any clarification or further information please do not hesitate to contact the ACEM Director of Policy and Research, Dr Andrew Gosbell (03 9320 0444 or andrew.gosbell@acem.org.au).

Kind regards

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