

Rural generalism: the New Zealand way.

Address for the Eric Elder Medal.

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It is possible that many general practitioners (GPs) are unaware that The Royal New Zealand College of General Practitioners (RNZCGP, the College) is home to two, not one, distinct scopes of medical practice and that it administers two separate training programmes; but interestingly, only one Maintenance of Professional Standards (MOPS) programme. And, despite the fact that the College as a whole is oriented to primary and community care, the second scope is oriented to hospital care.

I want to explain what is special and unique about this arrangement and why it is important not only for rural health care in New Zealand, but for medical generalism and the RNZCGP as a whole.

The second scope is Rural Hospital Medicine (RHM), and in 2018, it is 10 years since it received New Zealand Medical Council recognition. At its 2017 conference, the College awarded Fellowships to recent graduates of the RHM training programme and the first Distinguished Fellowship in RHM. It's fitting that this was awarded to James Reid. James has worked tirelessly for the Division of Rural Hospital Medicine since its inception. He is an exceptional collaborator and relationship builder and personifies the skills behind the success of the RNZCGP Division of RHM. It is also important to acknowledge the work of the other partners in this relationship, the wider College; in particular, its leaders Tim Malloy and Helen Morgan-Banda and their teams.

The concept of rural generalism is well established internationally and is seen as the cornerstone of rural medical practice. Rural generalism is defined as a broad scope of medical care in the rural context that encompasses primary, emergency and hospital-based care, as well as

advanced skill sets, a population health approach and team work (Box 1).¹ In Australia, the concept has helped justify a separate rural college and universities with a rural focus. But it seems to me it can equally be used to ensure rural inpatient and emergency care, as well as a range of advanced skill sets, remain firmly within the Royal New Zealand College of General Practitioners.

Although developed in Australia and moulded by the Canadians, the concept of rural generalism is relevant to New Zealand. We have, by any standards, a very dispersed population, and the sustainability of specialist models of care is questionable not only in our rural hospitals, but in an increasing number of provincial hospitals.²

Rural health data are not routinely collected in New Zealand, and there is no agreed definition of 'rural' for the purposes of health policy and research. This is a major barrier to identifying and overcoming the large rural vs. urban inequalities in access to services that those of us working in rural health know our patients face.³ It also makes it difficult to evaluate rural health services. We can only make inferences from the data about the importance of rural generalist medicine in New Zealand.

One source is the ANZACs QI (All New Zealand Acute Coronary Syndrome Quality Improvement) database that collects data on all hospital admissions for acute coronary syndromes.⁴ From this, we can tell that approximately one-third of all patients who are admitted to hospital with a heart attack in the Southern District Health Board (DHB) region are managed, at least initially, in a rural hospital by a rural generalist doctor. The same figures will likely apply to admissions for pneumonia, fracture reductions, croup, non-operative surgical problems like diverticulitis or pancreatitis, or end-of-life care, patients needing

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non-invasive ventilation or even fully ventilated patients for prolonged periods when transport links are cut off by weather. A significant proportion of the work that in urban areas is described as 'secondary care', is being managed by generalist doctors in rural New Zealand.

In 1995, General Practice gained recognition as a vocational scope, which was an important step but it feels as if the deal struck with our specialist colleagues was that general practice would stop at the hospital door. Rural GPs, many of whom had hospital appointments, expressed concern at narrowing the scope of rural general practice.^{5,6} At the same time, many rural hospitals were losing their specialist workforce.

It is not surprising that by 2005 the rural hospital medical workforce was in a state of crisis. One-third of positions were vacant, less than one-third were filled by New Zealand graduates and turnover exceeded 50% every 2 years. Seventy-five percent of rural hospital managers described the workforce shortage as 'critical'. There was no professional body or agreed standards of training and minimal clinical leadership.⁷

The first positive initiative came from the University of Otago. With typical foresight, Pat Farry had, along with Martyn Williamson, established the Postgraduate Diploma in Rural and Provincial Hospital Practice in 2002.⁸ For the first time, those of us working in rural hospitals, rural GPs and hospital medical officers, came together to learn and to examine critically our practice and the rural health services we worked in. The resulting community formed the Rural Hospital Doctors Working Party in 2005 and by 2008 the Medical Council had recognised the new rural scope of practice, the Division of RHM formed within the RNZCGP and Health Workforce New Zealand was funding the first registrars on the new training programme.⁸ This process moved much faster than it had for other new vocational scopes, aided by a recognition in all parts of the sector that there was an urgent need for action.

This University programme has continued and now forms the academic component of the training programme that is outlined in Box 2. The

result is a unique partnership between a University and Medical College. These institutions are not always natural partners, but much can be achieved when they work together to solve rural workforce issues.

The RHM academic programme is also unusual by university standards and has tested the accepted norms of the parent institution. The faculty is widely dispersed across rural New Zealand and actively involved in rural clinical practice, ensuring the programme is credible and relevant. The

Box 1. Rural generalist medicine definition¹

'Rural Generalist Medicine' is defined as the provision of a broad scope of medical care by a doctor in the rural context that encompasses the following:

- Comprehensive primary care for individuals, families and communities;
- Hospital in-patient and/or related secondary medical care in the institutional, home or ambulatory setting;
- Emergency care;
- Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues;
- A population health approach that is relevant to the community;
- Working as part of a multi-professional and multidisciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs.

Box 2. Components of the dual GP and rural hospital medicine training pathway for a typical trainee⁹

Two years of postgraduate base hospital attachments before entry into the training programme	
Training attachments	Academic components
Supervised (rural) GP training – 1 year (GPEP1) Additional unsupervised GP – 6 months	GPEP 1 seminar – 40 days
Hospital attachments at registrar level Internal medicine* 6 months Emergency medicine* 6 months Paediatrics* 3 months Anaesthetics or Intensive Care* 3 months Rural Hospital attachments 2 × 6 months attachments Advanced skill/elective training 6 months to 1 year	Postgraduate diploma in rural and provincial hospital practice Papers: • Rural Context • Communication • Medical Specialties • Surgical Specialties • Obstetrics and gynaecology and Paediatrics • Cardiology and Respiratory Medicine • Emergency Medicine
*Based on prior experience, many trainees may be granted recognition of prior learning for some of these attachments. This allows them to dedicate more than the minimum time to other attachments, including the acquisition of advanced skill sets.	Early Management of Severe Trauma Course Advanced Paediatric Life Support Course Advanced Cardiac Life Support Course (NZRC level 7).

administrators are also rurally based, currently in the Hokianga and Central Otago, leaving the programme with no presence on a main campus. Use is made of modern distance teaching technology including an online learning platform and video-conferencing. But the residential workshops, one per paper, remain a crucial part of the programme, providing the few opportunities the registrars have to engage with their peers face-to-face. These workshops are increasingly being held in rural communities. Most of the teaching is case-based and now includes high-fidelity simulation and other activities shown in Box 2.⁹

Many rural hospitals are still struggling to find staff, but progress is being made. By 2015, the vacancy rate had fallen to only 6% and only one-quarter of rural hospital managers described the medical workforce shortage as 'critical'.¹⁰

What has occurred within the RNZCGP is innovative and we should be proud of it, but the stakes are now higher. There is a group of young doctors investing their careers, and communities their health services, in this model. One party in this partnership is much larger than the other. There is no shortage of issues in general practice as a whole to occupy the RNZCGP, and it will be hard to keep in mind the needs of a relatively small group at one end of the generalist spectrum. It will be both important to include them in the wider College but at the same time ensure they remain empowered to solve their particular issues.

Seventy-five per cent of RHM registrars are undertaking dual training, enrolled in the RHM and GP training programmes concurrently. This important group of doctors are our future rural generalists. Considerable progress has been made in aligning the two programmes, but there is room to further streamline dual training – a single point of entry, reduced compliance and aligned assessment – in order to reduce costs and save time for all involved. The lessons learned in integrating RHM into the College may have relevance to other generalist scopes, including rural general practice.

It is easy for the public to think, particularly with the current debate in rural health education, that

rural doctors are produced by medical schools, when in fact we know that on graduation they are only half way there. There are three proven strategies for increasing the uptake of rural careers. The first is selecting students of rural origin, the second is quality exposure to rural health care in the undergraduate years but the third, targeted rural postgraduate pathways, may be the most important.¹¹ There is on-going discussion within the College around this important issue. GPs will continue to shy away from rural practice unless they feel equipped to face the challenges it presents. This needs to be achieved in an integrated and flexible manner that encourages generalist doctors of the future to move between urban and rural general practice and rural hospital practice in a supported way.

We have avoided a separate rural College in New Zealand, but have seen the creation of a separate urban-based College of Urgent Care.

Medical generalism is a broad church and we are beyond the point where one person can be expected to maintain the skills to be competent in every aspect of it at any given point in their career. The risk then is creating an array of separate and linear, but frequently parallel, training pathways. If we are to hold generalist medicine together, we need a different approach. We need to acknowledge and value the breadth, but view it as a spectrum, not a series of isolated boxes. We need to create pathways that facilitate, rather than become a barrier to, movement within this broad scope; pathways that are flexible and modular; that teach the skills and knowledge needed to practice competently in different parts of the generalist spectrum at different times in a generalist's career but don't force doctors to relearn what they already know.

The College is the natural home of medical generalism in New Zealand. The process of incorporating rural hospital medicine into the College has strengthened its ability to fulfil this role.

Personal note

The Eric Elder medal has personal significance. I undertook my 5-week fifth year GP attachment with the gentleman doctor from Tuatapere in

the mid 1980s. Dr Elder was by that time quite elderly and I was one of the last students to work with him. It was easily the most formative attachment of my undergraduate years. I was struck by his clinical skills and his relationship with the Western Southland community. The patients revelled in the stories they had collected about him over the years. He left me in no doubt that the greatest privilege of all is to serve the community you are a part of.

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