5 Rural Clinical Schools Program

5.1 Introduction

This chapter presents information regarding the national RCS Program, including:

- the establishment of the national Program, and the various medical education models which have emerged;
- a review of the achievement of Program objectives;
- the impact of the Program on national rural health workforce capacity;
- the effectiveness and future role of the Program; and
- enabling and limiting factors contributing to the Program’s achievements to date.

5.2 Background

The Rural Clinical Schools (RCS) Program was launched in 2000 to enable medical students to undertake extended blocks of their clinical training in regional areas. It differs from other, pre-existing regional medical training placement programs (e.g. the Rural Undergraduate Support and Coordination Program and the John Flynn Placement Program) because of its scale and scope: rural clinical schools are charged with delivering significant components of the medical curriculum in a rural environment, and are an integral structure within the host university medical school, with students undertaking a year or more of their medical training in a rural location. The RCS Program complements other placement programs which provide students with short-term opportunities to experience rural medical practice, and in many instances students who have undertaken short-term placements have been inspired to apply to an RCS for part of their training. The development of the Rural Clinical Schools Program has allowed construction and furnishing of teaching and learning facilities and student accommodation in dozens of rural and regional locations across Australia.

In broad terms, rural clinical schools exist to:

- encourage medical students (and medical professionals) to take up a career in rural practice;
- encourage rural health professionals to take up academic positions;
- improve the range of rural health care services in rural communities across Australia; and
- strengthen the health workforce in rural communities across Australia.

A model for these initiatives was first provided by the UNSW School of Rural Health, which established a campus at Wagga Wagga Base Hospital in 1999. The Flinders University RCS has also become recognised as a pioneer in community-based medical education in Australia, and has developed a model that has been adopted up by other schools in Australasia and ‘across the Western world’ (Wing, 2007: 344).

Of the 14 rural clinical schools across Australia, 10 were established between 2000-2001 and another four were launched in 2006-2007. This second round of RCS funding (including additional funding for the older RCSs) occurred in the wake of the 2006 announcement from COAG that 25% of all Commonwealth-funded medical students are to undertake at least one year of their clinical training in rural and regional communities. This decision recognised the influence of rural exposure during medical training upon students’ decisions to undertake rural medical practice. A majority of medical schools in Australia are now in receipt of RCS funding.
The Department’s *Parameters for Funding Rural Clinical Schools* are as follows (emphasis added):

- **Minimum student numbers** are to be met, based on 25% of DEEWR-funded places undertaking one year or more of their rural clinical training in a rural area (RRMA 3-7);
- Students are to be provided with a **range of experience** consistent with Australian Medical Council requirements for medical curriculum;
- Universities are to recruit and appoint **staff who (will) live and work locally**, including a full time coordinator, academics and administrative staff;\(^{27}\)
- **A maximum of 5% of the budget is to be utilised in the capital city**, unless otherwise approved by the Department;
- Universities are to engage and maintain **links with their local community/ies**. This includes organisation and chairing of a Community Advisory Board that comprises a broad range of representatives from the local community and government service delivery agencies;
- Universities are to work collaboratively with the local community, the state health department and other local tertiary institutions to **maximise the utilisation of local facilities and expertise** (e.g. student accommodation, travel and information technology resources);
- Universities are to maintain close **liaison with the Department about ongoing needs** regarding information technology, telecommunications, accommodation and infrastructure;
- Universities are to develop **transparent internal evaluation mechanisms** that will support external evaluation processes; and
- Universities are to endeavour to progress the rural health agenda (including research) within the medical faculty, other relevant health faculties and university departments to maximise the **efficient use of resources across rural health programs** (including RUSC and UDRH).

In general terms, medical degrees\(^ {28}\) commence with ‘pre-clinical education’ (e.g. anatomy, physiology) and then progress to ‘clinical education’, during which students see patients and medicine in practice. As students progress through their degree, they become increasingly involved in practical medicine – both in hospital and community settings – e.g., taking a patient’s history and undertaking a physical examination, administering injections and assisting in medical procedures.

The traditional model of clinical medical education (still dominant in metropolitan settings) is for medical students to undertake consecutive terms that each cover a certain field of clinical practice (e.g. 6 weeks in the paediatrics ward, followed by 6 weeks in general practice, then 6 weeks back in hospital on a general surgery rotation).

Rural clinical schools have developed a number of alternative models for clinical education – divergent from the traditional model described above, and also different from each other.

Many of those that operate in large regional centres have retained a hospital-based approach but, in a departure from the traditional model, provide what the *University of New South Wales RCS* describes as an ‘integrated teaching program’ of patient-centred learning:

> ‘Students work closely with several patients, following them through their treatment and closely observing and participating in total patient care, and gaining a holistic view of medicine. The Year 5 curriculum in paediatrics, obstetrics and gynaecology, psychiatry and community medicine is integrated into two semesters rather than distinct terms. This allows students to be attached to, for instance, a woman in the late stages of pregnancy, to

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\(^{27}\) If it is not possible to appoint a coordinator who lives and works in the region, universities are to appoint a senior academic who lives and works locally.

\(^{28}\) Medical degrees in Australia have been changing over the past decade, with ten medical schools now providing four-year graduate entry programs, and 12 maintaining traditional six-year undergraduate entry programs.
Essentially, this integrated teaching program means that rather than having separate clinical disciplines taught in separate blocks of six or twelve week terms, the disciplines are integrated across the entire year’s curriculum. This model of medical education is reportedly better suited to the health workforce dynamics of regional centres, where specialists on the wards are often visiting medical officers (rather than hospital staff) and sometimes work only part time. The model also accommodates the lower incidence of certain patient presentations in regional areas – i.e. six weeks may be too short a time period to provide a sufficient variety of cases in a field of clinical specialty.

A further diversion from the traditional model is for students to undertake this integrated clinical education based in community settings rather than hospital settings. This model originated from Flinders University, and is sometimes referred to as the ‘Riverland model’ after the area in which it was developed (in the late 1990s):

‘The PRCC (Parallel Rural Community Curriculum) students who move to the … regions for the academic year are based in General Practice and local health services to prepare for the [Year 3] exams.

‘Through the year the students must learn all of their medicine, surgery, paediatrics, obstetrics and gynaecology, general practice and psychiatry in exactly the same way as students based at Flinders Medical Centre. However instead of rotating through a sequence of discrete terms (medicine, surgery, etc) as their city-based peers do, the PRCC students learn these disciplines in an integrated way throughout the year. Although students are allocated to a specific general practice and have a GP Supervisor, the year itself is NOT only a general practice experience.

‘Students are expected to attend clinical activities related to all medical domains. They will encounter patients in the general practices to which they are attached and then follow them through primary care and the hospital system. At the end of the year the PRCC students sit exactly the same exams as their FMC-based colleagues in all clinical domains.”

There are variations of the above two models, and some RCSs run hospital- or community-based models in different locations, depending on the health service infrastructure available. The RCS in Western Australia has developed its own framework, called the Clinical Learning Embedded in Rural Communities (CLERC) program.

‘The students’ clinical placements occur in General Practices, local Hospitals, Community and remote Clinics, Aboriginal Medical Services and other health facilities. The [10] sites are heterogeneous in many respects, and accordingly are granted significant autonomy in the delivery of the program…

‘The content (and outcome) of the curriculum is identical to the urban curriculum, but it is delivered in a significantly different way. The students are taught and assessed (examined) to the same standard as the urban students and the results are entirely comparable to the urban programme.”

James Cook University (JCU), the University of Newcastle and the University of Wollongong are the only three RCS-funded universities whose main campuses are located outside of capital cities. All three universities have a regional focus across their entire medicine program, so from a student perspective there is little (if any) distinction drawn between clinical terms made possible by the RCS Program and those that would have been available otherwise. While to date the University of Newcastle’s approach

29 rcs.med.unsw.edu.au/ - emphasis added
30 som.flinders.edu.au/FUSA/GP-Evidence/rural/
31 www.rcs.uwa.edu.au
has been similar to an urban-based program, with the focus on metropolitan hospitals, the introduction of its Joint Medical Program with the University of New England at Armidale will mean a significant proportion of students will spend most of their undergraduate time in a rural area.

For James Cook University, the RCS can be considered as:

‘...the distributed rural clinical teaching infrastructure that supports longer rural and remote clinical teaching across Years 4-6 of the course. This includes 8-week rural attachments in Years 4 and 6 for all students as well as Years 5 and 6 for the group of students based at Mackay and Cairns.’

JCU has developed a model with a particular emphasis on regionalised community capacity building, partnerships and infrastructure delivery across sites.

For the University of Wollongong, the RCS activity is even more seamless – all students will undertake extended rural placements and do their third year clinical training through what the university calls ‘Community-Based Medical Education’ (based on the Riverland model).

Most RCSs have their ‘head office’ at one of the RCS training sites off the main university campus. However, UNSW and the Australian National University (ANU) are two universities that have an RCS ‘campus’ at their base location, in Sydney and Canberra respectively. For UNSW this is a function of history: the ‘Kensington office’ of the RCS is the former Rural Health Unit of the School of Community Medicine, which predated both the UDRH and RCS Programs. Among other things, this small office administers special entry programs and coordinates RUSC-funded student services; the UNSW RCS ‘head office’ is located at the Wagga Wagga RCS.

The plurality of models evident between (and within) RCSs demonstrates a strength of the Program’s administration by the Department, as RCSs have been free to design and deliver programs that utilise the capacity of the health services in their region (hospital and otherwise) to provide the range of clinical experience required by their university’s medical curriculum (see Program parameter 2 on page 61).

While the expansion of clinical education into ‘alternative teaching settings’ has been enabled in rural settings by the RCS Program, there has been no such funding program available for metropolitan clinical schools. As a result, rural clinical schools are at the forefront of this developing area of medical education. This has been recognised by many within the university environment, leading to some suggestions by consultation participants that medical schools could also develop alternative teaching settings in urban and suburban locations.

This evaluation has found no evidence to promote any particular model as ‘better’ than any other, in terms of educational or workforce outcomes. Each university (and its RCS) has placed an explicit focus on the quality of the educational experience provided to students; this is regarded by RCSs as fundamental to their raison d’être, and is not an area where RCSs would (or would be allowed by their university to) cut corners. Indeed, the diversity across the RCS Program is considered to be a strength in modelling the diversity of clinical practice in rural environments while at the same time demonstrating the quality of care, and thus training opportunities, provided in such environments. This demonstration that clinical medicine can successfully be taught in rural Australia is considered by some to be the greatest achievement of the RCS Program to date.

‘[The founders] had a vision to say there are GPs out there who can teach everything a 5th year needs to know.’ (RCS Head)
5.3 Achievement of Program objectives

5.3.1 Overview of the achievement of Program parameters

Overall, the RCSs have delivered convincingly when measured against the Program parameters, and in many cases are exceeding the requirements.

The first few years of an RCS’s operation require a significant amount of ‘gearing up’ – construction and/or refitting of buildings, development of local teaching contacts, design of programs, establishment of training places, and development of relationships with the local community. As a result, some of the recently-launched RCSs are yet to operate to their intended capacity in terms of student numbers.

The more established RCSs now have a demonstrable track record, and derive considerable satisfaction from their achievements. Most are particularly proud of the quality of medical education provided to students, which they argue is the same or better than the quality of medical education available in metropolitan clinical schools. RCSs demonstrate this through a range of measures, including:

- strong academic results for RCS students (who in most universities sit the same exams as their city-based peers);
- positive responses from students, who speak highly of the individual attention they receive from senior clinicians in hospitals and other teaching settings, and contrast this to being ‘three rows back, and the consultant wouldn’t even know your name’ in metropolitan teaching hospitals; and
- increasing demand for RCS places, which the Schools regard as a consequence of the above.

As a result, some established RCSs routinely exceed the 25% requirements in terms of the student numbers or face the challenge of more demand for places than can be met. There are some sites that have struggled to meet the quota. The reasons for this are unique to each site but may be related to the local demographics, training capacity of rural localities, the length of time the RCS has been established, or the way in which the RCS Program is promoted to medical students within the host university.

Staffing and recruitment strategies of RCSs have generally been effective, and feedback received in this evaluation validates the Department’s requirement that senior staff live locally. Local origin of people in leadership positions, or their willingness to relocate and join the rural community, has been a key enabler for RCSs to successfully engage rural clinicians in the aims of the Program and to motivate other community leaders to support the initiative and to assist the students during their time in the location.

This community involvement and partnership is evident in all RCSs, with two primary outcomes:

- ensuring that an adequate number of good quality training places are available which will be sustainable, beneficial for the local community and sufficient for curriculum requirements; and
- ensuring that students are ‘well looked after’ during their stay. Community support has been very strong in many locations, as the medical workforce shortage is of great concern to regional communities nationwide.

‘I would like to see them over produce. I would like to see the glut back [in] the 70s where you had to be in the top 10 percent to get a job in a hospital, whereas [now] you take the bottom 10 percent of anything you can get. At the moment for me in a really operational clinical sense it is about workforce, boosting up the workforce.’ (senior hospital clinician)

34 At some of the more established RCSs (eg University of Sydney, University of Queensland) positive word of mouth communication among students has reportedly resulted in demand for RCS places from students who have no inclination towards rural practice, but are simply interested in the enhanced training opportunities available in regional locations.
It was suggested by some informants within RCSs, universities and other agencies that, due to the level of funding provided, RCSs have not had to be as ‘creative and resourceful’ as the UDRH Program, in engaging with and developing partnerships across a wide range of stakeholders. However, some RCSs have embraced an expansive understanding of their role in promoting innovation and development within rural health services in addition to their role as providing clinical medical training.

‘I think you have got to be innovative in rural and remote health I think because when we need to come up with innovative solutions for local issues and each sort of local issue may be different, so innovation I think is a very important part of the rural clinical school activities.’ (RCS administrator)

It is true, however, that RCSs have had the funding to employ staff on competitive salaries or construct purpose-built facilities without necessarily needing to develop collaborative arrangements with other like-minded initiatives; however most RCSs have made efforts to build relationships with UDRHs, AMSs, health services and other health-related organisations such as general practice networks. Overall, the ability of RCSs to provide for their own needs has been beneficial for rural health education or rural communities: on one level the amount of money available through the RCS Program has enabled a high quality of medical education and the development of significant educational infrastructure; on another level the presence of RCSs has also benefited a range of other programs and initiatives, which in many cases have been able to utilise the people and facilities available through the RCS.

Rural clinical schools have also been perceived as promoting rural health within their universities, beyond the initial novelty of new buildings, new staff and new student pathways created by the Program, through demonstrating strong student outcomes and earning respect as equal partners in the university’s medical faculty rather than ‘the poor cousin from the country that nobody wanted to know about’. For many, this has been hard won through confronting traditional stereotypes about rural Australia and the quality of medicine practiced in rural communities and patiently demonstrating that clinical teaching in a rural setting can be as effective as in the urban environment.

‘RCSs are now seen as a godsend – 10 years ago they would have been seen as a threat’. (RCS Head)

There are examples of RCSs building a significant research agenda (e.g. Flinders University in the Riverland, University of Western Australia and Notre Dame University, University of Sydney in Orange, University of Tasmania). However, research has not been a major focus for many RCSs, particularly those still in the establishment phase. Some schools have taken the view that their contribution should focus on the local impact of population health issues, or undertaking population health analyses which contributes to the local health system planning and investment. In other areas, like the Riverland under the Flinders University RCS, a more substantial research program has been developed, strengthened by the creation of a position dedicated to generating a ‘research culture’, which is seen as valuable in and of itself.

5.3.2 Issues arising in the achievement of the objectives

As noted earlier, RCSs have identified a series of key achievements, and most people involved with the RCS Program are enthusiastic about participating in what is perceived to be a very positive step in rural health education in Australia. However, there are three broad areas of consistent concern across RCS-funded universities.

- Shortages in the current (and immediate future) health workforce, difficulties in recruiting some specialists (for example psychiatrists), and limitations in State/Territory hospital and health care systems impose natural limits to the number of long-term student placements that can be accommodated without jeopardising the quality of the educational experience.

This is an important issue, as all RCSs are presently operating with a growth philosophy (looking both to recruit new training sites and to expand the number and/or duration of student placements in existing training sites) and the number of medical students nationally is also increasing steadily (see Figure 5 below).
Preceptor burnout has been mentioned by many, particularly with regard to rural general practitioners, as a risk to the Program, particularly in the next five years until the expected increase in rural practitioners begins to be evident. ‘The problem is being asked to be the solution’, that is, those practitioners who are already overworked due to the shortage of doctors are being asked to assist in addressing the workforce shortage through increased teaching and supervisory roles.

RCSs do not operate with the economies of scale which metropolitan clinical schools enjoy. Without ongoing Federal funding, universities would need to significantly downsize (or in some cases dismantle) their rural clinical programs and revert to running short term placements only (e.g. through RUSC).

Details regarding the implementation of the Program are found in section 5.4 below.

Figure 5 – Commencing medical students in Australia (Domestic and International) 2000-2010

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<th>Year</th>
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<th>International</th>
</tr>
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</tr>
<tr>
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</tr>
<tr>
<td>2009</td>
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</tbody>
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Source: Medical Deans of Australia and New Zealand (http://www.medicaldeans.org.au/pdf/Table3.pdf)

5.3.3 Contribution to national rural health workforce priorities

In summary, there are some promising signs but no definitive answers to whether RCSs in Australia have (or have not) yielded higher rates of rural practice among participating students. However, there is evidence of positive attitudinal shifts towards rural training and practice. Some studies have suggested that an increasing number of students are seeking rural internships (Playford et al 2008, Wilkinson et al 2004), although these figures should be approached with caution as it is not clear to what extent this will translate into career decisions: Health Workforce Queensland (2008) reports that only 4.29% of former medical students from the two Queensland universities are working in RRMA 4-7.

There is also anecdotal evidence, from this evaluation, of workforce benefits from the RCSs through the attraction and retention of clinicians involved in teaching and supervision. Workforce outcomes are discussed in greater detail in section 5.4.1 below.

This evaluation has found some evidence of RCSs directly improving the range or quality of health care services in rural Australia; there are a number of instances where particular specialties that were previously not available in the community have become available because of a successful appointment by the RCS, sometimes as a joint appointment with the local area health service or UDRH.

There is some evidence of a contribution by RCSs to the national research agenda, although this varies from place to place. It is often identified through the provision of critical institutional infrastructure brought to regional locations (for example, enabling access to research libraries and resources). It is generally agreed that the priority of the RCSs in their establishment phase has been to create a
credible rural teaching infrastructure, and that the building of a research focus is the next priority as the RCS site matures.

5.4 Effectiveness and future role of the RCS Program within the context of the current national approach to improving rural and remote health services

This section discusses three ways in which the RCS Program has contributed towards national rural health workforce aims:

- increased student placements;
- capacity building for the existing rural health workforce; and
- increased rural health research capability and output.

5.4.1 Increased student placements

The number of medical students has increased each year for the past eight years (see Figure 5 in section 5.3.2) and is expected to do so for the next three years. In 2006 there were 379 medical students in the RCS Program (Department of Health and Ageing 2008a), and this figure is also expected to increase considerably over the next five years. It has been reported that the demand for rural internships is growing, and that the numbers of students actively seeking to undertake rural internships and rural vocational training has increased disproportionately to the ratio of rural-origin students (Playford et al, 2008)

“We clearly are beginning to see some return of interns to rural sites…we’re seeing a number of students who have elected to return as interns, and I think some who are currently in final year who have indicated an interest in returning. The numbers are probably in the order of, I suppose, 5 to 10 students.’ (RCS academic)

Most RCSs have established mechanisms for student feedback (e.g. student satisfaction surveys, debrief sessions) but few have established mechanisms for evaluating outcomes such as actual career choices or long-term impact on workforce shortages. To a large extent this is because the earliest RCS students are only now finishing their vocational training and making those career choices. There are a few limited examples of research projects conducted by honours/masters students that have involved some tracking of medical students, but this has generally been small scale and intermittent and mostly involved students’ stated intentions of career choices as they progress through intern years and vocational training. The FRAME (Federation of Rural Australian Medical Educators) Rural Clinical School Student Evaluation Project is a longitudinal tracking survey of RCS students which, similarly to the Medical Schools Outcomes Database (MSOD) tracking study of the Medical Deans Australia and New Zealand (MDANZ), hopes to establish over time a data set of RCS students, their characteristics and work intentions. Both projects are funded by the Department, the MDANZ study with the intention of tracking the workforce outcomes of all medical students and the FRAME study specifically to follow students who train with a RCS. Preliminary data from the FRAME study indicated a generally positive perception amongst RCS students of rural clinical practice, with 42.5% indicating a preference to rural practice for the future. Forty-seven percent of respondents came from a rural background. (DeWitt, Pallant and Cunningham 2008). There are inherent difficulties with this sort of tracking study, including participation rates across very dispersed sites, changes in student intentions over time, disparities between data collection across universities, and difficulties in tracking students as they enter the workforce. However, the FRAME project is a serious attempt to develop a comprehensive data set over time which will allow universities, RCSs and the Department to evaluate outcomes of RCS placements in terms of their impact on the rural health workforce shortage.
Case Study: Student numbers at the UNSW Rural Clinical School

The UNSW Rural Clinical School includes four main campuses – two in the Riverina region of southern NSW (Wagga Wagga and Albury) and two on the State’s North Coast (Port Macquarie and Coffs Harbour).

The chart below shows trend data from 2001-2006, tracking the number and percentage of fourth year UNSW medicine students undertaking their studies through the RCS. (The UNSW medicine course is a six-year undergraduate program).

These figures demonstrate the impact of new campuses and buildings as they are added to RCSs’ portfolios over time. They also highlight the need for campuses to continue their expansion in order to keep pace with the growth in overall student numbers in medicine. For example, UNSW saw a 25% increase in RCS student numbers between 2004 and 2006 (from 41 to 52) – this only increased the proportion of 4th year students at RCSs by three percentage points (20% to 23%) due to the growth of the medical student population as a whole.

Note that the percentages are based on all medical students studying at UNSW, not just DEST-funded places. The ‘25% requirement’ noted earlier in this chapter only applies to the number of DEST-funded places – UNSW consistently exceeds this.

Figure 6 – Proportion (and number) of UNSW 4th year students at a RCS, 2001-06.

Despite the limited evidence of workforce outcomes to date, all RCSs are convinced that they are part of making their university’s program as encouraging as possible of rural practice (both in general and in that specific location), and that this is beginning to demonstrate outcome trends, particularly from the more established schools. The demonstrated secondary benefits of the Program, such as the attraction of the university infrastructure to the community, the opportunities for rural clinicians to teach and participate in academic life while remaining in the rural environment, and the increased understanding of medical students regarding the challenges of rural medicine are all considered to be valuable contributions to the university, rural communities, and the rural workforce.

- RCSs are well aware of the logic of the program – i.e. the established link between positive student experiences in regional areas and eventual work location decisions that students will make. Some of those involved in the RCSs are themselves a product of rural student experiences, and the willingness of such a large number of experienced (and scientifically minded) medical practitioners to give of their time is evidence enough for some that the Program has a solid foundation.
‘This is not a pilot program that we’re waiting to see if it works. As far as I’m concerned – as far as we’re all concerned – this is the considered delivery of a proven long term model to address rural workforce shortage.’ (RCS academic)

- There is ample evidence of positive attitudinal shifts towards rural medical training and practice within universities and the medical education sector generally. For example, one RCS reported now being seen by some in the main campus as being ‘at the frontier, not in a backwater’. However, such cultural shifts takes time, and this is still an ongoing process in most universities.

  ‘The rural clinical schools are challenging the tertiary hospitals as the gold standard for educating our next generation of doctors, and we are incredibly lucky in [our university] because they sit around at the curriculum table and say “do you think we can do this as well as the rural clinical school does?”… It is challenging but it is incredibly rewarding, and there are – certainly there are people in the leadership positions in the university I believe that are really pro, but I think that they have still got some professors of disciplines that want to believe their world is the best way.’ (RCS academic)

  ‘You only need one poor experience [for a student] to think it won’t be good long term. So it needs to be a really good experience for people to want to go back.’ (medical student)

- There is also evidence from all RCSs of workforce contributions having been made through attracting and retaining senior clinicians with the opportunity to hold a university appointment, which has led to their involvement in teaching and supervision.

  ‘The RCS has provided a new zest for life; it gives you a bit of enthusiasm… after 20 years you get a bit jaded. It has probably helped others too. It’s true that if you’re a teacher you have less time to practise, but it also makes you a better practitioner.’ (clinical supervisor)

  ‘Seeing how invigorating that is to the clinician. It is really hard to measure, I haven’t been able to think about a way to objectively measure, but people describe that it has renewed them enough to continue them working in an area which otherwise they might have become burnt out in, and that is incredibly powerful. If we are actually making a difference to the workforce here and now because we are extending people’s working careers in rural areas, and I don’t know how you measure that. That is a huge difference.’ (RCS academic)

- A number of hospitals and general practice regional training providers also noted increasing numbers of Australian-trained medical graduates applying for positions as interns or as registrars in rural vocational training programs. In cases where these organisations could identify how many of these applicants were from the RCS/s in their area, the findings were mixed: some reported clear pathways from RCS to internship to vocational training all within the one area; others reported demand from rurally inclined students who had intentionally not gone to the RCS because they had wanted to get as much city experience as possible before doing their vocational training in the regions.

  ‘I have decided not to do a rural intern year, part of it is because the registrar I was with last year was fantastic and she did her intern training at [urban teaching hospital], and I saw how she managed – if we had to call someone or have to call [urban teaching hospital] to get some information or to send a patient out, she just had that intimate knowledge of how [the hospital] ran, how a big hospital runs, dealing with really sick patients. I thought she was a top doctor so I’d really like to model myself on that and I think I would like to get a big hospital exposure for this next year, and really throw myself in the deep end and then head back towards GP training after that.’ (RCS student)

- There is anecdotal evidence that the teaching and research infrastructure provided by RCSs contributes towards positive professional learning and development outcomes for those practitioners who access those opportunities.
'I think the rural clinical schools provide a type of professional enrichment that was very difficult to gain within the context of rural medicine previously.' (RCS academic)

One of the challenges of this evaluation is that even where the intended outcomes are achieved (i.e. the student goes on to work rurally), there is no way of knowing the counterfactual – i.e. whether they would have chosen to work rurally if they had not taken part in the RCS Program. As one student commented:

'We're all bonded in some way so maybe the place is wasted on us. I would have come out here anyway. Do you give the place to people who are already committed or to someone who's bonded, or to people who might not have made up their minds yet?' (medical student)

As noted above, a number of students indicated that they were deliberately not choosing to seek extended time in the RCS or pursue rural internships because they knew they would come back to the country anyway, so they wanted to take advantage of their training opportunities to get as much from the urban environment as possible. The fact that students may make the decision to stay in the city as long as possible before returning to the country, combined with some reports that students with no intention of practising rurally are seeking placements at the RCS in order to benefit from the enhanced learning opportunities, confound any direct correlation between numbers of RCS placements and eventual workforce outcomes. However, this does not negate significant benefits which the RCS Program is contributing to the current and future workforce.

For these reasons, RCSs are naturally resistant to having their funding tied to eventual work location choices of their students, as the RCS is only one experience within a long training process, and only one factor in a decision to live and work rurally. Other elements include what happens later in the training process (particularly during vocational training); what has happened earlier in the selection and training process (e.g. see University of Wollongong case study below); and life circumstances that are out of the control of any training program, e.g. family and partner choices and inclinations.

**Case study – University of Wollongong entrance questionnaire**

As a regional, rural and remote-focussed program, the Graduate School of Medicine (GSM) has a positive bias to selecting candidates who can demonstrate significant ties to an area outside of a capital city (RRMA 2-7). This is an extension of ‘rural entrant’ schemes in place in a number of universities, where the barriers to entry are slightly lower for students from regional areas.

Applicants to UOW GSM are required to put together a ‘portfolio’ as part of the admission application process. ‘Rural origin’ is not just a matter of having lived in a regional area – a high level of importance is placed on applicants satisfactorily demonstrating their service ethic in participating in community life outside of their employment environment. The rationale for this includes evidence from Canada that a student’s inclination and ability to participate in community life is a key determinant of whether or not their rural placements will result in eventual career decisions that take them back to that community (or another one like it).

The increasing competitiveness of the RCS selection process is another reason why some students who might take up a rural career eventually are not reflected in the RCS cohort. As one student explained,

‘there’s lots of competition, for people who don’t get in it’s pretty devastating. Students have to do a written application and an interview – someone said to me that ‘it’s quite nerve-wracking, I’m so keen to do rural but if I don’t get in I won’t know where to go’. People wonder why they didn’t get in, they really hang their hats on getting in, and families make decisions about where their partner’s going to go [for graduate entry students], it’s hard to turn away people because they didn’t get in.’ (medical student)
A number of participants, including students, have observed that the training provided in a rural location is equal to, and at times superior to, training which can be provided within the city. In the FRAME study, 97.5% of the 2006 cohort considered that patient access was the top factor to consider when deciding whether to attend the RCS (Dewitt, Pallant, and Cunningham 2008). One student observed:

‘we’re getting much more exposure [to clinical practice] here than in the urban setting. You get to know nursing and allied health staff more here because you are seeing them all the time.’

However, several instances were reported in which core teaching in a specialist subject (say oncology or cardiology) was unavailable to RCS students, who were still required to take the subject exam at the end of the year and tried essentially to teach themselves the topic. One student who found himself in this situation noted, ‘I wouldn’t want to be treated by me’.

In one RCS which is very oriented towards community-based training, student informants were equivocal about the balance between hospital- and community-based training, with one student considering that it had a negative effect, ‘I feel more useful in the hospital’, while another student said that he had decided to become a GP as a result of the increased exposure to general practice. The higher involvement with general practice was considered to be one of the significant differences between the RCS and urban-based training.

At most RCSs it was noted that the number of students who were applying for placements was increasing every year, mostly from word of mouth advertising by students who had spent time within the RCS.

‘[It’s a] fantastic program, especially for rural origin students, [and] also provides the best exposure for people not from the country. I have friends who had such a great time that they came back to the city and are now thinking of doing rural outreach work as specialists – I know about 10 people who had that experience.’ (medical student)

Many students agreed that they had greater exposure to a wider range of clinical work than they would have experienced in the urban setting, and that they had developed greater confidence as a result. One outcome of the RCS Program, therefore, is the provision of medical graduates who are better prepared to take up their positions as junior doctors. One student stated that he had found that he knew more than some of the junior doctors in the city, because he had already assisted with or at least watched procedures to which the junior doctor had not been exposed. Developing a greater level of confidence and experience in students before they enter intern years and vocational training will presumably enhance students’ learning and skill base in later years.

5.4.2 Capacity building for the existing rural health workforce

There is anecdotal evidence that the RCS Program has supported health professionals currently practising in rural and remote settings or strengthened the health workforce in rural communities. For example, practitioners involved with an RCS report:

- job satisfaction and enjoyment; enjoying the intellectual stimulation of teaching or supervising students (particularly after not having had the opportunity to do so for many years, or in their rural practice);
- the personal satisfaction and professional advantages of a university appointment;
- new challenges and opportunities, e.g. learning how to teach;
- encouragement from seeing students succeed and have positive experiences;
- building networks with other like-minded professionals (see RCSWA case study on page 74);
- new opportunities for research ideas to be picked up and progressed by others within the university; and
• development of a ‘learning culture’ within their team, the hospital etc, resulting in greater receptivity to reflect on practice and consider process improvements.

The RCSs are subject to the same challenges in recruiting staff as is the rest of the rural health sector. At the same time, each RCS has increased its staffing enormously as they have become established, as for example the RCS of West Australia which had 3 staff in 2002 and has 70 now. These are primarily fractional appointments of GP and other clinical tutors, so the full-time equivalent number is less; however the fact remains that the number of rural clinicians who now hold an academic appointment through the universities has increased. The effect of this on retention has been noted above, with numerous anecdotal reports of clinicians who found this opportunity energising and stimulating.

‘I don’t think we have seen much impact from it yet, [but] definitely from the medical workforce’s perspective there are a lot more of them starting to step up to the plate and say I am interested, I want to get into teaching, I want to do a bit more research. They are certainly much more acutely aware of the students being around, and that has been probably in the last eighteen months there has been quite a noticeable difference in that.’
(senior hospital clinician)

There are also reports of clinicians who have been attracted to a regional hospital, or to a rural general practice, because of the opportunity to hold a university appointment and to become involved in medical training. It does appear that the presence of the RCS is an attraction to recruitment of new clinicians to rural positions.

‘I came here because the [RCS] was here – it meant I could continue to be involved in research and teach. If it wasn’t here, I wouldn’t have come.’
(hospital clinician)

In areas where the medical workforce is recognised as ageing, direct benefits derived from the presence of the RCS were reported by stakeholders in the broader health system. For practitioners and specialists heading toward retirement, the option of teaching resulted in an extended working life, with the range of motivations expected in any group:

‘… most of them [GPs] are starting to think along the lines of retirement, and teaching as a mode of gradually retiring out as a nice option. They can pull back on some of their clinical work and pick up teaching, and it is not quite as demanding or as long hours. We have got a couple of really very excellent senior clinicians who are very very altruistic in their views and they are doing it – they are very much motivated about the future of the workforce. Some of the other guys I think see it perhaps as a little bit more of a comfortable ease out from clinical work.’
(senior hospital clinician)

The presence of the RCS was reported to be critical for recruitment in a number of regions, and conjoint appointments attracted clinicians with a genuine interest in practice teaching and research, enabling a better remuneration package to be offered because two organisations were each providing half a salary.

‘And I think the real focus in these schools is on development of a whole new population of what I would call clinician educators. And obviously I think one of the biggest challenges for the rural clinical schools is how they come in as universities to regional areas and start working with health professionals right across the board, many of whom since they left medical school or graduate training have had very little to do with university and therefore are not perfectly equipped to take on some of the academic and teaching roles that we expect of them.

‘So in response to your question about, you know, what effect have the schools had, well I think if we look now at the number of people who are affiliated in some way or another to the school, it’s actually enormous. We have some people on fractional appointments, some people on full time appointments and probably a list of, you know, 30 or 40 people who now teach into our program. Additionally, we have set up here a professional education unit with a permanent Head, a full time Head, who has this year for the first time set up a
regional graduate certificate in health professions education with 13 of our teachers now working, doing this graduate certificate, so I think what we're beginning to see here is the development of this clinician educator population …’ (RCS academic)

However, an alternative reading of the teaching role is that some practitioners find it draining to manage their teaching load on top of clinical practice and frustrating to not see ‘any signs of relief yet’ in terms of easing workforce pressures.

‘It's a little late for some – they are so busy that they are burning out…there will be a lag time before the new cohort is ready. This is the main threat to the program.’ (RCS Head)

This is particularly an issue for health services that have a workforce shortage:

‘The teaching allowances they give us are nice, but they're unspendable: there's no one in town with the skills and the spare time who we can hire to take the pressure off us, so the money just goes into the coffers and the GPs suck up the extra time.’ (General Practice Coordinator at an Aboriginal Medical Service)

In contrast, a hospital clinician argued that ‘burn-out implies dissatisfaction…for all the extra work that's been created, people are happier’. The opportunity to teach, and therefore to be challenged to keep up one's own skills and knowledge, was considered by most to have benefits which may in some ways outweigh the increased time commitments within an already burdened schedule.

The nett service capacity impact of medical students (as opposed to those further on in their training, e.g. registrars) is arguably a ‘zero sum game’, providing increased workforce capacity in some instances, only to take up time and resources at other times. Clinicians who teach students have varying views as to the usefulness of students, from the GP who stated that students are workforce in themselves – they are actually useful to the consultant who stated bluntly that students are not workforce.35 Still others considered that having students was a positive benefit to the rural health service but were unconvinced that in the long-term it would address the workforce shortage.

‘I’m very pessimistic that it will make a difference. It’s a good idea but we have to ask why haven’t we seen an impact and what important thing might we be missing? They mustn’t wait until 2015 to see that it’s not working. We’ve seen no impact so we need to ask why, what’s missing.’ (hospital clinician)

The RCS has made a significant investment in rural health through the development of infrastructure, including assisting rural hospitals, clinics and GP surgeries where required to build the facilities necessary to undertake clinical training. Practitioners reported that this investment in capital works was of great benefit to them and helped with management of workloads. For example, in one hospital the RCS had built an additional building equipped with office space, meeting rooms and high-quality video conferencing equipment, which were also available to the hospital for other uses. In other instances the RCS has contributed funds to general practice surgeries to provide consulting rooms, desks and computers for students to do patient examinations, tutorials, and study.

One outcome of this investment is the creation of an identifiable rural clinical educator pathway, through which clinicians can become involved in supervision, or become more formally involved in teaching, or even take up an academic appointment. This has provided an alternative model for doctors in rural areas, providing opportunities to combine clinical practice with academic work in a variety of ways.

An additional impact on the health workforce is influence on the medical culture, towards a more positive perception of rural medical practice. This appeared to be evident in two ways: Primarily, there was a sense that the RCSs had ‘proven’ to their urban colleagues that rural practice was first-rate in its own right, and that a rural medical career could be as stimulating, challenging and rewarding as an urban career. Students and clinicians spoke about a growing recognition that spending time in the

35 Further research would be required for any definitive commentary on the nett service impact of accommodating long term students in different care settings.
country would not damage one’s career but could in fact enhance one’s skills and experience. A
second way in which the RCSs are influencing the culture of medicine is by training a generation of
doctors who will have exposure to rural medicine, so that even if they subsequently choose an urban
career they would have a greater understanding of the ways in which medicine is practised in rural or
remote locations. This is considered to be a positive aspect with the potential to increase
communication and understanding between rural clinicians and urban specialists to whom they might
refer.

Case study – RCS as a network hub for rural and remote practitioners

In Western Australia, the RCS has established ten training sites across the State, encompassing
regional, rural and remote locations. The capacity of each site ranges from three students to ten, and
the type of site varies as well, with different emphases of learning sites and opportunities from general
practice surgeries to regional hospitals to Aboriginal Medical Services. Thus, some students may
spend more time in a GP surgery and visit the VMO-run hospital with their GP supervisor, while another
student might get greater exposure to an AMS, and a third student might spend their time
predominantly within a regional hospital. The variety of training sites is considered to be a strength of
the RCS: ‘we’ll produce [that doctor] but we’ll do it in 14 different ways…every site has got to the
endpoint in different ways’.

Once a student is allocated to a particular location, they remain there for a year, although they have the
opportunity to undertake two short placements of two weeks in alternative locations during the year.
During these option periods a student may choose to ‘top up’ on a subject with which they feel they
have had insufficient experience, for example pediatrics, Indigenous health or obstetrics.

Each site has at least one core academic clinical coordinator who is usually appointed at .5 or .6 FTE,
and a number of others so that each site has a total of about .2 FTE of coordinator time per student.
These coordinators are responsible for arranging preceptors, providing training and support for
preceptors, and organising the teaching schedule for RCS students as well as teaching and assessing
the students.

While in the beginning the RCS had to work hard to encourage doctors to agree to take up the role of
clinical coordinator, the Program has developed to the point that there are people who are seeking to
become involved as supervisors and coordinators. There is a major emphasis on education skills in the
RCS and some of the coordinators have taken up additional training in medical education with support
from the RCS.

Over time, a virtual network of clinical coordinators has developed which connects clinicians in rural and
remote locations with their peers across the State. The coordinators have established their own
communication mechanisms, and are increasingly sharing their experiences and learning resources.
An email network has been established which is ‘self-owned’, this is not generated through the RCS
office, an example of the learning organisation culture which was attributed to the founding head of the
RCS. This has contributed to an ‘added level of stimulation and interest’ and a culture of good will and
excitement’. There is evidence that this networking across the vast distances of Western Australia is
one of the aspects of the RCS which is contributing to the recruitment and retention of rural doctors by
increasing collegiality and academic stimulation, and by reducing professional isolation.

An additional impact on the health workforce is students’ exposure to interprofessional practice. Due to
the nature of rural practice, a student is more likely to experience a multidisciplinary team approach to
clinical care, and indeed several students commented that they had a much greater understanding of
clinical teamwork because of their time at the RCS. However, as discussed previously in chapter 4 of
this report, the extent of interprofessional learning opportunities (e.g. with nursing and allied health
practitioners) continues to be limited by incompatible and unsynchronised curricula.

It was recognised by many informants that a training pathway for a rural generalist is not yet available in
Australia and that this route might be important in providing a further solution to the workforce shortage.
A recent review noted that the decline of generalist physicians has led to a decline of availability of practitioners who are trained to work across procedural disciplines (e.g. anaesthesia, obstetrics, surgery) while there has been a growth of specialists and sub-specialists, who tend to practise in urban areas (Pashen et al 2008). This has exacerbated the shortage of hospital physicians in rural areas. Encouraging the role of the generalist physician would provide area health services with greater flexibility as clinicians could contribute across a number of skills areas and provide greater broad-based care to patients. This could relieve some of the pressure currently felt by general practitioners as well as the pressure experienced in rural hospitals which rely on locum doctors or fly-in, fly-out specialists.

“There is a need for rural generalists – there’s a trend in all disciplines towards increasing specialisation but everyone’s agreed that the disciplines need generalists (i.e. general surgery, general practice). RCSs are not [just] about producing GPs but about producing generalist rural physicians (GPs or otherwise); the urban areas need these too and the RCSs are beginning to influence the cities in this regard.’ (RCS Head)

5.4.3 Increased rural health research capability and output

As noted earlier, a small number of RCSs have been active in building a research agenda. However, for most the focus has been on developing their teaching model and delivering the curriculum to the satisfaction of the students and the university. The priority of teaching has drawn the focus of RCSs onto matters of recruiting/engaging clinicians and securing the commitment of health service administrators to support student training. Once RCSs have satisfied the sceptics within the faculty, the university or elsewhere, they are then in a better position to turn to other priorities – like research. This is not a question of RCSs not valuing research – it is just a matter of ‘first things first’.

“One problem is research – the RCS is now established but it’s taken time to get appropriate research happening – it’s largely public health research at the moment.’ (Dean of Medicine)

The University of Queensland (UQ) at Toowoomba has funded dedicated research capacity based at the Centre for Rural and Remote Area Health (CRRAH) in conjunction with the University of Southern Queensland, and James Cook University (JCU) at Townsville. Both the UQ RCS and the JCU RCS are prioritising research and evaluation to track impacts, outcomes and implications for rural health workforce recruitment and indicative trends towards retention outcomes. This research is currently limited by the early stages of RCS programs, with students only now progressing through to postgraduate stages.

In many instances the research activity is initiated by a local clinician with a particular passion to address a topic, in which case the RCS has offered access to university resources such as library facilities, administrative support for grant applications and management of funding, and to partnerships with other medical academics, resources which were not previously easily available to rural practitioners. The infrastructure of the RCS is considered by some to facilitate the building of a research culture which, while to date has not been embedded in rural practice, has potential to grow and to impact upon evidence-based rural medical practice.

“We spend 10% of our budget on research, and have major collaborations with the Aboriginal Medical Services … it’s starting to happen more. First there was the push to establish, but now we have employed pure researchers. It’s starting through local initiatives, which have an instant effect because the local doctor is initiating changes in practice … the RCS acts as a facilitator for larger research initiatives.’ (RCS Head)

5.4.4 Relationships with other initiatives and with key stakeholders

The RCSs themselves have an established network, FRAME, through which dialogue and sharing of information takes place. FRAME was described by one RCS Head as a:

‘forum for sharing ideas – there’s a strong sense of sharing, both problems and solutions.”
FRAME began as an informal network but is gradually becoming more structured as the RCSs themselves mature, now with two meetings a year and a growing understanding of how the network itself can be useful to its members, such as discussing policy, enhancing academic rigour in assessing outcomes at the national Program level, and becoming a forum for engaging with education and workforce development. Heads of RCSs were universally positive about the value of FRAME as a network for organisational and professional support between institutions which are otherwise quite geographically separated from each other and from their host universities. Initiatives such as the FRAME RCS student evaluation project, funded by the Department, demonstrate the potential for FRAME to provide an avenue for national research into medical student training initiatives and their outcomes.

Engagement with the university sector

The RCSs, at least those within metropolitan-based universities, function as an outpost of the host medical faculty. In this way, they differ from UDRHs which work across a number of faculties and even universities, and are not responsible for the teaching of a particular curriculum. Most of the RCSs see themselves as a separate but integrated component of the university’s faculty of medicine. For regionally-based universities, this relationship was even more integrated, with the distinction between the medical school and the RCS not necessarily evident to students but perceived as aspects of one institution.

‘The [regional medical school model] is all rural so you can’t separate out those students who are doing rural placements because everyone is working rurally. It changes the way you think about rural medicine.’ (RCS Head)

For metropolitan-based universities, there was some appreciation that the development of the rural clinical school had raised the level of awareness of rural health issues and also the possibility of rural careers. There was a corresponding need to maintain the identity of the rural-based RCS as part of the host university; that is, keeping it closely aligned with the culture and ethos of the institution. In general, however, it was considered that the benefits of the relationship between the RCS and the university appeared to be complementary, with each side gaining an advantage from the establishment of the RCS:

‘It's hard to tell what the impact of the RCSs has been on the university sector nationwide – it makes the unis more aware of rural areas, and bringing regional areas closer to city, it broadens the perspective, [and] generates innovation for rural service delivery… staff in rural areas now identifying as [part of the university], and rural areas are feeling the benefits of growing links with the city through the uni presence. Within the RCS there are the benefits of the uni structures for HR, IT etc.’ (Dean of Faculty)

Senior university academics (e.g. Heads of Medicine, Professors of Departments) spoke highly of the impact of the RCSs in making universities more visible in regional Australia, with the potential to encourage more rural students to attend university, or even study medicine. Several also considered that the RCS had a greater potential to contribute to medical training as a regional coordinator of a vertically integrated rural pathway. The ability of RCSs to offer a more intimate training experience to students, with a greater level of one-on-one training, was acknowledged, as was the high quality of training provided, evidenced by RCS student exam scores. The different organisation of the rural health structures compared to the city, were also considered by one Dean to assist in the building of relationships and agreements between the university and health services for training purposes.

‘One of the things that I've been very interested in, both metropolitan and in the rural areas, is our relationship and our integration with healthcare facilities. So, you know, that at a metropolitan level is mainly with very large teaching hospitals but obviously rurally it's with a whole heap of healthcare facilities. And I must say that it's actually, that sort of work has been easier in the rural areas and I think there's a lot more community engagement and some incredibly interesting opportunities in the rural areas around the engagement of our rural clinical schools and [UDRH] with the community, with the healthcare facilities, both primary and secondary.’ (Dean of Faculty)
Senior university academics and administrators favoured the continued separation of funding for RCSs as a workforce initiative, rather than providing funding through DEEWR. The reasons for this were two-fold: first, an appreciation that the ability of the university to use RCS funds was proportionally greater because the funding was quarantined, and second, a recognition that funding for universities was increasingly stretched to provide for the current levels of teaching and research.

‘Direct federal health-sector investment into university programs is definitely a good idea… There is an argument for preferential DoHA investment in the [commitment to the regional/underserved population agenda to address the workforce issue directly]. A particularly difficult issue for medical schools now is the yawning salary disparities for clinical academics with public hospitals and private practice.’ (Head of Medical School)

Medical Deans were particularly aware of the challenges posed to rural medical training by the lack of pre-vocational and vocational training opportunities, and the impact that this may have on the ability of the RCS to make a difference to the rural workforce. Many favoured a greater involvement of the RCS in all aspects of medical training from undergraduate through to vocational and post-graduate training.

**Engagement with UDRHs**

Collaborations with UDRHs are found in various locations, with several models of collaboration evident between RCSs and UDRHs:

- Separate but collegial Programs, with information sharing and at times sharing of facilities or providing opportunities for students from different disciplines to learn together;
- Strongly collaborative Programs, with a considerable number of interprofessional learning opportunities, shared projects (funded through both Programs), shared clinical or teaching appointments, and/or research collaborations; and
- Co-located Programs, in which, while separate accountability of funding streams is maintained, facilities, administration and teaching appointments are jointly shared, a united organisational identity is presented publicly, and projects or teaching streams are not presented as being from one Program or another.

In those places where the UDRH and RCS are either co-located or structurally linked within the university, there have been opportunities for co-operation and collaboration which have helped to develop a more comprehensive approach to workforce training and to health service innovation.

‘The UDRH has been a core or part of the core of the School of Rural Health since its inception and so it operates under the one banner. So we refer to the School of Rural Health within [the university] as being the overarching organisation and within that, the regional clinical schools and the UDRH. And so it’s run under the same administrative banner …and it works well. We utilise the facilities that have been set up for the rural clinical school but, you know, they’ve been utilised by the programs run out of the UDRH. But I must say that, you know, we have to be careful; I think it’s one of the risks of actually growing so rapidly, and I suppose also maturing as an organisation, is that each of the units, so each regional clinical school and UDRH are really, growing into an independent organisation capable of running by themselves. And I think the challenge for us as a School is to maintain that common vision and draw all these units together so that we are collaborating and utilising each other’s advantages to the greatest benefit.’ (senior university academic)

RCS students in particular seem to be in favour of closer links with the UDRH, recognising that they gain from interdisciplinary learning and from learning to work as a team.

‘There should be a better correlation with the UDRH – it’s really unfortunate that RCSs have fantastic facilities while UDRH students don’t get anything – there’s a loss of interdisciplinary learning and exposure.’ (medical student)
As noted above, there is some UDRH/RCS collaboration occurring already across the country, and this varies depending on the geography and location of the two Programs, personalities in leadership, and local opportunities for joint projects. There is certainly potential for greater collaboration; however this is probably best achieved through natural development and relationships rather than through contractual obligation. Some universities favoured greater integration, or collapsing the two national programs into one; others perceived distinct differences between RCSs and UDRHs and felt that they each had a distinct contribution to make.

The perception of the co-location model is varied. Some considered that there is a danger of medical training overwhelming other disciplines. On the other hand, others considered that there are greater benefits for interprofessional education from co-location. For instance it appears to make financial sense, offering economies of scale, administrative savings and sharing of resources such as libraries and teaching facilities. If an RCS is added to an existing UDRH, or vice versa, there is an enormous amount of infrastructure and relationship building that has already been developed, avoiding replication for new sites. The potential for interprofessional learning also seems to be easier to arrange, though the success of some non-co-located sites in achieving this suggests it has more to do with the organisation’s vision and beliefs than physical arrangements.
Case study - The Spencer Gulf Rural Clinical School

An example of co-location and collaboration between the RCS and the UDRH is the SGRHS based at the University of South Australia campus in Whyalla (South Australia). The SGRHS is a joint venture between the University of South Australia (holding the UDRH contract) and the University of Adelaide (holding the RCS contract).

This model has a number of advantages, such as the ability to share infrastructure (such as IT and administrative support, and the efficiencies of promoting a single program to stakeholders, especially the community stakeholders, and assists with networking and partnerships with local hospital, health services and GPs. The appointment of one Head of School to oversee both Programs assists in creating a seamless approach to the RCS and the UDRH activities at an operational level, and employees identify with a single ‘entity’ rather than just the RCS or the UDRH Program. The co-location model supports research across disciplines; and promotes a collaborative approach between the two universities and between the disciplines.

Equally, there appear to be some disadvantages to this model. The focus on filling medical student quotas has resulted in great efforts being made to engage with GPs (for preceptor training, the production of manuals, and involvement in exam workshops, for example). This is not available for allied health clinicians in the same way, as there is not the time or the funding available. The current difference in the funding of the Programs is more apparent in a co-located setting, and this creates competition and inequities which are in conflict with the model of collaboration. There are also some risks around the management of finances, particularly around cross-subsidisation, which require transparent monitoring mechanisms.

The success of the model is reliant on strong leadership. Finding appropriately skilled and experienced managers who are leaders is a challenge in any organisation, and recruiting a person with the requisite skills may be a challenge in a rural setting; hence, succession planning is of key significance. In the past various management models have been trialled, for example joint Heads of departments; however, this was confusing at both a governance and operational level. There is a risk that without strong leadership the model could become ‘activity focussed’, that is getting students into places, arranging accommodation, sorting out allowances and so on rather than following a larger vision. This has occurred to a degree at SGRHS in the past. It is hoped that the appointment of an Executive Manager will assist with some of these issues, providing strategic advice to the Head of the School, and leading administrative operations.

Engagement with rural clinicians and health services

Collaborations with local health service providers (private and public) are core business for RCSs, and have become second nature for those established earlier in the life of the Program. These collaborations are all brokered with a view to securing clinical education experiences for students, as well as contributing to the development of the rural health system more broadly. In the Riverland for example, the simulation centre is a key resource for the existing workforce, providing clinical training opportunities to multi disciplinary groups of practitioners.

The physical existence of a well-equipped building (and the sharing of meeting rooms and facilities with others in the community) has strengthened relationships with external stakeholders. This has reportedly built a sense of reciprocity, and in some cases created leverage, that has enabled some RCSs to draw on the time and goodwill of key individuals either in the community or in the health professions.

‘The RCS brings people together – in [small town] the local doctor’s meetings are now held in the RCS building, in [another town] the RCS building is becoming a hub for local doctors because of the library facilities.’ (RCS academic)
RCSs are highly cognisant of their dependence on good will, and invest resources in building and maintaining the networks on which the success of the program depends. One senior stakeholder described the effort in these terms:

‘So we’ve been able to provide these facilities, with bells and whistles as far as the audiovisual stuff, we’ve been able to provide them for the health services. And in every case I think we’ve had in mind that it’s crucial for us to have good relationships with these health services because if we don’t have access, for instance, to the regional hospital…..then we’re buggered. And our challenge is to make ourselves crucial for their operation as well so at the end of our 20-odd year lease for the building, that they see us as a vital part of what they do and how they operate and couldn’t see themselves working without us. That’s been the philosophy at every site and it’s resulted in very good relationships with those health services and I think it’s flowed through to the community as well. The same thing goes for the GP practices; all of those have been supported with capital works funding provided by the Department in the first instance and then we support them by yearly recurrent amounts depending on how many students they have and for how long and so on.’ (RCS academic)

Collaborations with local educational institutions are also evident, including with universities not affiliated with either the RCS or the UDRH Programs. One example is in Albury-Wodonga, where UNSW has partnered with Charles Sturt University to deliver anatomy training to students of both universities, using Charles Sturt University’s ‘wet lab’ and UNSW’s anatomist, who visits from Sydney (as anatomy is difficult to teach effectively via teleconference).

Similarly, the University of Sydney RCS at Dubbo is also working with Charles Sturt University to share facilities, and collaborate on joint ventures including a planned dental clinic located near both campuses. Years of collaboration between the University of Newcastle’s co-located Northern NSW RCS/UDRH and the University of New England have now been formalised by a jointly delivered medical program at the two universities.

In Bendigo, the North Victorian Regional Medical Education Network (NVRMEN) is a collaborative initiative between the regional clinical schools of the University of Melbourne and Monash University. Under the NVRMEN program there are 60 new places shared equally between Melbourne University and Monash, with 50% of students recruited from rural areas.

A partnership including the Monash University RCS and six other partners including the Bendigo Hospital, Community Health Services and the Division of General Practice, the regional training provider, the City of Greater Bendigo and Latrobe University has resulted in the agreement to develop a ‘super clinic’ (discussed further on page 81). Through these collaborations the RCS sees itself as ‘conceptualising primary care models and how they work’.
Case study – Border Medical Recruitment Taskforce, Albury-Wodonga

The Border Medical Recruitment Taskforce was formed by senior clinicians and health service managers in the Albury-Wodonga region in 2006 – it also includes representation from the local UNSW Rural Clinical School and the local Division of General Practice.

The group initially formed in response to a number of key vacancies in the hospital. In due course these vacancies were filled, partly through the personal and professional networks of Taskforce members. This initial crisis out of the way, the Taskforce decided to keep meeting to work on other aspects of the medical workforce.

The Taskforce has three areas of focus:

- **Immediate responses** to high-level workforce gaps are what brought the group together, and the Taskforce is ready to mobilise around any new vacancies for senior clinicians that may emerge. In seeking to make the region attractive to senior clinicians, Taskforce members have used the UNSW RCS as ‘another lever… another example of how your career is most certainly not going to be on hold if you come to work in Albury’.

- **The medium term strategy** relates to making the region attractive to junior medical officers, residents and registrars. Suitable accommodation for rotations is a critical issue, particularly if doctors are to bring their families with them rather than drive home to Sydney (6 hours) or Melbourne (4 hours) on the weekends. Also being explored is the capacity for registrars and residents to spend longer rotations in the region rather than having to return to the metropolitan teaching hospital.

- **Long term strategies** are based on attracting medical students to the region, and the Taskforce works very closely with students at the RCS to promote a positive image of rural practice. The Taskforce has stimulated part-time employment (through appeals to the Chamber of Commerce), provided heavily subsidised access to holiday accommodation owned by local clinicians (particularly in the local snowfields), and arranged social events where students mix with medical professionals and others studying in the area (e.g. a marquee at the Albury gold cup – the major annual race day).

The Taskforce operates without core funding from any workforce agency or government health department. Members of the Taskforce channelled funds from their own businesses and approached others (e.g. local councils) to contribute – which they did.
Interaction with other government-funded programs

Engagement with other government-funded programs occurs on various levels. Within the medical student population there are students in receipt of a range of national scholarships (e.g. the John Flynn Placement Program,36 the Medical Rural Bonded (MRB) Scholarship37 and RAMUS – the Rural Australia Medical Undergraduate Scholarship38). The RCSs are also able to offer information and assistance for students seeking to apply for scholarships or other rural exposure opportunities.

The interaction with RUSC – the Department of Health and Ageing’s Rural Undergraduate Support and Coordination Program – differs from university to university. RUSC resources a range of activities designed to support and encourage positive rural experiences for medical students (with a view to prompting rural work choices). In some universities this Program is managed by departments of general practice, where it was based historically before the advent of the RCS Program. In others, the UDRH has an active involvement in the organisation of RUSC placements. In still other universities, the RUSC funding is pooled with other sources of funding to provide additional rural experiences for medical students.

The place of RUSC with the RCS Program varies from place to place. Generally RUSC was highly valued in the early years of the Programs, where students were exposed to rural practice early and in a highly supported fashion. For some schools this is still the case and the RUSC placements form a part of the informal recruitment process, where potential students for the 3rd and 4th year rounds are identified. For others where the placements are over subscribed, the place of RUSC is less critical as a promotional opportunity although it can still be a valuable experience in testing students’ interest in rural practice.

Outside of the medical student framework, there is also interaction with the Australian General Practice Training (AGPT) Program, which is delivered by 21 regional training providers and provides vocational training for GP registrars. A number of these regional training providers are located in rural areas; varying levels of interaction and collaboration are reported, from ‘nodding acquaintance’ to close partnership (see case study below). Many informants, in RCSs, regional training providers, workforce agencies, and GP divisions, considered that there was potential for a greater partnership between all stakeholders involved in delivering medical training, to develop a ‘rural pipeline’ to ensure that there was a recognisable training pathway for students interested in practicing rurally. This was generally considered an urgent priority, with RCS and university stakeholders acknowledging that the lack of rural pre-vocational and vocational training places a risk to the Program, and other stakeholders considering that there was a loss of potential workforce to the metropolitan centres because of the lack of alternatives to urban training centres.

Some stakeholders within the State/Territory-funded health system identified room for improvement in some RCS engagement strategies. While the ‘ceremonial’ aspects were seen to be in place, for example, invitations to events, there was a reported frustration in some sites that people with a background in education and research have not been utilised in the conceptual and design phases of the program. In one area a stakeholder described this situation in the following way:

‘I think academia tend to stick with academia, and clinical operationals stick with clinical operationals, and I think we need to be much more aligned with each other. In this area we are about to undergo massive expansion - I think the RCS should be at the table with us now - should be discussing it but they’re not.’ (local clinician)

36 Students undertake a placement in the same rural or remote community for a minimum of two weeks per year, normally over a four-year period. Placements can be in a supervised general practice, hospital, Aboriginal Medical Service or other medical facility that provides primary care (http://www.acrrm.org.au/main.asp?NodeID=194).
37 An annual tax-free stipend of $23,222 (2008 figure), in return for which students are ‘bonded’ to practice in rural or remote areas of Australia for six continuous years upon completion of their vocational training (http://www.health.gov.au/internet/main/publishing.nsf/Content/work-st-mrb-summ).
38 An annual $10,000 allowance and rural mentorship program for medical students of rural and remote origin (http://nrha.ruralhealth.org.au/scholarships/?IntCatId=7).
Case Study – Australian National University and Coast City Country GP Training

Coast City Country Training (CCCT) is the general practice regional training provider (RTP) for the southern region of New South Wales and the ACT. The geographical boundaries of CCCT overlap the geographical regions of the medical schools of three universities – University of Wollongong, Australian National University, and University of New South Wales. CCCT collaborates with all of these in their role of providing vocational training for general practitioners. The southeast NSW and ACT region of CCCT is contracted to work with the ANU medical school and their relationship with the ANU is particularly close, ‘so close that it’s hard to distinguish – it’s all the ANU Medical School’.

CCCT has approximately 55 Registrars in the southeast NSW and ACT region, and they run two-day training programs in which they include the 3rd year students from the RCS. The aim of bringing them together is for the 3rd year students to be exposed to the role of GP registrars. In the learning environment, the medical students can use their academic learning while the registrars can use their clinical learning and they can share with each other, hopefully building relationships which will benefit them later on. ‘Modelling is subtle but it gives a positive role model and positive exposure to rural GP registrars.’

CCCT and the ANU Medical School also take the registrars and students out to rural areas for two days of teaching with local GPs. This event is held in different towns where the participants spend two days together, talking about rural practice and also learning from local practitioners.

An example of this shared teaching occurred in a small town where the local surgeon gave a presentation on acute abdominal topics to registrars and students. The surgeon and the GP demonstrated their collaborative approach, discussing the way they solved a particular problem. The implicit message was about collaboration and presented the specialist and the GP as equals. ‘It’s hard to measure the effect but I think it does help for students to see that.’

CCCT and the ANU Medical School have integrated their supervisor training, so that GPs who are supervising medical students also meet with those who are supervising registrars. Increasingly, they are encouraging students and registrars to train together, with the registrars taking on an appropriate level of clinical teaching for the students, freeing the GP to work with the registrar on more advanced teaching. ‘The RCS has a commitment to look after rural GPs, and we work to do it in an integrated way.’ The teaching staff of the RCS also are involved with registrar training, and the medical school is increasingly becoming a resource for bringing together the clinicians of the region.

The vision for this collaboration is to prepare the next generation of clinical teachers as well as rural doctors. Including registrars in clinical teaching provides them with a background and encouragement to take up teaching or training roles once they complete their training. Introducing students to GP registrars provides them with a model of men and women who have chosen rural practice and are excited about general practice. Bringing students and registrars together helps students to see what the path to general practice might look like. ‘When you teach students you realize how much you know.’ This encourages both GPs and registrars.

‘We couldn’t do what we do in the urban environment.’ The importance of relationships in building the systems which encourage integrated training, and the importance of funding – through GPET to the RTP and through The Department to the RCS – cannot be underestimated. The collaboration at all levels – from the strategic planning to the training on the ground – means that people are involved in decisions and have ownership in the processes. ‘The risk to sustainability is not the structures but the people, and trying to find new people.’ The visible integration of training is now attracting people to the region: ‘people hear that rural registrar training is good here’ and the RCS has made a difference because it has been an enabler in creating a demonstrable pathway to rural general practice.
**Impact on the Community**

Reports of high level support for RCSs from the local community were expressed in a range of ways across the sites, with examples including enthusiastic volunteers for clinical skills practice, the hosting of students, and general goodwill toward the effort to address the recognised problems of workforce shortages.

In some areas the contribution of the RCS has been more substantial, for example in Bendigo where the Monash RCS operates a primary care clinic. Established in 1997, it is now located in a purpose-built building, and provides health services for people who cannot access their usual GP, or would otherwise attend the hospital emergency department. The clinic is used as a training site for students, with staff appointments supported by the local health service as well as the university. Over time the clinic will become a ‘super clinic’ under the newly established initiative of the Department of Health and Ageing, and operate as an academic primary healthcare training centre, not only for undergraduate students but for postgraduate students, internationally trained students and internationally trained graduates. The vision for the model is that it offers a critical service, and provides the RCS with a training environment for students from medical and allied health disciplines.

A similar model is being implemented in Shepparton, where the School of Rural Health is funding the construction of a clinic building on their grounds (directly across the street from the hospital) which will provide clinical and teaching space for medical, nursing, and allied health practitioners.

A further impact of the RCSs on local communities is the investment itself, with each RCS operating as a local employer and contributor to the local economy. A number of sites referred to ‘buy local’ policies for their consumables, as well as the employment of contractors, maintenance and other ancillary staff as part of the operation of the Schools.

**Community Advisory Boards**

Community Advisory Boards are in some ways a misnomer for RCSs. The Boards appear to have been vehicles for RCSs to initially engage the support of key community stakeholders, and then to keep them engaged and informed as the RCS matures. They can be very valuable to RCSs in providing networking opportunities as well as securing goodwill and material support from local community members to make students welcome; some RCSs have convened second-tier committees at a local level in the smaller communities in which they operate for just this purpose.

‘The university gets people on side – people want to help – APEX, Lions, the local butcher who donates sausages for the welcoming BBQ…there are not many people who don’t know we’re here – it’s been very positive.’ (Community Advisory Board member)

However, Community Advisory Boards are generally less advisory and strategic than the name would suggest. They generally meet once a year and are generally vehicles for information sharing, in which the RCS leadership, and sometimes students, inform community representatives of their activities. While the RCSs were required to establish these consultative mechanisms, it is not clear what the purpose of these bodies is once the establishment phase of the Program has been completed. They were referred to with varying degrees of interest at different RCS sites, as being more or less important to the operation of the RCS. One stakeholder who sits on the Community Advisory Board acknowledged that he ‘sits on the Advisory Board but doesn’t do much; it’s a sounding board and could benefit from some governance and more input from the community base.’

**Engagement with Indigenous health practice**

The RCS Program overall has had little impact on Indigenous Australia per se. It was clear that some RCSs had developed more effective relationships with AMSs than others, and in some instances relationships were underdeveloped. An example of the former would be the Spencer Gulf Rural Health School which, as previously discussed, funds a health worker at the Pika Wiya AMS (see section 4.4.4). The AMS reports that all students placed at Pika Wiya are involved in a community project which directly addresses the needs of the local Indigenous community. This was reported to have been an extremely successful model and has been shown to have positively impacted upon the health and well-being of the community. The Aboriginal Health Workers are treated as the experts and this has also helped with increasing confidence and capacity in the local Indigenous community.
Most RCSs have some links with local AMSs, which may range from short-term to one-year student placements. Many AMSs have agreed to provide opportunities for RCS students to spend time within their clinics, and some are involved as well in the provision of cultural awareness and cultural security training. Most RCSs expressed satisfaction with the relationship they had with their local AMS, and most AMSs expressed a willingness to help in training future doctors, with the hope that their contribution will assist the next generation of clinicians to be better practitioners for Indigenous and non-Indigenous patients. AMSs recognise that they have the ability to provide a unique experience for medical students, which exposes them to the full range of clinical challenges seen in mainstream practice but which has the additional complexity of requiring the doctor to work cross-culturally.

‘Every student who has come through has enjoyed it – they are surprised at how much clinical medicine is there, and how much they learn.’ (AMS CEO)

It may be construed that the greatest benefit in the partnership accrues to the RCS, as they are able to provide additional student placements and to access an Indigenous perspective which enhances the medical student’s training. By and large, the AMSs have been generous in opening their doors to RCSs for student placements while maintaining their own demanding schedule of clinical consultation. However, some AMS representatives expressed a view that they did not always feel that this was reciprocated by the RCS, or that the magnitude of what they provided was recognised. In one AMS the question was raised of funding for the provision of Indigenous health training (which is a component of the medical curriculum and thus a requirement of the RCS), which the RCS had asked the AMS to provide. One doctor expressed the feeling that ‘they have got an Aboriginal health curriculum, they should provide it [rather than relying on us to do it for them]’. In another, the question was raised about the nature of the relationship and whether the RCS saw the AMS as an equal partner:

‘I think it should go both ways….when our capacity is down we don’t get any support from them, when we had no doctor the attitude was ‘we’ll stop coming out then’ rather than helping us find one…We’re helping them, we don’t just take students but we give them exposure to all areas, we have to allocate a staff member to [look after the students]’.

In other cases the AMS and RCS had developed stronger, more equitable funding relationships to overcome this issue, sharing appointments or funding particular projects. In some locations, some RCSs have developed partnerships with regional AMSs for research purposes, which are having a direct effect on the provision of health care because of the nature of the research intervention, for example smoking cessation research within a community. This topic is the subject of a large National Health and Medical Research Council (NHMRC) grant which the RCS of West Australia has won in partnership with Kimberley AMS.

5.5 Enabling and limiting factors

5.5.1 Enabling factors

Funding

It is unanimously agreed that the funding for the RCS Program has been generous and, indeed, that this level of funding has been one of the key factors in the success of the Program to date. The funding has allowed RCSs to build or purchase excellent physical resources (including teaching facilities, office space and state-of-the-art information and communication technology) and human capital which have, in a short period of time, created a parallel university infrastructure to rival that found in urban environments.

At the inception of the Program, universities were asked to bid for the amount of funding they required to establish an RCS. Because of this open offer, universities sought varying levels of funding, which have largely been maintained in subsequent contracts. Some universities have therefore received greater amounts of funding and have been able to be more lavish with the resources provided to their students than neighbouring universities. Students have been quick to notice this.
There are big differences across unis – [Uni A] students have to pay for their accommodation but [Uni B] students don’t… I don’t understand why there is such a difference.’ (medical student)

‘[There needs to be a] more even spread across the board for RCSs to – i.e. support and amenities – for unis to be transparent on what RCSs provide. Different geographies make a difference but there is still a big disparity – why is it so different when they are all trying to achieve the same thing?’ (medical student)

The distinction between the RCS as a workforce initiative as compared to the rest of the university sector is considered to be significant, with several informants stressing that the funding should remain with the Department of Health and Ageing rather than with the Department for Employment, Education and Workplace Relations (DEEWR). There was strong consensus that the achievements to date had been due to the nature of the Program as a workforce initiative, with a corresponding focus on influencing students’ career decisions, and that this would be lost if the Program were to be seen solely as another component of medical education (while recognising that the Program had to meet educational requirements and that it was already embedded within the educational sector).

Vision and leadership

An important contribution to the Program’s achievements to date was also considered to be due to the passion and commitment of the early champions of the idea. Some participants pointed to the advocacy of the then Minister for Health and many other early champions as a key factor in the establishment of the Program, including those who crafted the original proposal for what became the RCS Program. Others acknowledged the role of the founding heads of individual RCSs, who often had to battle the reluctance of the wider faculty or medical profession in arguing the virtues of the initiative. This need for vision and leadership continues, and succession planning was named by several as a risk for the future in ensuring that the RCS Program continued to demonstrate its effectiveness both as a training structure for medical students and as an influence on workforce career choices.

The quality of training places

Through the development of strategic personal and organisational relationships, RCSs have been successful in creating a large number of training places across regional Australia, both in hospitals, GP surgeries and other primary care settings. In some cases, this was made easier because regional hospitals did not have a high demand from interns, residents or registrars (this is changing as RCS students seek placements, as discussed below). It was noted by almost all students that the quality of teaching, through the exposure to a greater range of clinical experiences, generally surpassed that available in the urban setting.

‘Students are becoming more savvy. They are looking to the future, and with the increase in competition, they need to get high quality clinical education. They want to be able to differentiate themselves. You get better patient interaction (through the RCS model) and this is well known with senior doctors’. (medical student)

While this relational aspect of rural training has been acknowledged as an enabling factor, there is a corresponding risk due to the increasing demand for training places, discussed below. Furthermore,
while the quality of the educational experience needs to be highlighted as an enabling factor for the Program, there is some concern about whether this is likely to lead to better workforce outcomes for rural communities. To what extent are students opting to undertake an RCS place because they are interested in a rural health career, and to what extent are they doing it because of the recognised quality of the clinical experience and exposure to patients/clinicians, regardless of students’ career intentions?

5.5.2 Limiting factors

The capacity of health services to make training places available

As noted earlier, the number of long-term student placements that can be supported in any given area depends on the capacity of the health workforce and health systems to accommodate and supervise students. This was discussed by many stakeholders as a significant threat to the long-term sustainability of the Program.

In a sense, the RCS Program faces becoming a victim of its own success, as the positive feedback of RCS students leads to more students seeking places within the RCS. It has been suggested by some students, and recognised by some academics, that students may choose the RCS because of the quality of its training rather than because of an interest in rural medicine. This may have the unintended impact of reducing the availability of placements for students who are genuinely seeking to develop a rural career.

‘So students go out and have this great short placement in 1st year and it’s all nice and fluffy, and then they go out in the 2nd year and it’s all nice and fluffy, but then when they want to go out for their 3rd year [for a long-term RCS placement] there aren’t enough placements. So it gives the message that rural medicine isn’t in crisis and it’s not that important to go rurally so they stay in the city. Also a lot of graduate medical students are not rurally inclined so they are doing these placements but commuting from [metro area] rather than staying and engaging in the community. The [graduate] program was touted as the solution to the…workforce crisis but it won’t do it, it’s shafting the rural students who really want to work there.’ (student)

There are also additional constraints to the number of long term placements that can be supported, particularly where there is competition from other programs within medical education (e.g. shorter-term placements through programs like RUSC or John Flynn) or further up the ‘vertical’ training pathway (e.g. PGPPP, GP registrar training, specialist training). Some informants questioned the ability of rural communities and practitioners to absorb the increasing numbers of students who pass through their doors, for short-term exposure tours, for RCS training, or for intern or vocational training.

As the number of universities undertaking rural clinical education has increased, there have been some ‘gentleman’s agreements’ as a result of which established universities have moved away from placing students at certain hospitals (e.g. UNSW making available placements at Shoalhaven Regional Memorial Hospital in Nowra for University of Wollongong students). In other areas universities have formalised an agreement, for example University of Adelaide and Flinders University, both of which place students in Angaston in the Riverland, and the University of Western Australia and Notre Dame University, which jointly fund the RCS of Western Australia.

Where universities are competing for clinical teaching, however, whether in general practice or in regional hospitals, there will be increasing difficulty in accommodating the growing numbers of students, interns and/or registrars who seek to train rurally. In some regions it was reported that the system is at capacity, with one stakeholder commenting ‘there won’t be too many health services in the parts of [the State] that we operate in that don’t have students.’

With the growth in student numbers a strategy is increasingly employed to recruit new general practices into teaching the GP-based or community-based education model, recognising there are limitations on the ability to increase student numbers in hospital settings. A further strategy borrows from the approach used in the Riverland, where ‘teaching hubs’ are established to support students in surrounding locations. The hub provides teaching space, reference texts, and some staff time.
The geographical distance involved in rural clinical education is one of the unavoidable difficulties of this Program. As one UWA stakeholder noted, ‘we have the most dispersed medical school in the world.’ Distance brings with it the cost of travel (in time and money), an increased cost of living, and the potential for isolation (e.g. limited access to teacher training for RCS staff). Some clinical trainers also noted that there are risks involved for students who are required to do a great deal of country driving, particularly when they are not used to travelling such distances or on isolated stretches of road, often unsealed. These costs are accepted as one of the consequences of the rural training infrastructure; however they are also recognised as limiting factors due to the greater reliance on and need for adequate information technology, additional administration costs (due to dispersed sites), and isolation.

All RCSs have been able to access (or invest in) accommodation for students, and it was consistently reported that subsidised or free accommodation was a significant factor in attracting students to the RCSs. Longer term placements (e.g. of one year) do make normal private rental arrangements viable in the way that short-term rental agreements for six-week placements are not, so in some cases RCSs do not have the critical student accommodation needs of a program like the John Flynn Placement Program. In addition, where an RCS expects to have a critical mass of students on a continuing basis they have often purchased units or houses for communal student living. The cost and availability of housing varies significantly and in some areas which are experiencing an economic boom, such as Port Hedland, the ability to access any accommodation is a challenge. Student accommodation has also been raised by some RCSs as a limitation to establishing training posts in new areas.

The challenges of living communally with students and working closely with them on a daily basis were noted by several students. Several RCSs spoke of the efforts which they made to allocate students together who knew each other or who they had determined shared common interests, to alleviate the inevitable tensions which might arise when students are essentially spending 24 hours a day living and working together. Issues were also raised by students about the suitability of the accommodation for people who have partners and/or children with them.

In addition, some students were quick to acknowledge the inadequacies of their current student accommodation, and some staff members perceived that the expectations of students had risen dramatically with regard to adequate housing, putting additional pressure on the RCS to meet student expectations out of a concern that they would otherwise not be able to attract students who might potentially become rural doctors. Some RCSs have intentionally developed accommodation to suit couples or families, particularly where it was a graduate program (and students are a little older than in undergraduate programs). Elsewhere, couples and families are not as easily accommodated, and in some instances this was seen as a limiting factor.

A shortage of adequate rural accommodation is not a problem confined to the RCSs; this has also been experienced by staff who might be recruited to a UDRH, or clinicians who might be taking up a joint appointment with the local hospital.

‘The [hospital] accommodation was shocking so we bought our own, but it’s harder to get into the market now.’ (hospital clinician)

This same doctor wondered whether these sorts of difficulties discouraged students from considering rural careers.

‘I’ve wondered whether students hear what doctors are saying about living here and make their own mind up.’

Succession planning

There is a rich narrative history associated with the rural clinical schools, where the founders of RCSs and, in particular, the preceding programs which led to the RCSs, have attained ‘legendary’ status for their substantial commitment and contribution to rural health over many decades. While there is no doubt these accolades have been earned, there is an associated risk emerging in regard to succession planning. In effect the founders represent the generation which forged the way and ensured rural and remote health reached the national health agenda, and they are strongly supported by highly committed teams of academic and administrative staff. While a model of ‘charismatic leadership’ has served the RCSs well, this is not generally viewed as a sustainable model.
The challenge now for RCSs (and to some extent UDRHs), is to cultivate the leadership capacity to steer the program into the future, following the inevitable retirement of the ‘first generation’ of leaders.

5.6 Summary

The RCS Program has now enabled the creation of 14 dedicated rural clinical schools, with the establishment of significant tertiary infrastructure in rural Australia and the development of a strong network of academic rural clinicians. A number of alternative clinical training models have been piloted and found to be beneficial, including the Flinders University Parallel Rural Community Curriculum and other community-based training approaches. The successful provision of clinical training in the rural environment, evidenced by the academic results of RCS students in comparison with their urban counterparts, has demonstrated the validity of rurally-based clinical training.

It is too soon to determine whether this extended rural exposure through the RCSs has influenced medical students’ actual decisions to practise rurally. However, there is anecdotal evidence that the presence of the RCSs has influenced the recruitment of new clinicians to rural practice, and also assisted with retention of current rural medical practitioners. Evidence of student career intentions is also encouraging. The early cohorts of the RCSs will soon be establishing themselves in medical practice and over the next few years it should be possible to analyse whether the number of RCS-trained, rural doctors is increasing. Student tracking surveys should also enable longitudinal data to be collected with regard to RCS students and their later career decisions.

Challenges to the RCS Program, as for the UDRH Program, are the capacity of the health system to accommodate increasing student numbers, as well as recruitment of staff. The RCS Program faces an additional challenge due to the nature of medical training, as the number of rural internships, pre-vocation placements, and vocational training opportunities remain limited, potentially undoing the positive influence of the rural experience gained through the RCS placement if students find themselves spending extended periods back in the urban environment for pre-vocational and vocational training. The need to address this lack of capacity is pressing if the investment in the RCS Program is to be realised.