BUILDING RURAL CLINICAL SCHOOLS - AN HISTORICAL PERSPECTIVE

Australian National University

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CONTEXT

1860-1960 – 8 Medical Schools

1970-1990- +2

2000-2010 +8

Now 21

Why?

Workforce imperative

Political imperatives

Role of rural clinical school movement

Australian Government funding for university medical places

Posted 25/05/2022 by Dr Hazel Ferguson

As the gateway to the medical profession, medical schools have a role in addressing a range of issues in Australian health policy, including persistent geographical inequalities in access, and shortages in specialisations such as psychiatry.

Recent policy, including a limited redistribution of university medical places in favour of regional universities, has focused on redistributing existing resources to address chronic geographical shortages.

https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/FlagPost/2022/May/Medical_placesin regional, rural and remote areas

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ENABLERS

Community
Local Health Services
Local clinicians

Commonwealth
Funding
Support for possibilities
Stability and engagement

Broader health political environment

RCS success

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If you've seen one rural town/rural clinical school/rural teaching site you've.....

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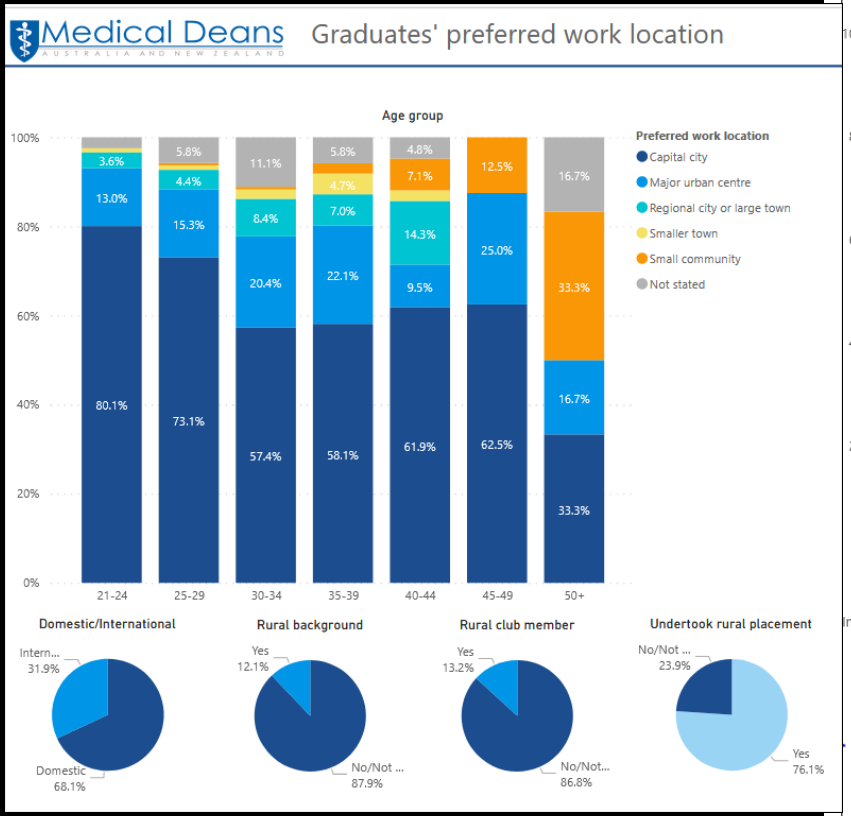
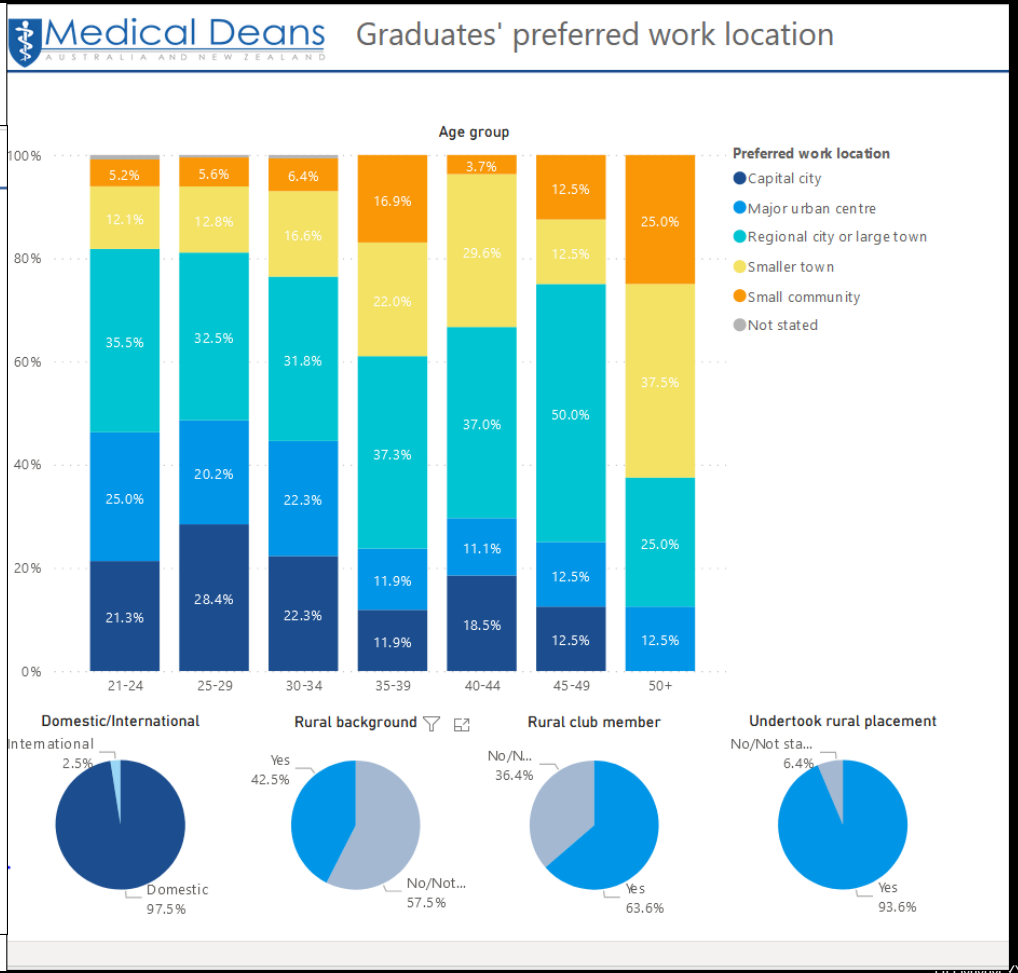
Outcomes





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We're going on career hunt…….

Impacts

Medical education

Aboriginal and Torres Strait Islander Health

Community – (and how do we measure it)

Broader political environment- advocacy

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A MODEL FOR COMMUNITY LEVEL IMPACT OF A RURAL CLINICAL SCHOOL

-towards measurement tools

Sally Hall; Hilary Miller; Miriam Glennie; Edward Reynolds; Michelle Irving; Amanda Barnard
Australian National University Medical School, Rural Clinical School, Canberra, Australia.

ANU Rural Clinical School

- Embedding medical school campuses and student experiences in rural communities is a key element of rural clinical schools in Australia,[1] and in community-orientated medical schools more generally.[2]
- Limited research has been conducted into the impact of rural clinical schools on the social life of communities where they are located and engaged.
- This qualitative, exploratory project employed a two phase approach using focus groups, key-informant interviews, participant observation and documentary analysis to describe the community-level impact of the ANU Rural Clinical School (RCS) on the host communities within its geographic footprint and to develop a theoretical model.

We aimed to:
- describe the impact of the RCS on rural communities where teaching activities occur;
- describe the impact of the RCS on the day to day life of the local health care system, and specifically on local services;
- assess impact on medical student supervisors of their engagement in teaching activities; and
- inform the development of a tool / mechanism for measuring community impact in a health care context

Our region

- 58 800 square kilometres (Australian Capital Territory & south eastern NSW.
- 616,000 people, 230,500 residing in rural New South Wales.
- 40 general practice training sites.
- 13 regional hospitals
- 1 tertiary referral hospital (Canberra)

Our program

- Four-year post-graduate MChD program, 3rd year students spend at least 8 weeks in rural clinical placements.
- Approximately 25% undertake a 12-month long integrated placement, focusing on general practice and local hospitals – the 'Rural Stream'. 26 Rural Stream places offered in 2015.
- Program organised around teaching / administrative nodes located in 5 sub-regions (study sites), with a central coordinating hub based at the ANU campus in Canberra.

Aims & Methods

This project adopted a realist perspective, drawing on ethnographic methods and rapid appraisal techniques, with data collection undertaken in 2 sequential phases.

	Phase 1	Phase 2
Data Collection	• series of 8 formative focus groups • sample = staff and students • + documentary analysis of historical local media reports (n=94, from 16 media sources)	• key informant interviews and site visits • sample = community-based individuals and groups, medical and allied health professionals, and local businesses (see Table 1) • participants selected using a targeted purposive approach with secondary recruitment of a convenience snowball sample.
Objective	• identify key themes and develop a working model of 'impacts' operating at the local level	• to explore and refine impacts and understand interactions and phenomena that explain the model.
Data Analysis	• thematic coding using grounded theory approach	• coded using structure developed in Phase 1, with allowance for additional open coding of emergent nodes and refinement of model. • followed by secondary coding to identify relationships between thematic nodes and develop context-mechanism-outcome (CMO) configurations to inform realist synthesis.

Table 2: Key informant sampling across 5 geographic sites

Sphere	Examples of Key informant groups / individuals	Number per site
Community groups	Service clubs, Disease / health related support groups, Community Advisory Board members.	3
Indigenous groups	Indigenous Homework Club, Aboriginal Medical Service.	2
Government services	Schools, Local Government, Corrective Services, non-health related community services.	3
Laypeople	Patients, community hosts, local business, site specific contacts, community leaders	8
Private sector health services	General practice and medical specialists in private practice, Community pharmacy, Divisions of General Practice / Medicare Locals / PHOOs.	6
Public sector health services	Ambulance and emergency services	6

Ethical approval was provided by the ANU Human Research Ethics Committee, protocols 2012/492 and 2013/440. The study was limited by the exclusion of Southern NSW Local Health District (LHD) staff, due to ethical constraints imposed by the LHD requiring separate in house ethical approval.

Results

- 102 interviews conducted with 117 respondents (response rate 72.6%), some interviewed in pairs or small groups reflecting organisational affiliations.
- Almost 36 hours of interview data, mean interview time approximately 25 minutes.
- Participants evenly distributed across the health sector (1/3), community based and public sector organisations (1/3), and individual community members (1/3).

A model of community impact

The model operates as a dynamic feedback system. When drivers are actualised they act as benefits which have an ongoing and reciprocal positive feedback effect. Costs in turn have a negative feedback effect through creating identifiable risks to sustainability.

Impacts result from both the presence of students in individual situations and more broadly as a result of the presence of the RCS and the University in local communities. RCS activity impacts differently on various community actors within different community spaces or spheres of influence.

Impacts were identified at the micro, meso and macro levels within communities, affecting individuals, specific groups and whole communities.

Individual actors were more heavily represented on the inputs side of the model, as they provide much of the time, energy and motivation to undertake specific work on behalf of the RCS, while communities and populations are more often the recipients of macro level benefits.

A Framework for Measurement

DRIVERS	COST OUTLAYS	COST BURDENS	BENEFITS
What aspirations/motivations drive engagement with the RCS? For whom? To what extent are these realised?	What do people do to support the work of the RCS? What input costs are incurred? By Whom?	What burdens result from RCS activity? What costs are borne? By whom?	What benefits are realised? For whom? How often? Are these actual or perceived? Do they outnumber/outweigh costs?

Who is engaged in the work of the RCS?
In what ways?
What threats to sustainability exist?
How ar does our reach extend?

Conclusions

- This qualitative investigation provides exploratory results to inform the development of survey metrics for ongoing assessment and monitoring of community impact.
- The features identified in the model provide an empirical and theoretical framework to support a comprehensive measurement approach, and are consistent with approaches such as the THEnet social accountability framework[3]
- Measurement mechanisms could be constructed from currently validated tools, existing data sources, and the development and testing of specific instruments.

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Successes

Back to this morning …..what was behind them?

Flexibility

Recognition and celebration of diversity

Connection

Generalist perspective of our leaders and clinicians

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Why the loss of generalism?

A generalist must develop the skills to	A specialist must develop the skills to
Tolerate uncertainty - generalists must manage a large proportion of patients with undifferentiated symptoms, including those who present early in the course of illness, those with evolving conditions, or those whose symptoms do not form a characteristic pattern of disease.	Reduce uncertainty - specialists are expected to discover a diagnosis and to investigate until this is achieved. If they are unable to identify a diagnosis within their own specialty, they are usually expected to discharge the patient or suggest referral on to another specialist, rather than manage the diagnostic uncertainty.
Explore probability - generalists see patients from an unscreened population with a relatively low incidence of disease. They require highly developed diagnostic skills, including recognition of common conditions and awareness of the limits of their knowledge. Their decisions are based on the epidemiology of the community and the consequent probability that the patient's symptoms are medically significant.	Explore possibility - specialists see a preselected population of patients with a relatively high incidence of serious disease. They require expert knowledge of the rare and esoteric conditions that are relatively more likely to be the cause of the problem in this population.
Marginalise danger - a key skill of a general practitioner is to recognise and act on potential dangers to patients and communities even when there is diagnostic uncertainty; this often requires referring the patient or initiating treatment before a diagnosis has been established (for example, in a case of suspected meningitis or cancer).	Marginalise error - a specialist must ensure that they reach an accurate diagnosis to guide treatment for the patient, in order to enable a successful outcome.

Source: Adapted from the Royal College of General Practitioners (RCGPUK), *Preparing the future GP: the case for enhanced GP training*, RACGPUK, 2012, accessed 8 October 2020.