GPSA
GENERAL PRACTICE SUPERVISORS AUSTRALIA

Supervision Roadmap

RURAL GENERALIST TRAINING IN VICTORIA

VICTORIA State Government | VICTORIAN RURAL GENERALIST PROGRAM

MONASH University

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BACKGROUND

Rural generalists play a major part in prevention, early intervention, and care coordination across an extended scope of medical care in small rural communities where access may otherwise be limited by physical distances, transport, and costs. Rural generalists are relied upon not only to deliver comprehensive primary care but to also provide the 24-hour emergency supports and other extended services that rural towns need. Individual specialties are not viable in small rural towns. Instead, training rural generalists (RGs) as doctors that can cover a breadth of relevant specialties on top of comprehensive primary care ensures equitable, cost-effective, sustainable care.

The Victorian Rural Generalist Program (VRGP) represents a significant state-wide investment in growing the next generation of rural generalists to serve in each of its five rural regions of Hume, Loddon Mallee, Grampians, Barwon South West, and Gippsland. No form of medical training is possible without high quality clinical supervision, and RG training is no different. Moreover, supervision on the VRGP is more complex where doctors need to learn a suitable range of core generalist skills to deliver services that communities need.

The VRGP pathway starts with supervision in Rural Community Intern Training (RCIT) programs in each of Victoria's five rural regions. However, to retain RGs beyond internship, a body of work needed to be undertaken to inform the expansion of supervised learning in the second year of RG training (RG2) in distributed rural communities where these doctors are intended to eventually work. The quality of supervised learning at this point is critical to achieving retention of RGs and progressing them to the next stage of fellowship training with a GP college: leading into FACRRM or RACGP-FARGP qualification endpoints as practising RGs.

AIMS

This collaborative project aimed to explore and expand on existing evidence about rural supervision to meet the learning needs of the RG2 group across a core generalist curriculum. It specifically focused on three rural regions of Victoria: Hume, Loddon Mallee, and Barwon South West. Further, this project aimed to use this information to develop a Supervision Roadmap to guide the implementation of high-quality supervised learning across core generalist curriculum in the RG2 year of the VRGP.

METHODS

This project was led by General Practice Supervisors Australia (GPSA) in collaboration with the rural regions, stakeholders, clinicians, and health service executives over a 12-week period (June-August 2021). It involved:

1. A literature review of curriculum and supervision requirements for RG2s and available resources to guide contextual understanding of the topic.
2. A VRGP trainee survey (50% response rate) to establish the current and future training needs of RG1s and RG2s on the VRGP.
3. A review of general practice programs at prevocational and vocational stages to inform supervision and educational requirements and funding opportunities relevant to the RG2 group.
4. Interviews with 13 GP supervisors (speaking on behalf of their practices) and 18 small and large health service executives to inform the enablers and barriers to supervising RG2 doctors across core generalist curriculum.
5. Interviews with stakeholders knowledgeable about blended/remote supervision models to inform guiding principles that the VRGP could apply to extend supervised learning in Victorian regions.

FINDINGS

The aggregate findings are summarised in five chapters:

CHAPTER	FINDINGS
CHAPTER 1: Literature Review	• Literature on rural supervision is mainly focused on registrars, with negligible material addressing RG2 supervision in small towns, across a core generalist curriculum. A range of supervision guidelines and various tools and resources are summarised as they may be useful for the VRGP.
CHAPTER 2: Summary of GP Training Programs	• There are multiple programs focusing on training in general practice, including at the prevocational stage, but they are not aligned, have different providers, can have limited focus on supporting supervised learning and have limited funding for supervision. All pay less than practices might gain from hosting a registrar.
CHAPTER 3: Survey of Trainees	• RG1s and RG2s have strong interests in procedural training, with few seeking non-procedural skills at the early stages of their training. This may be related to the curriculum demands within core generalist training and the traditional professional ideation about what constitutes a rural generalist.
CHAPTER 4: Interviews - Enablers and Barriers in the Regions of Interest	• Supervision capacity in the three regions is highly variable. It is more mature in the Hume, but less so in the Loddon Mallee and Barwon South West regions. Further, the supervisor workforce is burnt out and working at capacity with few other clinicians who are fellowed, invested in education, or able to take up supervision of RG2s atop of an increasingly busy clinical workload. • Across all regions, there are limited fellowed doctors to do level 1 supervision for RG2s because of recruitment/retention pressures and doctors retiring. The Loddon Mallee and Barwon South West are somewhat reliant on overseas trained and locum doctors, which adds to the supervision burden of a small number of fellowed doctors. Locums are not invested in fostering local training pathways. • All regions value selective recruitment of learners who are suited to their services as a cornerstone of successful supervised learning, but this takes time that many towns do not have given the pressure to deliver services to the community. Some regions like the Barwon South West have more social amenity attractors such as schooling and social opportunities, but other regions have towns that are not attractive for new doctors. Supervisors become de-motivated when trainees are not attracted to their training opportunities, and they have to teach doctors who are not committed to the region. • Supervision of the RG2 cohort is considered unsustainable in all but a small number of practices in Hume, and selective towns in Loddon Mallee and Barwon South West with historic experience of hosting medical students and RCIT interns. It helps to motivate supervisors in some cases when learners return or stay on to continue training and working in the region. Sustainable supervision models tend to involve the whole practice/service team in supervising junior doctors, which enables them to effectively manage their workload and maintain their billings. Such training practices have a strong learning culture and quality improvement processes around supervision of trainees/learners. • A range of other practices find the postgraduate year 2 (PGY2) group an unappealing cohort to host as they can have variable skills and create business risks, extra workload and increased financial pressure. They can also be hard to fit into the physical space of the practice. Practices want funding to support the supervision of RG2s.

CHAPTER	FINDINGS
CHAPTER 4: Interviews - Enablers and Barriers in the Regions of Interest (continued)	• Hospitals and health services in small towns in all regions are interested in expanding training opportunities and rely on GPs for supervision. However, health services walk a precarious line of keeping their GPs happy so as not to compromise Visiting Medical Officer (VMO) services to the hospital. There is inadequate funding to employ RG2s in small rural hospitals, especially compared with the funding following interns, and a limited palate for health services to employ RG2s over more advanced junior doctors with less onerous supervision requirements. • All regions identify a range of external systems pressures around shrinking VMO rosters, procedural work opportunities, and a centralisation of services. This is worse in locations closer to Melbourne/major regional hubs, commutable or attractive for specialists to visit. However, there are many untapped learning opportunities within generalist scope across clustered services in all the regions. These include specialist-led outreach and telehealth clinics, inpatient general medicine, aged and palliative care, and urgent care in the community and hospital, among other things. Non-procedural fields seem highly sustainable in all the rural regions. • In the Hume region there is strong success from regionalised medical training under a longer-term vision for the community's health services, drawing on strong concepts around RG-led service models (this region has the longest-standing Rural Community Internship Training program since 2012 called 'Murray to Mountains' or 'M2M'). There are many examples in all three regions of champions of RG training and grow your own philosophies. These are starting to expand accredited training opportunities by working across communities and with key stakeholders. However, due to the independence of health services and general practices, and the need to link supervised training opportunities across towns, funded regional coordination/ collaboration support systems are needed to help each region develop a mature training network across the RG development cycle. This likely requires a focus on the types of RGs each rural region needs in order to build an RG workforce that is sustainable and cost-effective.
CHAPTER 5: Interviews - Blended/Remote Supervision	• A range of principles underpin the potential use of blended/remote supervision which can inform innovative solutions as a back-up in situations where local supervision capacity may be limited. Across a generalist scope of work in rural areas, with less experienced doctors, there are more nuanced considerations including the need for an off-site supervisor to know the context of the rural setting the learner is in and to have clear roles and responsibilities. • Using remote or roving supervision options for RG doctors does not overcome the need for prevocational RGs to have on-site medical supervision. • Supervision that is not face-to-face is potentially more applicable in emergency and non-procedural fields rather than procedural areas. • Blended/remote supervision require specific governance, local roles and responsibilities, and systems if they are to work as an adjunct supervision model for RG training.

THE SUPERVISION ROADMAP

The Supervision Roadmap denotes that expanding supervised training for the RG2 group should be facilitated through a strengths-based approach addressing the needs of trainee and supervisor, wider system enablers and barriers, and drawing on best practice principles and evidence. Building supervised learning for the RG2 step of the VRGP required a focus on six main points as outlined below.

1	**Where to build supervision capacity**	This involves understanding the agreed rural region-specific endpoints for the VRGP and scanning for strong supervision opportunities across the relevant scope including at the RG2 step of the pathway. Key indicators can guide the selection of locations and clinical settings where sustainable supervision can be achieved. Cluster models, and opportunities for procedural and non-procedural skills, are considered.
2	**What supervision capacity to build**	The specific focus of the VRGP in each region could better align with training doctors for those RG practice models that are likely to be sustainable in rural regions longer-term. This includes considering the relevance of the range of procedural training that RG2s get, and whether procedural models are feasible to pursue in every region. Victoria may require a PGY2+ curriculum that is more focused on emergency care, general medicine, aged care, palliative care, mental health, and Indigenous Health, where providing RG2s with supervised learning opportunities may be more viable in the longer-term for small rural towns.
3	**Promoting the uptake of supervision**	This involves greater clarity about the VRGP group, their skills, experience, tools and resources that will support practices to engage with supervising RG2 learners and build the skills to manage this group of learners around a busy clinical workload and limited time. It also involves recognition and reward for supervisors as part of a VRGP supervisor community of practice.
4	**Influencing the systems level**	Not everything that needs to be done to enable supervision falls under the remit of the VRGP. It is noted that the VRGP will need to continually engage in widespread collaboration to foster system partnerships and engagement of stakeholders who play a role in unlocking the potential for high quality supervision capacity including at the RG2 level.
5	**Considering roving supervision**	This involves considering how the principles of blended/remote supervision could be applied to a rural region-specific roving supervisor (supernumerary), backing up the local supervision by fellowed doctors and wider clinical teams who have intimate knowledge of the learner's context and day-to-day interactions. This roving supervision concept could be explored for regions with limited critical mass of fellowed supervisors willing to engage, and for learners accessing local multidisciplinary team-based learning models. Specific principles need to apply to the design of these models for the RG2 stage and their scope of work.
6	**Committing to a gradual build**	This involves planning for a gradual process of unlocking supervision opportunities, which will differ by region. The short-, medium-, and longer-term period of increasing supervision capacity may involve using different strategies in different rural regions, but it will require clear planning and operationalisation by regional networks.

CONCLUSION

This research was exploratory in nature but covered a breadth of stakeholders in three very distinct regions and beyond. Overall, this project has unravelled some of the nuances of supervised learning for the RG2 step of the pathway, showing that supervision is affected in both practices and hospitals by multi-level systems issues. Some of these factors are amenable to the VRGP's direct intervention, and others require extensive collaboration. Some of the enablers and barriers will be stronger in some regions over others, and thus regional tailoring of the findings is recommended. Overall, the Supervision Roadmap identifies several ways that the VRGP can move forward to unlock more supervision capacity for building the future RG workforce for Victoria's rural regions. The VRGP and its stakeholders may benefit from committing to a gradual building process to grow supervision across the core generalist curriculum at the RG2 step of the pathway. Unless there is investment upstream in developing high quality supervised learning for RG2s, it may be hard to retain RGs and for the VRGP to realise its goals of growing a fit for purpose RG workforce for Victoria.

"The Supervision Roadmap identifies several ways that the VRGP can move forward to unlock more supervision capacity for building the future RG workforce for Victoria's rural regions."

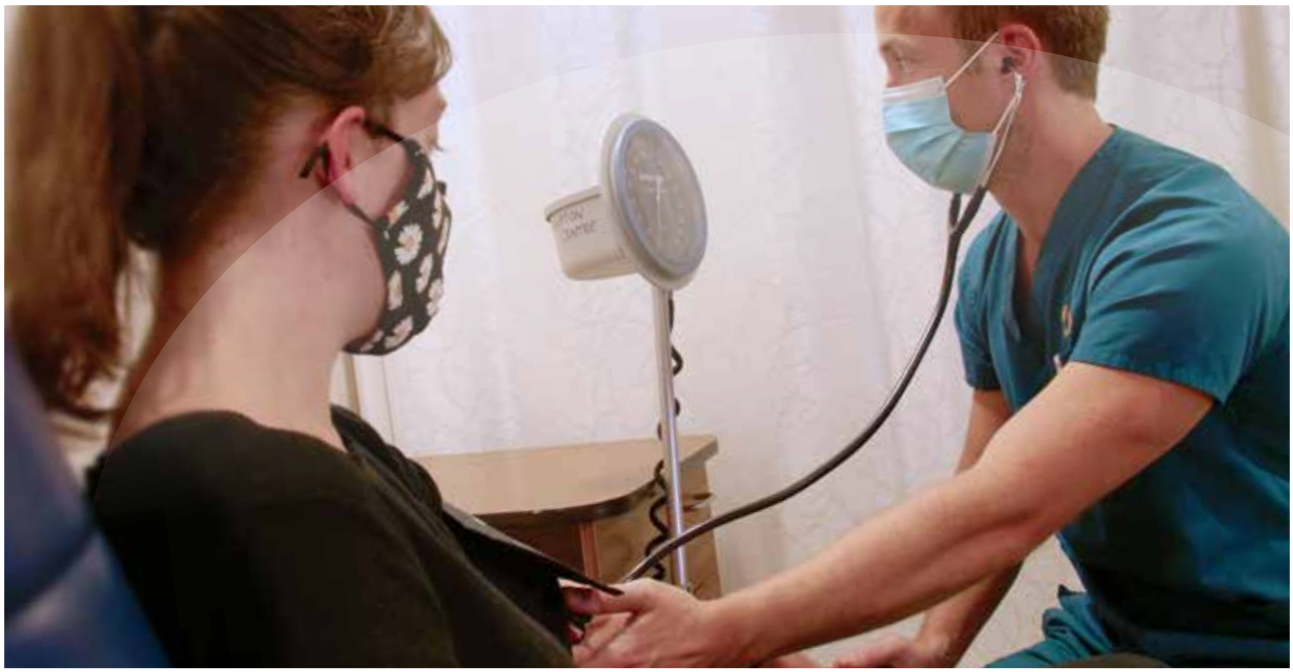
INTRODUCTION

The Victorian Rural Generalist Program (VRGP) represents a significant state-wide investment in growing a medical workforce that is fit for purpose and supported to work in distributed communities across a rural generalist scope. Rural generalists (RGs) play a major part in supporting access to comprehensive primary care along with 24-hour access to emergency support and other extended services across Victoria's small rural communities where access to specialists is limited and distances, transport systems and costs may be a deterrent to care. Local RGs play a major part in prevention, early intervention, and care coordination across an extended scope, ensuring equitable, cost-effective, and sustainable care for rural communities.

The VRGP encompasses a state-wide end-to-end training model which is based in one of five rural regions – Hume, Loddon Mallee, Grampians, Barwon South West, and Gippsland. The VRGP has been built on Victoria's existing Rural Community Intern Training (RCIT) programs, implemented progressively since 2012. Approximately 30-35 RCIT interns are based in small rural towns each year, gaining at least 10 weeks' experience working in general practice often with RG mentors/supervisors. However, to retain this group beyond internship, a body of work is required to inform the expansion of accredited second year RG training (RG2) in distributed rural communities where these doctors will eventually work.

RG2 trainees are around their second-year post-graduation from medicine (PGY2). They need to get high quality learning in this year to develop skills across the core generalist curriculum and learn to practise safe and high quality rural medicine relative to their stage of learning (1). The core generalist training (CGT) requirements for a PGY2 doctor entails taking opportunities to do supervised rotations in primary and secondary care within small rural communities. This touches on disciplines such as anaesthetics, obstetrics and gynaecology, paediatrics, emergency medicine, and general practice.

The focus of this project is on informing a Supervision Roadmap, to help the VRGP expand supervised training in these areas at RG2 level, specific to the context of the Hume, Loddon Mallee and Barwon South West regions and their training priorities. Informing the RG2 training expansion in relevant small rural towns is complex. It requires mapping of the contemporary enablers and barriers to supervised learning across the required curriculum, and an understanding of the scope and volume of experience at the RG2 level. It also requires consideration of blended/remote supervision options across a regionalised training model with potential application to the VRGP at large. To this end, General Practice Supervisors Australia (GPSA) worked collaboratively with the VRGP regions of Hume, Loddon Mallee and Barwon South West, and Monash University, between June and August 2021, to explore the dynamics of RG2 supervision and inform recommendations for increasing supervision capacity of RG2s in distributed communities in Victoria – a Supervision Roadmap.



DEFINITIONS

The supervision field is fraught with terminology issues, and misunderstandings are quite common (2). For this reason, definitions of key terms and acronyms are outlined in Table 1 and Table 2.

Table 1: Definition of Key Terms

Term	Definition
Clinical supervision	• The regular structured extended encounters that happen one to one which involves intensive relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleagues (3). • The supervision partnership addresses functions of quality control, maintaining and facilitating competency and helping supervisees to work effectively (3). • It includes aspects of both mentoring and coaching – supporting someone's personal and professional development (e.g. mentoring) as well as looking after their performance (e.g. remedial supports) (2). • Supervision differs from training (which is more based on teaching facts and figures, rules, and guidelines). Rather it covers the messiness of the real-world realities of practice (4). • It is also much wider than educational supervision which is about reviewing progress in a training program (2). It is aimed at reflecting on casework and building professional skills for competent clinical work (4). • Effective supervision, because it happens across the lifespan, nurtures reflective practice (4). It should thus encourage careful listening and posing of challenging questions that are open and malleable rather than fixed. These processes encourage learners to make connections between actors and meaning within medicine (4).
Intern	Junior doctor in the first year of training after graduating from medical school (PGY1).
PGY2	Junior doctor in their second year after graduating from medical school, and has completed their 12 month internship to gain registration with the Medical Board of Australia.
Pre-vocational learner	In contrast with "trainee" a term that is interchangeable with "registrar", the term "learner" is typically used for someone who is at the level of post-graduate training where the specialty area has not yet been chosen and is therefore not yet officially enrolled in specialty training with a college.
Vocational trainee	This term applies to someone undergoing post-graduate training in a specialty area; in general practice, this trainee is better known as a registrar.
Remote supervision	Remote supervision involves the supervisor being off-site and the learner getting in contact with their off-site supervisor by telephone or videoconference (e.g., Teams, Zoom, Skype). Remote supervision models may be blended, as defined below (5). This model is a response to educational and workforce needs often in rural and remote communities.
Blended supervision	The blended supervision model, which integrates off-site supervision with available local supervision resources, is a pragmatic alternative to traditional supervision. It is a form of remote supervision which is augmented by clinical teaching visits to the practice by the supervisor or a medical educator (5).
Rural community	Rural communities are defined as Modified Monash Model 2-7 (6). In smaller rural populations, from MM4+, or 15,000 population or less, a higher proportion of GPs work in procedural areas of care (emergency, surgery, anaesthetics and obstetrics and gynaecology) (7).
Rural hospital	Rural hospitals vary in size and may have more general and less specialist services and multipurpose facilities that maximise health service access for the needs of a large and diverse geographic catchment of people.
Rural generalist doctor	A medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care, and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team (8).
Supervision components/ functions	• Restorative/supportive: This is the component of supervision where the supervisor helps the supervisee with coping strategies, stress management, burnout, debriefing. • Formative: Development of skills and knowledge of the supervisee. • Normative: Component of supervision that deals with policies, procedures, guidelines, protocols, standards, and norms.

Table 2: Definition of Acronyms

Acronym	Definition
ACCHO	Aboriginal Community Controlled Health Organisation
ACRRM	Australian College of Rural and Remote Medicine
AHPRA	Australian Health Practitioner Regulation Agency
AGPT	Australian General Practice Training
ALS	Advanced Life Support
AST	Advanced Specialist Training
CGT	Core Generalist Training
CME	Continuing Medical Education
DCT	Director of Clinical Training
DMO	District Medical Officer
DMS	Director of Medical Services
EIN	Echuca Intern Network
EVGPT	Eastern Victoria General Practice Training
FACEM	Fellowship of the Australasian College of Emergency Medicine
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
FARGP	Fellowship in Advanced Rural General Practice – awarded in addition to the vocational FRACGP
FRACGP	Fellowship of the RACGP
FTE	Full-time Equivalent
FTF	Face-to-face
GP	General Practice/General Practitioner
GPA	GP Anaesthetist
GPO	GP Obstetrician
GP-RG	General Practice Rural Generalism
GPSA	General Practice Supervisors Australia
GPT	General Practitioner Training
GPT1	General Practice Term 1
GPT2	General Practice Term 2
GPT3	General Practice Term 3
GPT4	General Practice Term 4
HMO	Hospital Medical Officer - a doctor with three or less years of experience and not yet performing the duties of a Medical Officer or Registrar
IMG	International Medical Graduate or overseas-trained doctor
IP	Independent Pathway
M2M	Murray To Mountain intern program
MBA	Medical Board of Australia
MCCCGPT	Murray City Country Coast GP Training
MDRAP	More Doctors for Rural Australia Program

Acronym	Definition
MM	Category of remoteness under the Modified Monash Model (MMM), ranging from MM1 through MM7: where MM1 is a major city and MM7 is very remote
MMM	Modified Monash Model – used to measure remoteness and population size on a scale of MM1 to MM7
O&G	Obstetrics and Gynaecology
PEP	Practice Experience Program - a self-directed education program designed to support non-vocationally registered (non-VR) doctors
PGPPP	Prevocational General Practice Placements Program
PGY1	First year post-graduation from medicine, also referred to as "intern"
PGY2	Second year post-graduation from medicine
PIERCE	Prevocational Integrated Extended Rural Clinical Experience
PMCV	Postgraduate Medical Council of Victoria
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCIT	Rural Community Intern Training
RG	Rural Generalist
RG1	Rural Generalist in first year of training
RG2	Rural Generalist in second year of training
RG3	Rural Generalist in third year of training
RJDTIF	Rural Junior Doctor Training and Innovation Fund
RMO	Resident Medical Officer – a fully registered Medical Officer who has completed at least one year of full-time clinical experience
RTO	Regional Training Organisation
RVTS	Remote Vocational Training Scheme, a Commonwealth funded program providing vocational training for medical practitioners in remote and isolated communities (MM4-7) and Aboriginal and Torres Strait Islander communities (MM2-7) throughout Australia
VMO	Visiting Medical Officers - GPs in private practice granted clinical privileges to provide medical services in a public hospital or health service
VRGP	Victorian Rural Generalist Program

PROJECT OBJECTIVES AND ETHICS

The objectives of this project were determined by the Project Advisory Group (Table 3). They included:

- Developing an understanding of the RG1/RG2 trainee needs and interests that will inform supervision requirements at the early stage of the VRGP training pathway.
- Informing the enablers and barriers to supervision of PGY2 doctors in smaller rural communities in the three subregions of interest.
- Developing an understanding of the requirements for supervision/accreditation associated with different doctors, e.g., registration status and programs/stages of postgraduate training.
- Developing an understanding of the potential supervision opportunities through local and blended/remote models.
- Producing a Supervision Roadmap to inform how supervision can be progressed for accredited RG2 learning in rural communities in the three regions of interest.

This project was underpinned by an ethical framework, with ethics approved by the Monash University Human Research Ethics Committee (MUHREC) project no: 29263 on 28 May 2021.

PROJECT GOVERNANCE

To achieve its objectives and ensure regular input from key stakeholders, project governance was overseen by an advisory group which met three times, and a working group that met weekly to manage operational issues (Table 3).

Table 3: Project Team, Roles and Responsibilities

Position	Name	Role	Working Group	Advisory Group
GPSA				
Lead investigator	Dr Belinda O'Sullivan	Ethics, lead project, staff management, governance, interviews, data synthesis and reporting.	Yes – Chair	Yes – Chair
Project manager	Ms Carla Taylor	Project management.	Yes –Secretariat	Yes –Secretariat
Co-investigator	Mr Glen Wallace	Technical advice about supervision, GP training and connection with GPSA stakeholders.	No	Yes
Research specialist - clinical supervision	Dr Priya Martin	Support for interviews, analysis and reporting.	No	No
Regional Coordinators VRGP				
Hume	Ms Merryn Lodding	Local intelligence, priorities, connections, and feasibility testing for the model.	Yes	Yes
Loddon Mallee	Ms Gemma Bilardi		Yes	Yes
Barwon South West	Ms Leanne Dix		Yes	Yes
Executive Stakeholders				
Numurkah Cobram Nathalia Health, CEO	Ms Jacque Phillips	The perspective of project funders, and rural health services.	No	Yes
Northern District Community Health, CEO	Ms Mandy Hutchison	The perspective of project funders, and rural health services.	No	Yes
Timboon and District Health Service CEO	Ms Rebecca Van Wollingen	The perspective of project funders, and rural health services.	No	Yes

PRIORITIES

The priorities for the three regions were informed by the service mapping that was done in each region prior to this project (summarised in Appendix 1). Adding to this, the Project Advisory Group confirmed their objectives for the expansion supervised learning at RG2 level, over the course of two weeks' discussion (Table 4).

In the Hume region, the objectives were to create posts to meet the pre-requisites of RG supervision in a financially viable way. It was noted that extensive collaboration was needed for training pathways to expand. Some of the options to expand training posts that were under consideration included using outreach specialist clinics and expanding continuity of exposure to general practice as RGs transitioned across the VRGP learning stages.

In the Loddon Mallee region, it was noted that there is a strong demand for many advanced skills, and widespread capacity for more RG doctors on the rosters. This included an overall demand for emergency skills and rostered on-call services. Paediatrics skills needs were debatable as many cases were being transferred to bigger centres.

In the Barwon South West region, it was noted that there was an overall reliance on rotations and seconded doctors to fill positions, along with significant competition with major health services to get enough PGY2/3 positions recruited. There was some supervision capacity in most advanced skills areas, but pathways based in this region were noted to be very under-developed.

A core priority for the project was also defined. It was for the project to inform supervision models that could be implemented for a safe, quality, person-centred training experience in small rural communities of each region, as well as giving thought to aspects that might be scalable to other regions. To do this, the intention was for the project to explore the lived experience of the supervisors and what enables or challenges their involvement supervision.

Table 4: Supervision Priorities

Issue	Loddon Mallee	Hume	Barwon South West
Core priority	Supervision models we can implement for a safe, quality, person-centred training experience in small rural communities of each region, as well as being scalable to other regions. Understand lived experience of the supervisors and how to enable supervision.		
Priority (region-specific)	Building general practice rotations in the smaller towns. Continuous GP experience throughout the pathway.	Expanding core generalist training particularly in anaesthetics and obstetrics and in some areas that are not currently part of the Hume network.	Increasing GP and health service supervised core generalist training at PGY2, across the board.
Current capacity	Only one Loddon Mallee practice is taking RCITs. RG2 expansion urgent. More training experience exists in the corridor to Melbourne (e.g., Castlemaine) but the northwest corner is where RG need is (lacks access to non-GP specialist services + distance/ cost to people to travel).	There are already 9 accredited RG2 clinics connected to RG pathways following the RCIT (most well established RCIT program in this region). Lots of RG2s interested in Hume so filling places has high potential, but also competition.	Only one GP practice is taking RCITs and RG2 in 2022 in Warrnambool. Portland Active Health also provide rotations to intern and PGY2 trainees All trainees report a great experience.
Where could expand	Supervision could expand in Kerang, Cohuna, Rochester, Robinvale, Ouyen (Loddon, Buloke, Gannawarra) and Swan Hill municipalities.	Could expand the supervised training in Kilmore, Yea, Corryong, Bright, Myrtleford and Beechworth. Enabling RG1 and 2 rotations in clinics already accredited for GP registrar training could be an option.	Could expand the supervised training in Colac, Hamilton and Portland.

Issue	Loddon Mallee	Hume	Barwon South West
Perceived challenges	Limited experience supervising - practices in the northwest corridor towards Mildura may have had less access to medical students and therefore less access/affiliation with teaching altogether. Sole general practitioners and general practices common including in the Wimmera. Workforce over-stretched (COVID-19 pressures + ongoing recruitment issues). May be 5 GPs but all working part-time and not all registered. Older retiring GPs working with younger generation that have different expectations.	Appetite for RG2 supervision is not quite there. Depending on level of registrar and their training needs, gets harder or easier to make supervised training happen. Can't be predictive about trainee needs, even with case management (new cohorts, new needs all the time) and equally trying to match the community needs. College requirements can be challenging to address e.g., for ACRRM core generalist training it is harder than for RACGP.	Junior doctors are going back to Geelong to get the training they want. Not sure why the other practices or health services are not engaging with trainees.
Perceived enablers	Practices in corridor to Melbourne who are taking students/interns/RG2s could provide key lessons about enablers (Why are they? What works? What value it is to them?). Swan Hill has a GP clinic, where it may be possible to expand supervision. Kerang District Health Service (DHS) also has a GP clinic where supervised training could be built. Practices may take on supervision if they have more support to engage with it. RVTS remote models seem to work, but their success is partly because they select carefully.	Already a core of engaged health services and practices from which to learn/build exemplars. Yarrawonga Health accrediting core generalist training of 6 months (ACRRM RG3) (Why are they? What works for supervision in this model?) Potential new partners in Kilmore that have something to offer.	Warrnambool seems keen to take RG2s and recently accredited to do. Portland has just started taking on accredited core generalist training (Why are they? What works for supervision in this model?)

CHAPTER 1: Literature Review

The literature review explored:

1. The training requirements of the VRGP pathway, with a focus on doctors at the RG2 stage.
2. The enablers, barriers, tools, and resources to support accreditation of General Practice (GP)/RG training posts with a focus on supervision requirements.
3. Blended/remote supervision models.
4. Supervision resources relevant to rural supervision models.
5. Enablers and barriers to rural supervision.

THE REQUIRED CURRICULUM

A doctor pursuing an RG career is required to complete the curriculum of other interns and then the training requirements of RG work under a general practice college (ACRRM and RACGP-FARGP) pathway to become a fellowed rural generalist. Before they enrol in GP training, RG doctors need to complete several requirements for eligibility. The pathway is outlined in the steps below.

STEP 1 - Eligibility – internships for general medical registration

Once they complete medical school and start working, doctors, regardless of their specialty interest, need to complete a range of rotations to gain general registration and be eligible to apply for specialty training. These are governed and administered by the Medical Board and The Postgraduate Medical Council of Victoria (PMCV) (9 10). Internship rotations include completing 47 weeks of training to gain general registration. This comprises three core terms (10) of:

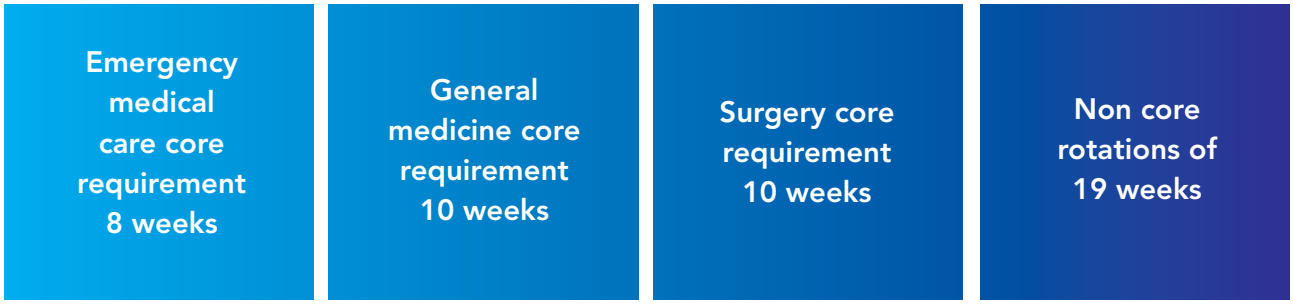
a. At least 8 weeks of emergency medical care.
b. At least 10 weeks in general medicine.
c. A term of 10 weeks in surgery.

This equates to 28 weeks in total for core internship training that all doctors in Australia must do. Within the remaining weeks of internship, they can then complete:

- A range of other approved terms to make up 12 months (minimum of 47 weeks FTE service, so that leaves 19 weeks they can use in other options) (10).

These requirements are reflected in Figure 1.

Figure 1: Requirements of Internship Training According to the Medical Board of Australia (10)



For doctors who are intent on an RG career, it makes sense to use these non-core rotations to get some generalist training experience in hospitals and/or general practices. To this end, the VRGP's RCIT (locations noted in Figure 2), first established in Hume in 2012, allow interns to be based in rural general practice for up to 20 weeks and rotate into larger health services for their core internships rotations (11, 12). As such, the RCIT model assists RG1s to develop skills and linkages relevant to working as a rural generalist in areas of practice needed in the community (11, 12). In this model, it is possible for Victoria's independent hospitals and health services to agree to do joint credentialing and privileging to unify governance across a region and thus allow seamless movement of doctors between services. Some of these RCIT programs also include a jointly funded Director of Clinical Training (DCT) who can manage the education and placement requirements (12). RG1s in Victorian RCITs typically manage hospital inpatients and residents in aged care facilities, and have structured interaction with visiting medical specialists and rural generalists working in small rural health services (12). This helps them build skills and networks relevant to ongoing RG practice.

Figure 2: Location of RG1s in Rural Community Intern Training (RCITs) based in Victoria

STEP 2 - PGY2 or later Fellowship requirements

Beyond RG1, if doctors plan to continue working in Victoria's small communities as intended under the VRGP, those who were in RG1 (interns in the RCITs) and who passed all necessary milestones, are given priority in recruitment to Rural Generalist Year 2 (RG2) positions. Trainees seeking to enter RG2 training can otherwise do so through lateral entry (applying to the VRGP and meeting the requirements). To enter, they merely complete their registration with the VRGP, which links them with the relevant Regional Coordinator who facilitates their case management. At RG2, doctors are getting more embedded in core generalist training (CGT), whether they are already enrolled with a specialist GP training college or not at this stage (Box 1).

In RG2, doctors may already be enrolled in a GP fellowship (under one or both GP colleges) and, if so, may be completing their first year of the GP-RG training program (which mostly occurs in the hospital setting). The requirements they need to follow are dependent on the GP College/s they are enrolled in.

ACRRM

ACRRM ideally requires RG trainees to gain paediatrics, obstetrics and gynaecology, and anaesthetics experience (expecting 10 weeks each at PGY1+, though this is typically done in PGY2), as part of its CGT (Box 1) (13).

Box 1: Definition of Core Generalist Training

> Core Generalist Training (CGT) covers three years of training, typically understood under the ACRRM model but equally applicable for an RG pursuing the RACGP-FARGP route. It involves developing broad generalist knowledge, skills and attributes in primary, secondary and emergency care in rural and remote contexts and fostering essential rural generalist knowledge and skills in paediatrics, obstetrics and anaesthetics (1).

PAEDIATRICS

To get the paediatrics component can be challenging in small rural health services, whereby this can be fulfilled through a post accredited by PMCV, RACGP or ACRRM (as a CGT or AST - Advanced Specialist Training - post). Overall, the trainee must seek to do 10 or more weeks FTE in paediatrics at RG1 or above (Figure 3).

This can be done as:

- A ten-week block OR
- 6 months+ of FTE in an emergency department placement where at least 25% of the presentations are children OR
- As a general practice placement or integrated rural hospital placement where there is a supervisor report and logbook and attendance at education sessions. ACRRM also notes trainees can do Prevocational Integrated Extended Rural Clinical Experience ("PIERCE") placements, as developed by the Queensland Rural Generalist Program, to cover anaesthetics, paediatrics and obstetrics providing there are enough cases to fulfil logbook requirements e.g., 50 paediatric cases and a supervisor report for each discipline. These options also require attendance at two education sessions.
- ACRRM also allows paediatrics to be fulfilled by a paediatrics outreach service and two educational activities in paediatrics (online or FTF) (and attendance at educational activities) (1).

Figure 3: Summary of the ACRRM Requirements RG1-2+ - CGT

Paeds 10 weeks typically RG2+ but can be done in RG1 atop of core requirements of internship	**Anaesthetics 10 weeks typically RG2+ but can be done in RG1 atop of core requirements of internship**	**Emergency 10 weeks RG1 (core requirement of internship) and 3 months RG2+**	**Obstetrics and gynaecology 10 weeks typically RG2+ but can be done in RG1 atop of core requirements**

ANAESTHETICS

With ACRRM, anaesthetics training needs to equate to 10 weeks or more FTE, at RG1 or above, with training accredited by ACRRM (CGT or AST) or PMCV or RANZCA/JCCA or with a supervisor with appropriate anaesthetics qualifications/credentialing when undertaking sessions. This can be done as:

- A standalone 10-week anaesthetic placement OR
- 6 months or more FTE in a combination of placements providing anaesthetics (e.g., ICU, emergency, or retrieval) or an integrated rural hospital placement e.g., PIERCE (with log of 50 cases and supervisor report and letter from hospital) OR
- A minimum of 10 anaesthetic half day sessions, under supervision of a GP anaesthetist or specialist anaesthetist (50 cases in logbook) if it is combined with an advanced airways skills workshop/RVTS workshop (evidence of completing training) OR
- ProStart Anaesthetics program which requires undertaking sessions with anaesthetist while working through the program or AST in anaesthetics (JCCA) (1).

EMERGENCY

Emergency skills are strongly encouraged as part of ACRRM CGT. This means that trainees should be consistently pursuing emergency experience including during RG2 (overall requirements of 6 months' experience by end of CGT is outlined in STEP 3, Figure 3 and Figure 4). These have the same accreditation options as anaesthetics, but with the ACEM instead of RANZCA/JCCA. This can be completed as:

- 3 months' emergency placement OR
- Minimum of 60 (8-hour shifts) in an emergency department OR
- Minimum of 12 months FTE in an integrated rural hospital or hospital that provides 24/7 emergency cover (demonstrating a minimum of 60 shifts) (training organisation records and supervisor reports and letter from hospital about dates and locations of placement) OR
- Minimum of 12 months of providing one in four after-hours or weekend cover in an emergency department in a hospital that provides 24/7 emergency cover (training organisation records and supervisor reports and letter from hospital about dates and locations of placement) OR
- Advanced specialised training in emergency medicine (1).

OBSTETRICS AND GYNAECOLOGY (O&G)

Obstetrics and Gynaecology skills are required equating to 10 weeks or more from RG1 or above, with similar accreditation options – ACRRM CGT, PMCV or RANZCOG (fellowship or advanced). ACRRM expects trainees to address this through:

- 10 weeks or more FTE in O&G placements (supervisor with appropriate O&G qualifications/ credentialing when undertaking sessions) OR
- Clinical attachment or work with a specialist or GP obstetrics for 10 half-day sessions over or <6 months (evidence of intrapartum care through deliveries or simulation course certified completed, letter about dates and location of placement, case log of 25 antenatal and 25 postnatal cases and logbook) OR
- GP placement (evidence of intrapartum care through deliveries or simulation course certified completed, letter about dates and location of placement, case log of 25 antenatal and 25 postnatal cases and logbook) OR
- Integrated rural hospital placement e.g., PIERCE (evidence of intrapartum care through deliveries or simulation course certified completed, letter about dates and location of placement, case log of 25 antenatal and 25 postnatal cases and logbook) (1).

RURAL AND REMOTE PRACTICE TRAINING

CGT also requires that RGs progress towards competencies for safe practise in rural and remote primary care. These are accredited by ACRRM specifically. ACRRM expects RGs to gain 12 months overall of rural and remote practice experience at RG2+ (Figure 5). This is counted as trainees:

- Living and working in MM4-7 (case by case MM3) averaging 4 or more days per week (including fly-in, fly-out models) OR
- Completing blocks of at least 3 months' duration (shown in supervisor report and training organisation records).

In PGY2, the ACRRM handbook denotes primary care should ideally include experience of 2 days per week or over within the course of 3 months (1).

SECONDARY CARE

This requires completion of 3 months or more secondary care at RG2 or above. This is accredited by PMCV or ACRRM or a specialist college. It is done:

- In a hospital placement providing skills relevant to rural practice including a minimum of 60 inpatient rural generalist hospital shifts of minimum 8 hours duration) (1).

ADVANCED SKILLS YEAR PREPARATION

Principally, the ACRRM fellow at PGY2 is preparing to move into an AST or general practice training at RG3 (they stay in hospitals before moving out to general practice), thus the RG2 is a grounding for deciding what skill they plan to pursue and getting enough experience in this skill to show emerging competence when they move into it. This is particularly important where rural generalists in AST in Victoria will often be working under supervision of specialists working only in that field, who may not understand the scope of a rural generalist nor their context of work, and therefore may have high expectations of competence in one key area, relative to any doctor focused on a single field/body system/population (1).

RACGP

In RG2, the RACGP only requires trainees to do paediatrics and three rotations of choice relevant to general practice (13), although rural generalists even if training in the RACGP-FARGP model may wish to extend their skills in preparation for an RG career. The paediatrics rotation is accredited with PMCV or RACGP as part of basic training.

NOT YET ENROLLING IN GP TRAINING

If RGs do not enrol in GP training in PGY2, for example where they do not feel ready or want more hospital experience, they may remain working in hospitals and general practice wholly under PMCV accreditation (9). Under PMCV requirements, RG2 doctors remain under clinical supervision but take on increasing responsibility for patient care (9). They begin to make management decisions as part of their progress towards independent practice, particularly towards the end of each term, and towards the end of their second postgraduate year. As a rule, they should consult their clinical supervisor regarding patient admissions, discharges, and significant changes in patient clinical condition or management. Clinical learning should be supported by appropriate prevocational medical training to support the doctor's professional development needs and enable their transition to the next stage of their development, which is vocational training.

The general requirements of PMCV at this level of learning are that (14):

- Doctors have learning objectives that align with the Australian Curriculum Framework for junior doctors.
- Doctors have access to a formal education program.
- They have access to work-based teaching and learning (at the rotation/term level).
- The facility provides for PGY2 doctors to attend formal education sessions and ensures that they are supported by senior medical staff to do so.
- The facility specifies the dedicated time for teaching and training for the formal education.

- The PGY2 training program provides opportunities to develop knowledge and skills relevant to the domains of clinical management, communication, and professionalism.
- PGY2s have formal orientation programs and are supported and supervised where appropriate to provide safe and effective clinical handover between terms and shifts.
- The facility provides regular, formal, and documented feedback to interns/PGY2s on their performance within each rotation.
- The facility promotes strategies to enable a supportive learning environment.
- Supervision, rostering, and duties are consistent with delivering high quality, safe patient care with PGY2 welfare in mind (rosters reflect a balance between service provision and training; the number of patients in the care of the junior doctor, and the severity of their conditions is at a level at which the junior doctor can provide safe continuing care).
- PGY2 doctors are always supervised at a level appropriate to their experience and responsibilities.

STEP 3 – Beyond RG2 including requirements of GP training

Overall, under ACRRM, by the end of three years of CGT (one of which is typically hospital-based, leaving two years to do the rest), registrars should have accrued at least 6 months in rural or remote practice and 6 months in secondary care, as well as 3 months of emergency care (1) (Figure 4).

Figure 4: What is Required Under the Total Banner of ACRRM CGT

As such, within CGT, trainees with ACRRM should continue to take options both to extend their emergency and secondary care skills and to work in rural general practice after PGY2. This means that, after RG2, it is relevant to continue to consolidate the depth and range of experience of RG2 (paediatrics, obstetrics and gynaecology, anaesthetics, emergency and rural and remote general practice), noting the secondary care areas of interest plus the required emergency skills (1). The ideal training placement for ACRRM at this stage involves working in a rural general practice, admitting into the local hospital, providing inpatient care and after-hours cover in the emergency department. Experience in rural primary, secondary and emergency contexts can also be gained through different placement options via ACRRM (1).

The AST occurs over one year with ACRRM, and this can be commenced at RG3 or above. As such, rural generalist registrars in RG2 may need to be preparing to pick their AST, and getting enough experience in it, for them to start it with confidence. The location of the AST needs to be appropriate to the discipline.

The overall pathway to GP fellowship with RACGP (before taking on the single year of advanced rural skills training as required within the FARGP) is one year of hospital training followed by three GP terms over the course of PGY3-4, coupled with an extended skill of 6 months.

ACCREDITATION OF TRAINING POSTS

All GP training happens in accredited teaching practices.

ACRRM

According to ACRRM, training posts must provide the opportunity to work at the required scope, type, and volume of clinical experience, at an appropriate level of responsibility to develop emerging doctors who will be competent (1). Posts that are accredited by the PMCV as part of CGT are recognised as accredited posts by ACRRM. These posts are suitable for doctors requiring higher levels of supervision, for example doctors who commence GP training in their second postgraduate year and are in RG2 (1). ACRRM also recognises posts accredited by other specialist colleges as suitable for short-term placements for mandatory training requirements, such as anaesthetics posts (1).

RACGP

From the RACGP's perspective, training posts must also be accredited teaching practices and involve adequate supervision matched to the pre-vocational learner (15). Under the RACGP, a general practice training post is defined as one that incorporates a range of settings, including hospitals, private clinics, community primary care facilities, or extended skills posts. These posts must meet the current Standards for general practices. A hospital setting is considered suitable for the part of the RACGP training that is allocated to hospital-based skills development, RG2 or extended skills training (15). If a training post does not meet this definition, the training provider can seek approval of the RACGP to accredit the post (7). Extended skills posts are accredited by the body appropriate to the skill and require a supervisor experienced in that skill and process for planning what will be learned (15).

The process of accrediting training posts for the Australian General Practice Training (AGPT) and Practice Experience Program (PEP) programs is overseen by the Regional Training Organisations (RTOs) on behalf of the Colleges, and these groups have extensive local intelligence about training practices and training opportunities in their regions. In Victoria, the RTOs include Eastern Victoria General Practice Training (EVGPT) and Murray City Country Coast GP Training (MCCCGPT). As part of accrediting training posts, consideration is given to the quality of training, trainee preferences, and community needs. RTOs play a role in supervisor professional development. Other organisations that support supervisors include GPSA, who develop teaching plans and supervisor guides, and connect supervisors to a national community of practice.

REQUIREMENTS OF SUPERVISION AND ALTERNATIVE MODELS

PMCV

With regard to the PMCV requirements of accredited intern training posts, the following conditions apply (9):

- Interns cannot work in units that are not accredited for intern training.
- Core terms in emergency, medicine, and surgery must meet the mandatory intern training.
- Requirements and allocations must fulfil the requirements for general registration.
- Rotations must be continuous, involve direct patient care, and generally not involve travel between multiple sites.

ACRRM

ACRRM has a supervisor guide (16). It denotes supervisors must have the required qualifications and be registered with the Medical Board of Australia (MBA). Supervisors for the CGT or AST need to have the requisite skills to manage learners in these training pathways. Supervisors are expected to provide oversight, guidance, and feedback to a trainee on matters related to personal, professional, and educational development. This includes giving feedback on strengths and weaknesses to maximise learning and patient safety. For rural and remote primary care under CGT, accreditation by ACRRM for 'rural and remote medicine' requires supervisors to be equipped with at least 5 years' rural experience or have supports in place.

ACRRM stipulates those supervisors need to:

- Understand the training requirements and the breadth and scope of knowledge, skills and experience that are required to gain FACRRM.
- Understand the type of supervision that is required for an individual doctor in training.
- Negotiate methods and frequency of communication with the doctor in training.
- Meet with the doctor early in the placement to discuss and appraise the doctor's skills and experience and develop a learning plan.
- Provide appraisal and formative assessment of the doctor in training in accordance with their stage of learning.
- Provide or facilitate structured educational activity requirements according to the doctor in training's stage of training and experience.
- Organise own clinical workload to be compatible with teaching commitments.
- Ensure number of doctors under their supervision does not exceed their ability to provide effective supervision.
- Ensure that another supervisor is available when they are not available to the doctor in training.
- Participate in supervisor training and other activities to further develop supervision, teaching, and mentoring skills.

ACRRM acknowledges that supervisors generally work at the same site as the doctor in training.

However, supervision may be provided off-site or remotely where the training post has no on-site supervisor or the on-site supervisor does not have adequate rural or remote experience (16). Neither the rules nor the process of accrediting an off-site/remote, or blended model are clearly defined. It is probable that such models should be guided by the ACRRM Supervisors and Training Posts Standards which define the requirements of supervision in Domain 2, including ensuring that trainees have the appropriate knowledge, skills, and supervision to deliver quality patient care (17). This includes:

- Having a nominated, documented supervisor, responsible for the educational supervision.
- Accredited supervisor being accessible either face-to-face (FTF) or virtually when a registrar is working.
- Other health professionals contributing to the supervision of registrars.
- Using a model of supervision that is tailored to the registrar's needs.
- Using role models (clinically and professionally).
- Supervisors possessing attributes consistent with supervision role.
- Supervisors completing ongoing training as a supervisor and being familiar with the ACRRM curriculum.
- Using a range of teaching methods/resources.
- Having skills and the clinical scope to match the nature of the post (primary care, secondary care, emergency care, rural or remote practice (MM4-7 or MM3).

RACGP

Regarding the RACGP requirements of supervision, RACGP requires that this matches the competence of the learner and their learning needs in the context of the training post. The 3rd edition of standards for general practice training (RACGP, November 2020) set out the requirements expected of general practice training posts, supervisors and the training providers who deliver the training program (15). They include criteria denoting that the registrar's competence should be assessed prior to placement in any post and monitored throughout the training term. Where placing a trainee in a post that has remote supervision, there needs to be specific elements within the supervision model that will match the level of learner skills relative to the nature of the workload (15). The supervisor will need to record assessment activities and the progress with competencies throughout the placement, which are backed up by assessments done by the trainee's medical educator. The process of approving the post is via the Regional Training Organisation (RTO) and this includes how the supervisor will communicate with the RTO over time. The RACGP Standards include a definition of competency and competence as set out in Box 2.

Box 2: Definition of Competency and Competence by RACGP

Competency - An observable ability of a health professional, integrating multiple components such as knowledge, skills, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure acquisition by a professional. Competencies can be assembled like building blocks to facilitate progressive development (15).

Competence - The array of abilities across multiple domains or aspects of physician performance in a certain context. Statements about competence require descriptive qualifiers to define the relevant abilities, context, and stage of training. Competence is multidimensional, dynamic, and changes with time, experience and setting (15).

The Standards also dictate that a model of supervision is developed to ensure quality training for the registrar. This includes covering all areas that need supervision and showing how the model will be reviewed and adjusted over time (15). This needs to outline a schedule for RTO reviews, and steps to gather feedback from supervisor and registrar, and critical incident triggers.

Elements of the supervision model that the RACGP wants addressed include:

- Defining responsibilities of supervisors.
- Orientating registrars to practice.
- Monitoring registrar's competence.
- Assisting registrar to plan their learning.
- Providing feedback to registrar.
- In-practice educational support.
- Outlining processes for selecting supervisor with appropriate capability for the training context.
- Detailing the practice infrastructure supports, education and training.
- Identifying clear, impartial pathways to resolve issues including training related disputes.
- Using regular evaluation of the supervision model.
- Ensuring that risks are appropriately identified and managed.
- Showing how feedback is regularly sought from the supervisor and supervision team and registrar and how this is analysed and used to monitor and improve supervision models.
- Showing how the registrar can ask for and receive assistance in all clinical situations.
- Ensuring that Aboriginal and Torres Strait Islander (ATSI) health posts are meeting principles for training.

Remote, team-based, or blended models of supervision have the approval of the RACGP (15).

The training provider is required to provide evidence of how:

- The supervision is matched to the registrar's competence.
- Appropriate supervision is provided utilising registrar skills where possible, always within available supervisory boundaries, as required for the registrar.
- Cultural safety and competencies are monitored and managed, especially in Aboriginal and Torres Strait Islander training posts (15).

According to the RACGP, there is a process to follow as part of applying to trial an alternative process for supervision if it complies with RACGP Standards. This involves the RTOs contacting the relevant State Censor. Any trial of a rural generalist supervision model needs to get feedback from the Rural Censor (the National Rural Faculty Censor) (18). The RTO must fill out the details of the proposed processes for which they are seeking approval (endorsed by the Rural Censor) and send this to the relevant State Censor (Dr Edward Vergara in Victoria) to provide a cover letter of support as part of the application. Once the application is completed, it is sent to vtstandards@racgp.org.au (18). The trial process application requires the following information (18):

- Category for approval: training post/supervision (remote/team/Aboriginal health)/alternatives to hospital training and other.
- Clarifying information about the process to trial.
- The context in which the process will be used.
- Why this alternative is necessary compared with existing arrangements.
- What issues it will address.
- Who was involved in the planning process.
- Outcomes that are expected.
- The planned commencement dates.
- Any risks and how these will be managed.
- How registrars will be selected and by whom.
- The stage of training of the registrars will be in (18).

For alternative models of supervision (18):

- Who the lead supervisor is proposed to be.
- Who the supervisory team will be and their roles.
- An AMS, how Aboriginal people have been and will be involved.
- Ways in which the registrar can seek and receive support when needed.
- Who the contact person will be if the registrar has a problem.
- Contingencies in place if the supervisor cannot be reached.
- How this process will be monitored.
- Alternative arrangements if the supervision process breaks down.

A copy of the form is included in Appendix 2.

An evaluation must be completed by the Regional Training Organisation (RTO) at 6 and 12 months post implementation of approved trial process. RTOs are to complete the evaluation form and send to the relevant State Censor with a copy sent to vtstandards@racgp.org.au. RTOs seeking approval to extend a process, must submit more forms, giving at least 4 weeks advance notice of a planned continuation date. Extensions can be approved for 3 years only. RTOs can also apply to continue the approved process as part of 3-yearly re-accreditation cycles (18). Under these trials, one-off models need to comply with the 4 x 4 rule: one practice, one registrar, one context and one training term (Figure 5).

Figure 5: The 4-by-4 Rule for One-Off Models for Accredited Training

There need to be appropriate arrangements to address patient safety, registrar stress and fatigue (which can result from work and lifestyle factors), supports for the registrar's wellbeing and methods to get patient feedback. There also needs to be a system for managing critical incidents and that they are reported to the RTO and RACGP. The RTO plays the role of evaluating the model through the lens of quality of training and safety of the patient, registrar, and supervisor.

In developing and reviewing models of supervision, the training provider will consider factors that commonly contribute to stress and fatigue (single practitioner providing 24 hours on-call or after-hours health care, prolonged consulting hours, adverse environmental conditions especially in rural or remote regions and provision of emergency care, especially between 2am-6am) (15). The rosters are also reviewed to explore whether the registrar has enough rostered recovery time and leave available to them (15). The intensity demands and nature of the general practice will also be considered, with respect to registrars being new, unfamiliar, or unsupported in the training setting. Under pilots, the supervisor will also be reviewed for their capacity to manage additional responsibilities in and after-hours (15).

PMCV

At the intern level, PMCV sets the following requirements for clinical supervision:

- Interns must consult a clinical supervisor regarding management plans for all patients.
- All patients should undergo review by a more senior doctor (at some point during presentation/admission) prior to discharge.
- Their immediate clinical supervisor must be always awake and on-site and at no time should interns be the sole doctor in the emergency department.
- Interns should not be expected to manage obstetric patients or children less than two years of age without direct supervision.
- Interns should not be expected to consent patients for surgical procedures.

For those RG2s who remain in a PMCV-accredited non-GP training post (an extension of the intern year, mainly in hospitals with or without primary care rotations) the PMCV denotes that doctors need a term supervisor (19). Their role is:

- To provide timely and effective feedback including when performance does not meet the expected standards.
- Identify areas for remediation and be involved in providing this support and notify the relevant parties.
- Have enough contact with the doctor to allow a valid assessment of their performance across the team, supplemented by consultation with other members of the team to form a comprehensive picture of the junior doctor's performance during the term.
- A formal review of the doctor's performance must occur at mid- and end-term points, which is the mutual responsibility of the supervisor and the doctor being supervised.
- The term supervisor should also handover to the term supervisors of the next term.

THE BLENDED SUPERVISION MODEL

The blended supervision model, which integrates off-site supervision with available local or on-site supervision resources, is a pragmatic alternative to traditional supervision (5). Blended models may be relevant where it is necessary where there are fewer supervision resources, such as in rural settings. They have mainly been discussed in relation to allowing registrars to be placed in practices that are considered likely to provide good training but are unable to meet the traditional supervision requirements, whilst still addressing Standard 1.2. It has a place because AGPT-enrolled registrars are not able to access RVTS supervision options (the RVTS was originally conceived as a program that would allow rural and remote communities to keep their doctor whilst they trained, whereas AGPT registrars undergo a matching process for practices in a region of choice).

In blended supervision models at the registrar stage, it is possible to use on-site GPs who wish to contribute to supervision but do not want to be accredited teaching practices (5). Despite not wanting a formal supervision role, they are potentially still useful for their knowledge of practice, context, and healthcare systems. The model can also use Aboriginal health workers who are able to assist with cultural competence, along with practice nurses and allied health professionals who are able to supervise within their scope of practice.

To ensure the combined supervision meets the outcome standards of ensuring patient safety and facilitating registrar learning, off-site supervision and teaching must be included along with the organised local supervision resources. Given blended models can be volatile if one clinician leaves the team, a project quality improvement group and sustainability plan may be needed to enable troubleshooting. These models are more successful and sustainable if they are structured and rely on systems, rather than individual persons.

Implementing a blended supervision model can be facilitated by a framework (which systematically helps to identify gaps in clinical and educational supervision for the purpose of accreditation of the training post) (5). An example from the published literature is included in Appendix 3. The framework largely revolves around: 'How the model is making sure the registrar's patients are safe?' and 'how the model is making sure the registrar is learning?' Activities that the framework note as primarily the responsibility of the clinical supervisor include (5):

- Orientation of the registrar.
- Being available to respond to a registrar's clinical questions during consulting hours.
- Conducting audits of registrar patient care, such as random case analysis.
- Responding to critical incidents and complaints.

The supervisor is also expected to ensure that the level of supervision is matched to the registrar's competence. The framework suggests that the questions about educational supervision might include, 'How is the supervisor helping the registrar to learn?' Activities include (5):

- Developing and reviewing the registrar's learning plan.
- Facilitating educational opportunities that evolve from clinical work.
- Providing registrar tutorials.

Trainee factors are also related to blended supervision models including (5):

- Selecting trainees who have demonstrated or have competence in reflective practice, who completed training like Advanced Life Support (ALS) and are good at seeking assistance when needed.
- Other selection issues may be fit and interest in the community, communication, and independent learning.
- Building connections to networks and supports in the community.

Atop of this, in 2013, Wearne et al published a paper to inform the practical steps involved in setting up postgraduate training via remote clinical supervision based on literature and their personal experience of GPs providing remote supervision (20). They noted that remotely supervised doctors learn via virtual autonomy in clinical decision making and working at the limits of their abilities. As such, it fits that this model suits experienced registrars with resilience, insight into their strengths and weaknesses, capacity to self-monitor and correct, and willingness to seek help. The remote supervisors in return need to be strongly focused on facilitating registrar learning, monitoring their wellbeing, and supporting registrars holistically. Matching the right registrar to the right placement and the right supervisor is considered pivotal.

SUPERVISION RESOURCES

GPSA, alongside the RTOs, plays a specific role in supporting the uptake of supervision through its new supervisor guide (21) and, specific to rural communities, its guide related to supervision in after-hours environments (22). The New Supervisor guide outlines the benefits of becoming a supervisor and core supervision skills, including coaching, communicating, teaching, showing emotional intelligence, managing conflict resolution, being professional and managerial. It also highlights the attributes of learners, including the learning styles that need to be accommodated as part of being a supervisor. The core requirements to become a supervisor are also outlined:

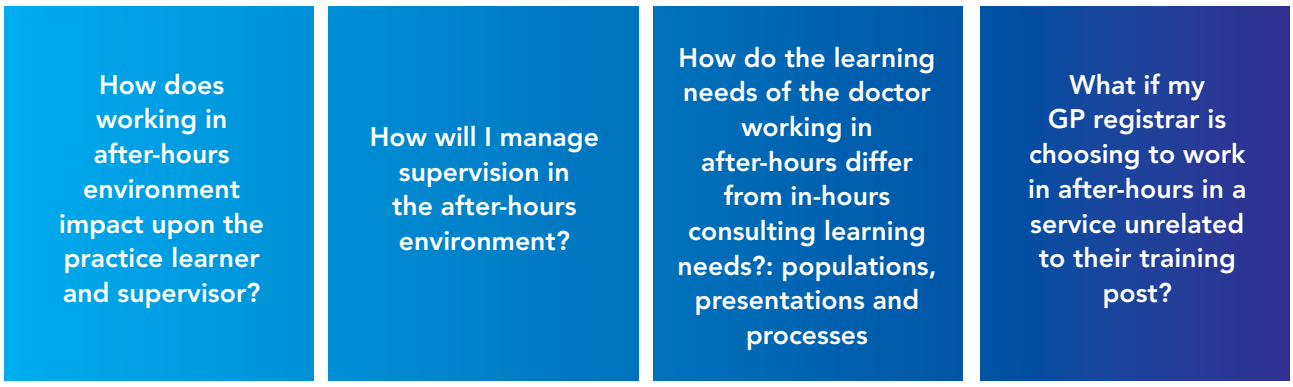
- Full and unrestricted registration as a specialist GP under AHPRA.
- Fellowship is highly recommended.
- Professional involvement in the GP profession.
- Commitment to ongoing professional development aimed at improving performance as a general practice educator.
- Meeting the requirements of specific colleges or programs (21).

The new supervisor guide also provides a GP supervisor's toolkit incorporating methods of teaching and specific tools such as learning plans and establishing the learning environment. This guide mainly relates to supervising GP registrars. GPSA also has a range of new quality frameworks to guide the implementation of best practice clinical learning environments (suitable for all general practice learners) (23) and what entails quality within general practice supervision (24).

The GPSA new supervisor guide dictates that early in the placement of any GP learner, GP supervisors need to accommodate 'on the run' teaching within their appointment schedule, including less frequent appointments for GP supervisors, scheduling catch-up time, moving patients to less busy colleagues with their agreement, and avoiding the temptation of squeezing in extra patients (21). GP supervisors do not need additional indemnity insurance but they may incur legal issues if they don't inform learners about when they need to contact them for advice, don't know the learner's blind spots, don't provide regular feedback, and/or fail to deal with errors (21).

With regards to supervising in an on-call environment, GPSA has mainly produced guidance about situations where GP supervisors are managing registrars that are working across the practice and the hospital (22). The RACGP also has Standards for outside normal opening hours and Standards for after-hours services which are accredited against the RACGP Standards. The main consideration of this material is that the supervisor provides the right level of support for the registrar working in an on-call environment, as per their stage of learning/skills and the demands of the on-call environment (the considerations for learning in this environment are outlined in Appendix 4). GPSA suggests that there are four main issues that supervisors need to consider when establishing supervision in the after-hours environment (Figure 6) (22).

Figure 6: The Issues Supervisors Need to Consider with Regards to a Registrar Working in After-Hours Environments



The GPSA website also includes several myths about who is responsible and liable for supervision around the employment arrangements in place (Appendix 5) (25). In short, these note that registrars are typically employed in after-hours environments through their practice employment, but it is possible that they are employed as a contractor directly with the hospital. If so, the supervisor needs to be aware that the registrar will be covered by their own workers compensation insurance, medical defence insurance and public liability insurances for work at the practice and the hospital where they are performing on-call work. The registrar will be confined to the scope of work for which they have appropriate qualifications such as advanced qualifications in anaesthetics. At times, the registrar may have a wider scope of qualified skills than the supervisor, which is fine. Registrars working at this wider scope must be covered by relevant insurance and it is the registrar's responsibility to manage this.

Supervision in the on-call setting may be in place by phone. It is still important that the registrar has access to this for the duration of the on-call shift. If something goes wrong in the hospital, the hospital's liability insurance may come into play but equally, the registrar's supervision arrangement/s may be prosecuted (25). Supervision in the after-hours environment can be negotiated through the same framework to appraise blended learning as proposed in research by Ingham, noting the specific incorporation of the on-call part of the learning (5) (Appendix 3). This can be used to set up an agreement between supervisor and learner, for the roles and responsibilities involved. Once a supervisory agreement is in place and all parties are happy with it, it is important to discuss how the registrar's learning needs will be managed when working after-hours. This involves discussing and documenting a learning plan specific to the after-hours environment (Figure 7). A learning plan helps the supervisor and registrar to navigate their directions with respect to learning (26). If the GP registrar is doing after-hours work unrelated to the supervisor's practice, it is important to establish their motivations for this work and whether their interests might be addressed in other ways (22).

GPSA also has a wide range of educational resources to support registrars to address particular skills (27). It provides regular webinars that are recorded and uploaded for viewing at convenient times.

Figure 7: Considering a Learning Plan for After-Hours Supervision

What are the learning goals/ plans for after-hours work - how are they different from in-hours work?	**Are there any safety issues involved in after-hours work and how will they be addressed?**	**What areas of the registrar's practice are least proficient and lack confidence related to working in the after-hours setting and who will address this?**	**What resources will be used to meet the learning goals and how will progress be measured?**

SUPERVISION ENABLERS AND BARRIERS

Supervision within medical education is changing with the times. Supervision encounters have shifted away from simply imparting information and have become increasingly informal and dialogue in style. Supervision has evolved to include more discursive and broader considerations of the learner, inclusive of supporting their work-life balance and their learning needs (4). Supervision demands are increasing because there are wider dimensions that doctors need to embed in professional clinical practice including medical ethics, social norms, quality improvement and teamwork. This includes further considerations of these matters in the rural context, where communities can be medically underserved and doctors work at broader scope.

Hospitals

There is limited information about supervision of junior doctors in small rural hospital settings. One body of national research identified that junior doctors (in their first four years of medical work) are highly satisfied (85%) and have significantly higher satisfaction with work-life balance, ability to obtain desired leave, leave at short notice, personal study time and access to leisure interests than metropolitan doctors (28). Metropolitan junior doctors were more satisfied with the network of doctors supporting them and opportunities for their families (28), perhaps hinting that the breadth of supervision in rural healthcare teams may be less relative to junior doctors' interests in connecting with different specialist mentors (known to be related to helping to navigate entry to specialty training).

General practice

The literature about supervision enablers and barriers in general practice at the PGY2 level in distributed rural towns is also scarce. These settings may have fewer qualified doctors, whereby conditions of supervised practice by the Medical Board may affect training capacity (Appendix 6) (29). Other research denotes that smaller rural practices and those with overseas trained doctors, are less likely to supervise GP registrars than other rural practices, but there is no difference in supervision participation by the rurality of the practice (30). This research suggests that supervising registrars is associated more with the practice structure and dynamics than where any one rural practice is located (30). Fostering supervision in small rural practices may depend on building capacity by linking them with larger practices or health services where there is more capacity. It may also rely on encouraging rural overseas-trained doctors to fellow and become supervisors.

Supervision requirements and systems for allocating registrars may pose some challenges for rural GP businesses in smaller towns (31). GPs in small rural towns enjoy supervising registrars and can see their value for improving patient access, practice quality and enthusiasm for being a rural GP (31). However, planning for registrars is challenging when a small and busy rural practice shifts the business to host a registrar and they are not allocated one. This can mean that short-staffed practices need to rapidly flex their resources around external decisions (registrar and RTO intentions) (31).

The learning opportunities can be rich in small rural communities (32), but individual doctors working at a generalist scope may be stretched in responding to the range of community needs with more limited staff available, and may thus find it challenging to fit in structured teaching/reflection time (33). Small communities where doctors work at a broad scope, and learn to make independent decisions, may extend a learner's skills more rapidly than environments where the scope of practice is narrow and protected (32, 33). But it also risks over-exposing learners unless they know when to check in about areas they are not sure about (often by phone and sometimes on urgent matters) (33). Junior doctors on a pathway to become rural generalists for example, may turnover, if they sense that they could be placed in a position that leaves them exposed medico-legally, without sufficient back-up (34). Although the conditions of being a rural generalist and using clinical courage may be normalised for those who are invested in socially accountable medicine, which shifts the focus away from the doctor to serving the needs of communities (35), new doctors may find it overwhelming (34).

Rural generalist learners also need to learn how to work effectively with broad rural healthcare teams. As such, rural supervision models tend to encompass flexible systems to allow doctors to check in with both local staff and the formal supervisors who may be 'on the run' (33). These environments may require careful matching of registrar competence to setting, and making time for learning, over simply providing a service, so that learner can grow in their skills and confidence and the patients are safe.

Further, the supervision model in small rural towns often needs to balance the achievement of a workforce for the community along with someone who is progressing towards training milestones. Such was the origin of the RVTS model which was piloted in 1999 (5). Rather than agreeing to minimal standards of learning because of a more urgent workforce or service need, Worley et al depict the importance of rural generalists learning from experienced clinicians who know the context:

High quality clinical learning requires not just knowledge but also the development of wisdom, passed down through supervision and imprinted by relevant patient interactions within a context (8).

Other literature points out that regionally networked training (embedded within a respectful learning culture), with generalist supervision, may produce skilled clinicians who practise safe, rural generalist medicine (36). However, these regionalised networks involve multiple supervision touch points that may take some time to embed. Feeling supported is often related to practitioners having back-up and competency to deal with the unknown, but this back-up tends to involve teams of specialists working in other services being available in a timely way to assist with advice (36). Findings from a recent systematic review note the impact of clinical supervision on healthcare organisational outcomes (37). The review identified that it is not enough for organisations to implement clinical supervision to tick a box, but rather measures need to be put in place for ensuring and enhancing the effectiveness of the clinical supervision provided and the supervisor – which are prerequisites for effective clinical supervision. The review noted that there is also evidence to suggest that ineffective supervision could be doing more harm than good because clinical supervision outcomes at the patient, health professional and organisational levels, are inter-linked.

CHAPTER 2: Summary of GP Training Programs

GPSA undertook a desktop review of all GP pathway-related programs to identify supervision and education requirements as well as payment and support that might be available to practices. Doctors at the RG2/PGY2 stage may be attached to any number of programs linked to general practice training (Table 5). These include at the pre-vocational stage - Rural Junior Doctor Training and Innovation Fund (RJDTIF) and the More Doctors for Rural Australia Program (MDRAP) or Practice Experience Program (PEP) or - at the vocational stage - the AGPT Program, or Independent Pathway (IP) or Rural Vocational Training Scheme (RVTS). Each has nuanced requirements for eligible doctors and supervisors and the rewards for supervision. These programs are important as they may provide funding for engaging supervisors. However, their lack of integration and different timeframes for implementation may cause them to compete for practice teaching resources and supervisors, particularly within the context of small rural practices or practices with few supervisors and limited time.

The RJDTIF, MDRAP and PEP programs are intended to provide entry level skills relevant for entering vocational training as a general practitioner in rural settings, but practices are likely to weigh up taking these learners over the opportunity of taking registrars, a group they are more familiar with, and who generate income for the practice (often relate to supervisors losing personal income for loss of billings due to teaching time and the level of support that early career doctors need in a general practice business environment). For RJDTIF, the general practice is required to provide high quality supervision (not defined) and support to junior doctors undertaking rural primary care rotations and be accredited or able to meet PMCV accreditation standards and oversee all patients the junior doctor sees (as the junior doctor has no Medicare provider number), in their own consulting room. The program provides more or less funding for supervision from a fixed amount per head of doctors supported, after travel and accommodation are paid for. This results in more or less funding depending on distance and accommodation costs in different geographic settings. MDRAP, administered by the Rural Workforce Agencies, requires that depending on a doctor's prior general practice experience, participants will be supervised at a level relevant for overseas-trained doctors as defined by AHPRA (level 1 or level 2 for defined periods and subject to demonstration of competence) and doctors with greater than 6 months experience in general practice may not have to meet the supervision requirement. The MDRAP doctor comes with billing status at A2 level. The PEP involves doctors being employed in a practice already and accessing a supervisor via the RTO or the RVTS. Depending on a learner's prior general practice experience and their AHPRA requirements, supervision requirements on the PEP may be higher or lower and this is determined between the supervisor and the RTO. There is high potential that every encounter needs supervision.

The recent iteration of the RDJTIF specifically requires linkages with rural generalist training pathways. However, there is nothing requiring MDRAP or PEP doctors to link with a pathway, despite these programs also being relevant to the VRGP pre-vocational stage of RG training and seeking to address rural medical workforce development.

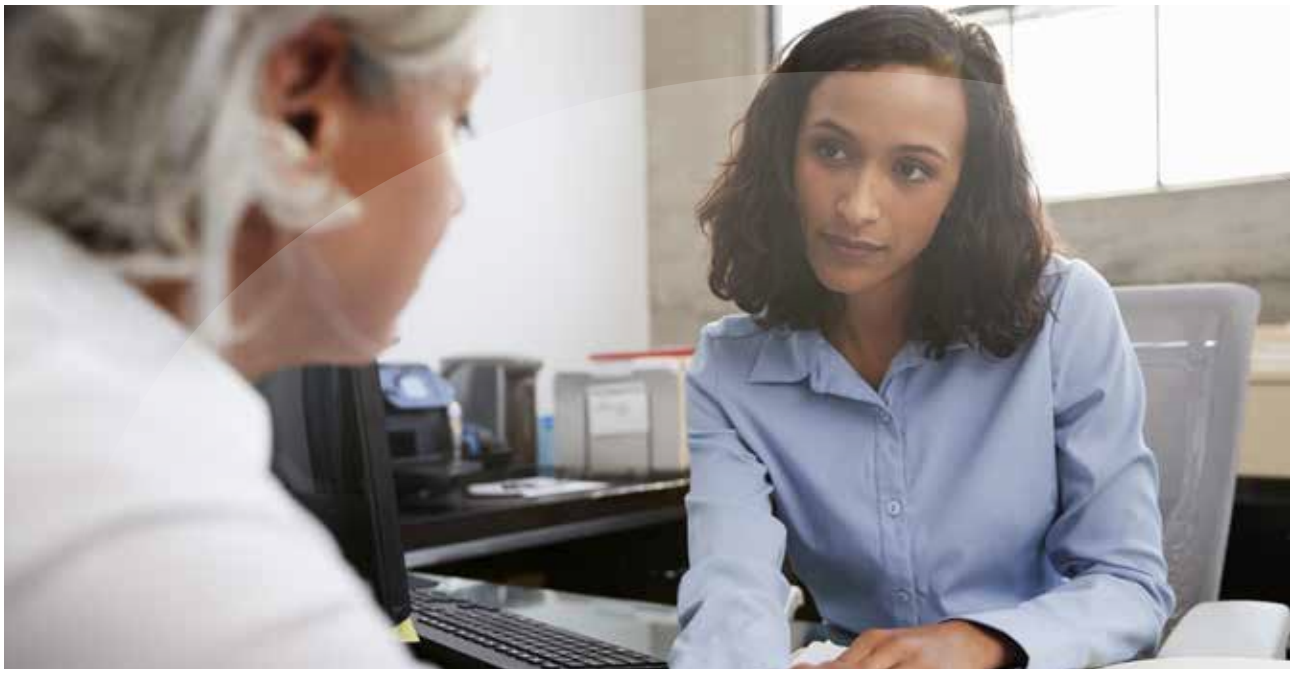


Table 5: Desktop Review of Postgraduate GP Programs and Their Supervision Requirements

Who	Volume nationally	Length	Target	Accredited practice	Supervision requirement	Educational requirements	Payment for supervision effort
Rural Junior Doctor Training and Innovation Fund (RJDTIF)							
PGY1-2 (junior doctor) on a pathway to become a rural generalist (linked with State Rural Generalist Program).	110.	8-13 weeks.	Must be employed as PGY1 or PGY2 in hospital willing to rotate junior doctors to rural (MM2-7) general practice.	Yes - for PGY1/ PGY2.	GP or other health supervisor - Must have high quality supervision and every encounter supervised.	Expected to link with rural pathway e.g., rural generalist program, and their inherent educational requirements/ opportunities.	Whatever left over from 40K allocated per trainee, to pay for junior doctor salary, transport, accommodation for 8-13 weeks per junior doctor (est. 8,000 or less if distances further, est. $1000/wk if use 10,000/ junior doctor over a 10-week term and distances not as far).
More Doctors for Rural Australia Program (MDRAP)							
PGY3-5, domestic and overseas-trained/ or foreign graduate of Australian medical school (junior doctor), apply like the Rural Workforce Agency Victoria (RWAV).	Uncapped limited by available practices to employ doctors (offer of employment).	2 years + extension up to 4 years.	Must be employed as a GP in a general practice or have a job offer with a general practice as a non-VR doctor in MM2-7 and DPA or AMS or directed to work under s19(2) or s19(5) exemptions.	Not necessarily.	GP supervisor must address AHPRA supervision requirements related to doctor's registration status. Also, if <6 months experience in GP, have MDRAP supervision plan submitted to RWAV, and supervisor report is then considered by relevant RWA, to ensure adequate supervision to skill level. Generally, candidates seeing 'at-risk' presentations as documented in RACGP standards, must consult supervisors before these patients leave the practice until doctors' competency is established. If doctors have prior general practice experience, appropriate supervision is still established in relation to the work location (scope/risk).	Must complete foundational modules of GP colleges within 6 months and take steps to apply for AGPT and do GP relevant AHPRA related professional development.	Variable, but can base it on highest available funding of 30,000 per year, equating to 576/wk.

Who	Volume nationally	Length	Target	Accredited practice	Supervision requirement	Educational requirements	Payment for supervision effort
Practice Experience Pathway (PEP)							
4 intakes per year, pass PEP entrance assessment, basic life support.	Uncapped, requires offer of a job of at least 6 months duration in same practice.	6 month terms taking 12-18 months to complete.	Must be employed as a GP in a general practice or have a job offer with a general practice as a non-VR doctor in MM2-7. May have limited, provisional or general registration.	Yes – RTO accredited practices.	Need supervisor via RTOs/RVTS. Supervision requirements are higher or lower depending on a doctor's prior general practice experience and AHPRA requirements, (potential that every encounter needs supervision).	Must maintain continuous progression through self-directed learning via RACGP (40 CPD points per 12 months), 4 mini CEX assessments applied to direct observation and 6 additional mini CEX and 2 case analyses per term and an MSF process. Same expectations they meet ACRRM curriculum including 12 months rural remote primary care.	No payment.
Independent Pathway (IP)							
4 intakes per year, online application, referee reports and MMIs. Training happens in ACRRM accredited training post and registrars must have an approved clinical supervisor.	Uncapped, requires have a job and experience.	4 years.	Non-VR working in MM2-7, AMS, retrieval services or other accredited ACRRM facilities. May have limited, provisional or general registration (completion of AMC clinical is not a requirement, just passing the AMC's CAT-MCQ and doing workplace-based assessment of 12 months' supervised practise).	Yes.	Allows remote (off-site) supervision. A minimum level of clinical supervision is not specified. The supervisor should be available in person or by phone when the doctor is working and needs to be adjusted according to the doctor's needs/safe practice. The supervisors must commit to observe 6 consultations over 12 months and provide feedback.	Self-guided learning and case management overseen by training officer/medical educators - align with ACRRM curriculum. Do facilitated webinars and FTF training (2 mandatory workshops for 5 days each and require leave for) as well as FTF emergency courses.	No payment.

Who	Volume nationally	Length	Target	Accredited practice	Supervision requirement	Educational requirements	Payment for supervision effort
Remote Vocational Training Scheme (RVTS)							
Annual intake, into positions accredited by ACRRM or RACGP.	30, must have job in general practice.	3-4 years.	Non-VR doctor working in rural remote (n=22)/ ACCHO (n=10), completion of AMC clinical is not a requirement, just passing the AMC's CAT-MCQ) and workplace-based assessment of existing supervised practise.	Not necessarily.	Allows remote (off-site) supervision, must have level 3 or 4 supervision available (supervisor by phone and review practise regularly for safety). Completion of early training assessment as online test when commence which informs resources needed for learning. First 6 months – remote supervision involves one hour per week, second 6 months – one hour per fortnight, thereafter, one hour per month excluding advanced skills training. Supervisors assist case review, development of learning plans, review of general problems and discussion and assistance with completion of the RVTS online modules. 360-degree feedback in first year of training for formative learning.	Distance education (live weekly webinars (60-90 minutes), 2 per year FTF workshops/or virtual, clinical teaching visits, regular remote (off-site) supervision + cultural mentor + registrar training coordinator + peer support. Education follows curriculum for RACGP/ FARGP and ACRRM.	$150/wk first 6 months, then $75/wk in second 6 months and then $37.5/ wk for second year equates to average of $112.4/wk in first year and $37.5/wk in second year - average over two years is $75/wk.
Australian General Practice Training Program (AGPT)							
PGY2 onwards into positions accredited by RTOs on behalf of ACRRM and RACGP. When applying for the AGPT program, doctors request a preferred region(s) where they wish to train. Doctors consider how the opportunities available in each region match their individual interests and learning requirements	1500 places annually.	2 years of 4 terms.	Registrar - GPT1.	Yes.	GP supervisor via RTO/RVTS – must do administration and regularly oversee clinical learning and in-practice teaching.	3 hours of educational release/wk to attend training outside the practice. Participate in dedicated in practice teaching of 3 hours duration/wk.	$560/wk (GPT1) training practice subsidy and $420/wk teaching allowance (calculations based on high per week subsidies) = $980/wk.
			Registrar - GPT2.			1.5 hours of educational release/wk to attend training outside the practice. Participate in dedicated in practice teaching of 1.5 hours duration/wk.	$280/wk (GPT2) training practice subsidy and $210/wk teaching allowance (calculations based on high per week subsidies) = $490/wk.
			Registrar - GPT3.			No educational release.	Nil.
			Registrar - GPT4.			No educational release.	Nil.

CHAPTER 3: Survey of Trainees

In order to practically plan for supervised training in the VRGP at the PGY2 level, it is important to understand the interests of trainees. A survey with closed-ended questions was developed by working with the regional coordinators, and circulated to the VRGP RG1 and RG2 cohorts in the Hume, Loddon Mallee and Barwon South West regions via an online link, by email and SMS (survey is shown in Appendix 7). Trainees firstly read the explanatory statement and consented. The survey took approximately 5 minutes to complete. Two rounds of follow up reminders, and a final follow up by the regional coordinators directly of the trainees, was undertaken to boost the response rate. The survey achieved 34 responses (50% response rate) including half of the trainees currently in PGY1 (RG1) and the other in the PGY2+ (RG2 level) of the VRGP.

HOW MANY RESPONSES?

- 34 (50% response rate).
- 17 (50%) were PGY1 and the remainder PGY2+.
- Of the 17 in PGY2+, 5 (33.3%) were in funded RG2 positions and 8 (47%) were registered with the VRGP and awaiting RG2 positions.
- 8 of the PGY2+ group (47%) were already enrolled with AGPT.

PROFILE

- 15 of the 17 PGY1s had done community rotations as part of their internships in 2021, in places like Warrnambool, Yarrawonga, Echuca, Cobram, Kyabram, Mt Beauty, Mildura, Benalla.
- 5 of the RG2+ group and one in the RG2+ group had done community rotations last year in places like Warrnambool, Ararat, Benalla and Yarrawonga.
- 12 of the PGY1s and 7 of the PGY2+ were planning on getting more experience in hospitals next year before entering GP training. A further 4 PGY2+ were planning advanced skills training in 2022 (a mix of ACRRM and RACGP-FARGP).

AREAS OF RG PRACTICE PLANNING TO PURSUE:

Of all the RGs who responded, a range of future practice interests were expressed (many including multiple advanced skills that were mainly procedural in focus):

- 21 (62%) planned GP with some emergency +/- other skills and one just emergency work.
- 18 (53%) planned GP with some anaesthetics +/- other skills.
- 9 (26%) planned GP with some O&G +/- other skills and one just O&G work.
- 7 (21%) planned GP with some palliative care +/- other skills .
- 6 (18%) planned GP, with some paediatrics +/- other skills.

WHAT COLLEGE ARE THEY PLANNING ON?

- 17 (50%) planned or were affiliated with ACRRM, 11 (32%) with the RACGP-FARGP and 4 (12%) with both colleges.
- One was planning on leaving RG to pursue RANZCOG and another wanted more hospital experience before deciding on the college to pursue training with.

Overall, the breakdown of RG practice interests by trainee in PGY1 and PGY2+ demonstrated a broad need for CGT, covering a diversity of mainly procedural skills areas (Table 6).

Table 6: Range of Skills interests of Trainees in PGY1 and PGY2+ (RG2 Level) of the VRGP

Trainee	GP	Emergency	Anaesthetics	O&G	Palliative care	Geriatrics	Paediatrics	General medicine	Psychiatry	Sports medicine
PGY1										
1		X								
2	X				X	X		X		
3	X			X			X			
4	X	X	X							
5	X	X	X		X					
6	X	X	X	X			X			
7	X			X						
8	X		X					X		
9	X	X		X			X			
10	X	X						X		
11				X						
12	X	X		X						
13	X	X	X							
14	X	X	X							
15	X	X	X				X			
16	X									
17	X	X						X		
PGY2+										
1	X			X						
2	X	X			X					
3	X	X	X							
4	X				X					
5	X	X	X				X			
6	X	X	X							X
7	X				X					
8	X		X		X					
9	X			X						
10	X	X	X							
11	X	X	X	X						
12	X	X	X		X					
13	X	X	X		X		X		X	
14	X	X								
15	X	X	X							
16	X		X							
17	X	X	X	X			X		X	

TRAINING NEEDS PERCEIVED THIS YEAR:

Training needs perceived this year for PGY1s aligned with the typical intern rotations but included general practice – areas like emergency, general medicine and surgery which is a requirement of internship. At PGY2+ level, the perceived training needs for this year included paediatrics, O&G and emergency, with some having interests in getting more experience in rehabilitation medicine and psychiatry (Table 7).

Table 7: Training Interests This Year for PGY2+ (RG2 Level) of the VRGP

Trainee	GP	Emergency	Anaesthetics	O&G	Palliative care	General surgery	Paediatrics	General medicine	Psychiatry	Rehabilitation medicine
PGY2+										
1				X					X	
2				X	X		X			X
3		X					X	X	X	
4		X								
5				X			X			
6				X						X
7	X			X			X			
8		X	X	X			X			
9	X	X	X							
10		X	X	X						X
11		X								
12		X				X		X		
13		X	X	X			X			
14		X	X							
15	X									
16		X	X							
17		X	X				X	X		

TRAINING NEEDS PERCEIVED NEXT YEAR:

At PGY2+ level, training needs perceived for next year, included an emphasis on general practice, emergency, anaesthetics, paediatrics and O&G rather than general medicine, palliative care and psychiatry (Table 8).

Table 8: Training Interests Next Year for PGY2+ (RG2 Level) of the VRGP

Trainee	GP	Emergency	Anaesthetics	O&G	Palliative care	General surgery	Paediatrics	General medicine	Psychiatry	Rehabilitation medicine
PGY2+										
1		X					X			
2	X									
3	-	-	-	-	-	-	-	-	-	-
4	X									
5	X		X	X						
6		X								
7		X					X			
8			X							
9		X								
10		X								
11	X	X	X							
12			X							
13	X		X	X			X			
14	X									
15	X			X			X			
16			X							
17		X	X				X	X		

CHAPTER 4: Interviews - Enablers and Barriers in the Regions of Interest

GPSA aimed to interview both practices and health services currently supervising doctors and GP-RGs to inform the enablers and barriers to supervising the RG2 group across a wide scope of core generalist training. Before undertaking this, GPSA reviewed its GP supervisors using the categories defined under the Modified Monash Model (MMM) for the three regions in question (Table 9). This suggests there is a reasonably active GP supervisor population in each region, particularly the Hume and Loddon Mallee, including within MM3 and MM4-7.

Table 9: GPSA Supervisor Members in the Three Regions by Rurality

Rurality	Hume	Loddon Mallee	Barwon South West	Total
MM2	31	56	33	120
MM3	42	61	25	128
MM4–7	89	75	39	203
Total	162	192	97	451

Working closely with the project advisory group and working group, GPSA built a list of all relevant GPs and practice managers, health service executives and stakeholders with knowledge of blended/remote supervision, by name, email, and phone number. The GP and health service stakeholders were mainly targeted to the priority areas for this project, for example the northwest corner of the Loddon Mallee, not excluding the opportunity to learn from other parts of the region (priority areas shown in Table 3). GPs/practice managers and health services were invited by email and phone (SMS), where interested participants read the explanatory statement and consented. There were three email reminders and the regional coordinators prompted various participants to contribute to the study. A total of 13 GPs, 15 small and 3 large health services in the regions of interest were interviewed, representing 20-50% of the stakeholders invited in each of these groups (Table 10). Notably, many of these stakeholders spoke on behalf of their whole community and service or practice, such that a broad range of data was gathered. Interviews were around an hour in length, as determined by the interviewee. Additionally, selective stakeholder interviewed for Chapter 5, commented on enablers and barriers to supervision of RG2s in the regions in question.

Interviews followed a semi-structured interview schedule that was tailored to interviewee type (Appendix 7). The frame of questions was informed by the literature and piloted with the advisory group. The interviews were targeted at informing a Supervision Roadmap as a practical set of recommendations for the VRGP to promote supervision for the RG2 step in the VRGP.

Table 10: Interview Invitations and Respondents in the Regions of Interest

Interviews	Invited	Completed
GPs	65	13 (20%)
Small health services	30	15 (50%)
Large health services	12	3 (25%)
Total	**107**	**31 (29%)**

Interviewees were sent the interview guide prior to the interview. All interviews were conducted via Zoom or telephone, and audio was recorded with consent. Each interviewee was assigned a unique identifier. The transcripts were read in total, and the data was arranged thematically (38), to inform the Supervision Roadmap. The themes around the enablers and barriers related to different levels of the system. Where a theme was commonly mentioned it was described as 'major', where it had moderate commentary 'moderate', and where it was mentioned by fewer stakeholders 'minor'. All themes are presented because this reflects the full body of data to inform the Supervision Roadmap.

ENABLERS IN THE REGIONS: SUMMARY OF THEMES

Theme	Sub-theme
Health system	• Funding for small rural hospitals. • Coordination and case management.
Local governance	• Regions committed to long-term collaborative planning. • Relationship between hospital and the community. • Whole town involved in training. • Using outreach clinics. • Accreditation of rural training models. • Credentialed at relevant scope. • Contracts that allow PGY2s to see more cases.
Recruitment and retention	• Town attractive for supervisors and trainees. • Co-employment by hospital and community. • Critical mass of fellowed doctors. • Selective recruitment of trainees to fit rural setting. • Succession results.
General practice/ hospital	• Generalist learning opportunities. • Procedural work sustainable in the location. • Skilled supervisors with interest in next generation. • The whole team involved in supervision. • Ways of supervising prevocational doctors viably. • A learning culture. • Quality improvement and safety oversight. • Space in the practice. • Funding for supervision.

"I really think that there needs to be much more integration to the training, the private and the public ... and the interviews and the placements must be in sort of cooperative system … if we had a trainee who was both placed in private and public, and we did a shared model, they could actually do things."

"I've seen [VRGP staff] doing incredibly successful case management of junior doctors, and really getting to know them on a personal level so you can actually work alongside them and grow them in a career that matches their personality and matches where they want to head."

"The vision is that we will grow a workforce that can adapt and be flexible to meet the changing local community health needs … relationships with our doctors, we've got to be really tuned in to the family dynamics and their background and their cultural backgrounds, as well as their learning needs … I've seen it work."

ENABLER: HEALTH SYSTEM

- **Funding for small rural hospitals**
- **Coordination and case management**

Funding for small rural hospitals

A minor theme was that changing the way that small rural hospitals are funded could be an enabler to their sustainability and therefore their capacity to engage in training pathways. One health service executive thought it would be better to:
"Treat communities like ours the same way that you do Aboriginal medical healthcare centres. Block funded. Don't make it open to private ... we know the only way they can be sustainable is if they're properly funded..." 222_HS(LM).

But another block funded service noted that they were hamstrung by a finite budget not inclusive of training. They were not funded to employ PGY2s and relied on the GPs:
"We're a blocked funded, not activity funded, hospital. We have a finite budget, with no line item for registrar training at the moment; but if we were funded to employ PGY2 registrars, then we signed an agreement with a local practice for them to go there for their clinic time, that might be possible. But ... it's possibly better for them to have a home in general practice and come to us ... we'll give them an experience in the hospital, because we can't provide the four years of RG training for them ... it always gets back to ... where's the money coming from ... if these positions were clearly funded, then that could be a possibility." 048_HS(Hume).

Coordination and case management

A major theme was that coordination and case management are enabling. This is because across the multiple sites, there was a massive investment of time needed to encourage independent health services and practices in different towns to work together for supervised training:
"Enablers [of supervised training across various sites] would also be someone like the VRGP coordinating that to help set it up because I know from a practice manager perspective, a massive amount of our practice manager's time is organising all the different learners and they've all got different requirements and rules." 191_GP(Hume).

The VRGP case management was noted as successful:
"I've seen [VRGP staff] doing incredibly successful case management of junior doctors, and really getting to know them on a personal level so you can actually work alongside them and grow them in a career that matches their personality and matches where they want to head." 157_HS(Hume).

The lengthy time involved in coordinating rural training was reiterated by a health service:
"The model I've described to you is actually an enormous amount of work on a small rural hospital to put in place, and we've had to employ a medical workforce coordinator to do some of that." 133_HS(Hume).

Practice Managers were recognised as key enablers to coordinated training:
"...basically the carriers of communication into their practices and to their supervisors; and to create opportunities for them to connect, to be able to find resources within the region." 188_ST(LM).

The RTOs also supported coordination, predominantly collaborating with agencies and communities to support rural registrar training:
"In my job [as an RTO] I'm looking at the issues as to what needs does a community have, and how can they be filled ... I work with VRGP. I work with PMCV ... health services ... training hubs, and sometimes the local governments to try and find a coordinated and collaborative solution." 188_ST(LM).

Much coordination time was needed to support split placements between towns:
"...I've got a registrar at the moment that's doing 50/50, 1 lot in [x], the other in [x]." 165_ST(LM).

ENABLER: LOCAL GOVERNANCE

- **Regions committed to long-term collaborative planning**
- **Relationship between hospital and the community**
- **Whole town involved in training**
- **Using outreach clinics**
- **Accreditation of rural training models**
- **Credentialed at relevant scope**
- **Contracts that allow PGY2s to see more cases**

Regions committed to long-term collaborative planning

A moderate theme was regions committed to collaborative planning to grow the workforce:
"The vision is that we will grow a workforce that can adapt and be flexible to meet the changing local community health needs … relationships with our doctors, we've got to be really tuned in to the family dynamics and their background and their cultural backgrounds, as well as their learning needs … I've seen it work." 157_HS(Hume).

The planning needed vision and foresight:
"…we actually need visionaries … this is a big job, it's going to take four or five years, let's do the planning. Let's get going." 060_HS(Hume).

Another noted longer-term vision was essential because the problem was so multi-layered:
"So that real long-term planning, that's so important for the regional locations like ours. It's a multi layered thing." 067_GP(BSW).

The relationships for cross-regional planning were built up over many years:
"Everyone gets along very well and recognises the strength that comes from having a good working relationship between as you say secondary and primary healthcare providers. So, that's been built up over many years." 064_HS (BSW).

Those who had been involved in the longer-term journey noted:
"…if I espouse anything it's please stick with it. Funders, please stick with it. I've been working with interns now since 2012. We've got some success and runs on the board ... and the beauty of programs like VRGP, is that there is some potential there that in five to 10 years we will actually see some outcomes out of this project." 157_HS(Hume).

Relationship between hospital and the community

Another moderately strong theme was the relationship between health services and the community was essential to grow supervised learning:
"…it's a township relationship to make sure that we have GPs so that we can provide the services to our health service." 022_HS(BSW).

Some GPs commented:
"We've got this lovely connection with the local hospital … yes, there is a wonderful environment of communication and open doors, all the way to the top in the health service for the private practices." 129_GP(BSW).

The relationship between the health services and GPs that was mutually supportive helped with trust and enabled a growth mentality:
"I think we've been working really hard … on building our relationship with them and so they [GPs] feel really comfortable. I believe they want to feel comfortable with us in the health service and that we're not going to hang them out to dry." 201_HS(BSW).

The relationships between hospitals and practices were also enabled by practice managers:
"The clinic practice manager, she would coordinate the [heck] … out of this [training of doctors]... She would make sure that they had everything they needed." 201_HS(BSW).

Where most GPs in the town worked on VMO rosters, it was excellent for cross community engagement:
"The majority of our medical staff, particularly the ones who do the ward rounds, are GP VMOs who work in the community … and it's great because you've got a quorum of people who, in order to be a GP VMO you've got to have other people on-call with you." 176_HS(LM).

Whole town involved in training

A fairly minor theme was around having the whole town involved in training:
"…it's how the whole town works, how to get them involved in everything. Before we used to have an orientation person to organise them to go out and do activities in the community, go out and milk cows, see how farms work and understand occupational health and safety in that context." 009_GP(LM).

A friendly town was attractive to doctors:
"I always say my friends were the Godsend and they used to help me and still help me if I'm stuck over here, I will say can you get sign off from me from the school … it's one of those communities where you actually want to bring up your young kids…" 226_GP(LM).

Using outreach clinics

A moderate theme was about using outreach clinics to enable PGY2 rural generalist training. A range of health services and GP clinics had stable outreach clinics which provided on-site exposure and back-up supports:
"We've got about 15 visiting specialists … look, if you're grappling with a gynae type situation and you're not 100% sure what to do, you can pick the phone up and talk to our specialists, because they'll be more than happy to take your phone call … they're quite happy to just take the phone call and give you some advice." 123_GP(LM).

The range of specialists visiting or available via telehealth was fairly pronounced in some rural communities:
"We have a paediatrician who comes every six weeks. We have a cardiologist who comes probably quarterly but then does telehealth in between. We have a visiting geriatrician and then we have a bunch of regular telehealth … [and] two endocrinologists…" 191_GP (Hume).

The visiting specialists were longstanding in some cases:
"We've got excellent specialists coming out … they've been coming up for 20 years … for the most part, they actually see their commitment to the town as a service. And they do it. So, they're incredibly generous to us and how they do it … they don't need the money. They do it … because they're committed to the town." 060_HS(Hume).

Accreditation of rural training models

Another minor theme was about accredited training, which had been achieved for iterative steps of the rural generalist pathway:
"We are now accredited for six months in anaesthetics, six months in paediatrics, six months in emergency, six months in obstetrics. And the first year of rural generalist basic training, which is the RG1 or can be the PGY2 level." 007_HS(BSW).

This was enabled by RTOs and communities working together to negotiate accreditation of rural-specific training models:
"The MCCCGPT registrars weren't really allowed to work in that sector [urgent care] because they're not given time off from work in general practice … we're just trying to get that approved by MCCCGPT to say that this is alternative rural training." 101_GP(Hume).

These models included considering how to build in accreditation for breaking the traditional blocks of training into shorter integrated learning stints across a range of locations and clinics or health services:
"…if you rotated them through a number of smaller towns doing say two weeks in each one, that'd probably work really well." 009_GP(LM).

"…as long as it didn't have to be blocked … they could spend time working as a supervised [learner] in antenatal clinic, in the birth suite, in urgent care, and in theatre, with our GPAs…" 048_HS(Hume).

Credentialed at relevant scope

Another minor enabler for expanding rural training opportunities was credentialing rural clinicians at relevant scope based on their local experience, not just their qualifications:
"We've got some anaesthetists that have been here for 30 years now; I would have said, through those 30 years, they're equally skilled and capable as a specialist anaesthetist working in other parts of the country, yet their scope of practice is limited, by virtue of their qualification … they work in a very narrow sort of field … you could credential them to do more things that will be very helpful from the system perspective." 064_HS(BSW).

Credentialing was tightly tied to the clinical service capability framework, and this helped assure health services that training would be safe in the context of their service capacity:
"So, I arrive in [x], there is no credentialing. It's a mess, right? And then the Health Department says we're going to have a surgical capability framework, and you have to comply, and they assess [x] as a level two service and we are actually doing up to level four surgery … so we can do this level three surgery." 060_HS(Hume).

Contracts that allow PGY2s to see more cases

A minor enabler was GP VMOs or specialists having increased opportunity to work across lists in small nurse-led rural hospitals or medically staffed hospitals:
"If I'm on-call and something's happening, I'll just call them - in fact, I've got them on my text. So, I'll actually text them both and say, hey, we've got this happening. If one of you wants to come up, not both, please come up … assist the orthopaedic surgeon or … for an appendix … in theatre." 036_GP(LM).

This depended on PGY2 doctors having a contract which allowed this, and then connecting with opportunities under qualified rural generalist supervisors that may be working in the local or nearby hospitals:
"[In small rural hospitals] You [supervisor] need to tell your medical director and your theatre manager … I'd like him to come across. Is that okay with you? And then the medical director needs to define who is actually supervising … he's my responsibility. I'm watching everything he does." 036_GP(LM).

There were also times that the PGY2 in the hospital was supernumerary on a task and could flick over to learning opportunities with VMOs:
"[Use supernumerary opportunities] … [If on a surgical rotation] there's actually a senior registrar showing up … he came to my end, and said I'm just interested to see what you're doing … and I would encourage that person to write down that it was a lap hysterectomy anaesthetic in their logbook." 036_GP(LM).

"…if you rotated them through a number of smaller towns doing say two weeks in each one, that'd probably work really well."

"…as long as it didn't have to be blocked … they could spend time working as a supervised [learner] in antenatal clinic, in the birth suite, in urgent care, and in theatre, with our GPAs…"

ENABLER: RECRUITMENT AND RETENTION

- Town attractive for supervisors and trainees
- Co-employment by hospital and community
- Critical mass of fellowed doctors
- Selective recruitment of trainees to fit rural setting
- Succession results

Town attractive for supervisors and trainees

A minor theme was that supervised learning was more likely to be successful in towns that were attractive to doctors. This could vary by the size of the town and the community feel, with bigger and smaller hospitals offering different attractors:
"In the bigger hospitals, from time to time anyway, with hosted GP proceduralist trainees, in things like anaesthetics and obstetrics … the clinical experience is normally cited as a positive. And … in smaller towns, a lot of trainees do say that our staff and communities are a lot more friendly." 200_HS(Hume).

Another noted: *"I think … we need to be giving people really good placements that are fun. I recently went for a visit to [x] and it is such a fun place to be. It would be amazing place for a junior doctor to go and live and get to know the community: the people there would be so welcoming."* 110_BHS(LM).

Attractive places had positive health service culture and good size and service base:
"…we got a lot of applications down here. I think the last time we advertised for positions, we had about 42 CVs, out of which we chose one. I think we've been very lucky in that sense. I think [it says a lot about] the culture of the practice, the size of the practice, the services in the practice…" 123_GP(LM).

Retention was strongly tied to finding love:
"The ones [registrars] that stay are the ones that have found love, you know, and or settled into a community and now that they feel like they have a future there." 165_ST(LM).

"And three of the four interns this year … all women … are already married, or settled, or live on farms or, you know, … they already have … their personal lives kind of sorted." 176_HS(LM).

Co-employment by hospital and general practice

A minor theme for enabling supervised learning was building co-employment of trainees across public and private providers in rural towns:
"I really think that there needs to be much more integration to the training, the private and the public ... and the interviews and the placements must be in sort of cooperative system … if we had a trainee who was both placed in private and public, and we did a shared model, they could actually do things." 060_HS(Hume).

The public system was seen as valuable for learning if linkages could be made within a wider pathway development process:
"We know that public hospitals do have the capacity … it would be nice if we could then link those people into an entire pathway where they might have an interest, and then see them stick around in [x] for a longer period of time, or in this region..." 064_HS_(BSW).

Critical mass of fellowed doctors

A major theme for enabling supervision was having enough fellowed doctors, interested in supervision, on the ground:
"We've got a big supervisor group. So, there's four partners … and all of the partners are experienced supervisors, two having been registrars with us." 082_GP(LM).

This improved the viability of supervision:
"I think if you have enough resources [scaled up size, spare doctors] within the practice that I think makes it viable; if you do not have the resources, I think it's going to be very hard. So, I think you need to pick the right practice for something like that." 123_GP(LM). Viability was not necessarily about remuneration, rather it included trying to fit supervision into a model where doctors wore: *"multiple hats … [and were] in demand."* 129_GP(BSW) as they covered a broad scope of rural generalist workload in small rural towns.

Critical mass allowed the supervisory workload to be cross-delegated, and led by more senior experienced supervisors supporting more junior supervisors:
"We have six fellowed supervisors, two I would say are the really senior and the other four supervisors are the offspring of the two initial ones…" [of 7 FTE] 191_GP(Hume).

"We have four accredited supervisors. We've just lost one so we're down from 5. And we were having one of us each day so the registrar would know exactly who the supervisor is on that day, for our registrar's they have a lead supervisor who is mainly responsible then for them to go to with any other main issues." 101_GP(Hume).

Selective recruitment of trainees to fit rural setting

A moderate theme was the need to foster selective recruitment of trainees that are most suited to rural generalist work, the community and the organisational culture:
"Ensuring that you have the right people that are going to be appropriate … be consistent with the behaviours that you expect within an organisation … it took us six or seven months to recruit to the position and to get the right person … lots of people applying, but not often the right fit for us." 064_HS(BSW).

Selective recruitment meant screening for the perception of rural medicine as inferior to metro-medicine:
"They really think that country care is subpar and that we're all still boiling urine. But the clinical exposure that they get here is quite remarkable" 176_HS(LM); Rural areas needed specialised skills: *"I think it's really a specialised area that you need to recruit the right people for it."* 137_BHS(Hume).

The PGY2 learner's capacity to be reflective and honest about their lack of procedural skills was important for their fit to the RG scope of work in rural towns:
"You've just got to explain who you are, and you've got no experience, announce to the room, put it up on the whiteboard: John Smith, junior doctor, no anaesthetic experience … we've got this incredible network we can put you in touch with..." 036_GP(LM).

Succession results

A minor theme was that some respondents were enthusiastic about supervising because they had been able to recruit locally-trained graduates to their practice:
"We've had four or five [trainees] that have stayed very long term. And as I said two of them are now partners, so the job is certainly enjoyable to doctors at that degree of experience, and knowledge and clinical expertise." 116_GP_(BSW).

"We've actually scored quite a few registrars out of our residents, that's because they work here for three months, learn about the place, learn about us … so yeah, we've got a dozen of those." 129_GP(BSW).

The employment of graduate champions from the local area provided an avenue for training leadership because they related positive aspects of their own training in the area:
"I came here as a registrar ... I loved my term up here because I had my own space and oh my god it was just the best … I went why don't I just do another six months? ... I came back to [x], went down to Melbourne, got married, and decided to come back for five years. And that was 2003." 101_GP (Hume).

This contrasted with less positive succession outcomes from supervising:
"We've actually had two local people who already lived in the town, go and do medicine and then come back … they're the only two interns that we have had that are actually still in the clinic." 191_GP(Hume); but enthusiasm amongst supervisors about teaching doctors about rural generalists, which in some cases translated to graduates who worked on specialist rosters in nearby regions and which supported the practice.

ENABLER: GENERAL PRACTICE/HOSPITAL

- **Generalist learning opportunities**
- **Procedural work sustainable in the location**
- **Skilled supervisors with interest in next generation**
- **The whole team involved in supervision**
- **Ways of supervising prevocational doctors viably**
- **A learning culture**
- **Quality improvement and safety oversight**
- **Space in the practice**
- **Funding for supervision**

Generalist learning opportunities

A strong theme enabling supervised RG2 learning was the wide range of generalist learning opportunities in different settings. This included in general practice: *"[We do] … acute medical or paediatric or post-operative … we do geriatrics and palliative care … acute respiratory … abdominal and chest pain … pneumonia … and acute psychiatric care because there's no other place you can get it, really …. good range to be exposed to."* 009_GP(LM). Another commented: *"[In our practice, we] provide anaesthetic lists at our local hospital. We have a GP endoscopist … provide the urgent care cover at our local hospital … we have a significant amount of like emergency department type presentations that just walk into our practice … we see a large paediatric population."* 101_GP(Hume). Others commented: *"We run an antenatal clinic within the practice … then obstetrics wise then there's on-call … for 24 hours. And called to births, or to see patients that have presented pre- or postnatally."* 129_GP(BSW). This included admitting inpatients: *"So we admit under our name and then we do our ward round each day."* 129_GP(BSW).

Health service executives reinforced learning opportunities for RG2s: *"I've got two theatres, I've got dialysis, I've got chemo, theatre, acute, all that sort of stuff, plus all your community stuff."* 021_HS(BSW). Another commented: *"[We have a] 30-bed inpatient unit, a 30-bed high level care nursing home, a 30-bed lower-level hostel accommodation. We have an outpatient facility … 24/7 obstetrics service … about 300 babies a year … an urgent care centre that sees more than 10,000 presentations a year."* 048_HS(Hume).

Many GPs also noted the generalist learning opportunities for RG2s to learn in aged and palliative care: *"I think in aged care facilities, it's a huge responsibility and huge learning curve, to look after people in aged care facilities … I mean, it's really palliative care."* 039_GP(Hume); *"… there's a huge potential there … the aged care sector."* 207_GP(LM).

One GP noted covering multiple nursing homes: *"I am covering currently two of the nursing homes, one … attached to our hospital and one is a private one."* 226_GP(LM); *"We've got three nursing homes in the area that we attend … we do palliative care, both at home and in the hospital or the local hospice…"* 116_GP_(BSW).

Procedural work sustainable in the location

A minor theme was about the sustainability of procedural training, as an important factor for enabling supervised training at generalist scope: *"You've got to pick the sweet spot … Is it going to be a town that grows in five years and become too big to have GPAs? And it's all specialists? Or is it too small that it's not sustainable? And that's hard when you're not willing to move around … [towns x and y] have [specialist] cartels where they'll basically work as a group and squeeze out independents [VMOs]."* 036_GP(LM).

Skilled supervisors with interest in next generation

A strong theme was that supervisor skills and their investment in educating the next generation was enabling. Some doctors who were supervising already expressed strong value of on-the-job supervised learning over didactic teaching for growing quality doctors:
"It's actually about clinical exposure and real-world experiences … your best training is the patients that you see…" 207_GP(LM).

Another mentioned that supervising helped with job satisfaction:
"There's nothing better for us as the older generation to see bright young ones coming through, and enthusiasm? It brightens our day." 036_GP(LM).

A recurring theme was the need for supervisors to have skills and resources:
"…supervisors need to be dedicated to the task, you know, they just, they shouldn't be there nominally … they should be present in that task with an understanding, and they should be trained." 067_GP(BSW);
"…basic supervision skills and basic teaching skills, you know, how to give feedback, that sort of thing…" 082_GP(LM).

One expressed the level of focus needed for high quality supervision may depend on doctors who have practice currency but don't have the demand of patients:
"So it's a retirement job … you're not clinical facing, but you still have to be contemporary in practice … you still need to do professional development, you still need to demonstrate that performance review." 021_HS(BSW).

One health service identified that not all supervisors will have been trained to support junior doctors:
"To foster the junior doctors … some people will have completed some supervision training and others won't have…" 177_BHS(BSW).

The whole team involved in supervision

A strong theme for enabling rural generalist supervision for RG2s was the use of the whole practice and hospital team to support learning:
"It's just the whole team. The whole team is the enabler." 039_GP(Hume).

Rural health services in some cases had nurse practitioners who could assist RG2s:
"I work with a nurse practitioner in ED. And … I think she would be fine to supervise the HMO2s ... she still will constantly just run things past me." 082_GP(LM). Other health services noted *"…we're actually building a programme that is inclusive and thinks about the broader team and the value of other disciplines to support this model and support the junior doctor."* 157_HS(Hume). This was facilitated by recognising: *"The nurses and allied health, it's a huge team. I've seen a lot of growth in team thinking and working as teams rather than individual practitioners … almost sort of wraparound services."* 157_HS(Hume).

It was also noted that models worked where the whole GP team was rostered to supervise and to promote PGY2s going to the supervisor who was rostered which was considered equitable for the GP team:
"It's very much rostered on … we'll have it written at the top that you're on to cover them and they know to call you for that morning … you're distributing it all very evenly across [the supervising team] … you get all engaged in teaching and then … it's someone else's turn the next day." 191_GP(Hume).

"…supervisors need to be dedicated to the task, you know, they just, they shouldn't be there nominally… they should be present in that task with an understanding, and they should be trained"

This helped to prevent burnout:
"And you can have days where you're just like, I don't have a student." 191_GP(Hume).

Using the team meant connecting the learner to the whole clinical setting and gathering feedback from across that setting:
"[They can do] 10 meetings with the allied health staff, they understand what's going on in the community, it's that whole multidisciplinary approach, we have nurses with extended practice ..." 034_HS(BSW).

This approach facilitated access to *"360-degree feedback"* of the learner so that the term supervisor could *"...source that feedback... talk to the nurse on the ward and other key stakeholders..."* 177_BHS(BSW).

It was clearly noted that RG2s could gain insights from non-medical clinicians:
"Who can supervise interns and PGY2s ... it doesn't always necessarily have to be a doctor ... [it can be] a nurse practitioner or nurse with the skills they can be trained into ... musculoskeletal medicine from the physiotherapist for instance." 067_GP(BSW).

Ways of supervising prevocational doctors viably

A major theme for enabling PGY2 supervised learning was methods for GPs to oversee prevocational doctors viably so as not to over-burden their normal workload and enable sufficient billings. Some examples of viable methods included:
"They just come with us to the nursing home ... they can be seeing one patient while you're seeing another patient ... they can be typing your notes and doing those kinds of things as you go." 191_GP(Hume);
Another commented: *"[Supervising PGY1s and 2s] ... we've got an extra person here to take time to assist the senior doctors and nurses to facilitate better health outcomes..."* 221_GP(BSW).

Wave consulting worked as well:
"...you've got a student and a PGY1 who aren't eligible for Medicare [provider numbers]. Then the supervising GP touches base with each of those learners and then there's a business Medicare transaction." 157_HS(Hume). Another GP commented: *"A patient will be booked in for half an hour with the intern, and then they're actually booked for a 15-minute slot with me ... I'll go into the intern room, and the intern will present the case to me, and then we'll manage it collectively as a group."* 191_GP(Hume).

Various methods were used to ensure prevocational learner's skills were assessed thoroughly up front:
"... [for interns we are] parallel consulting at the beginning ... to see where do they ask for help. ... get that idea as to what is their scope of practice, how much knowledge do they have." 101_GP(Hume).

Supervisors might be more inclined to facilitate supervision of RG2s for hospital on-call work if there was a supervision payment from the hospital or if the VMOs were paid a higher on-call fee:
"[GP VMOs are paid] ... at the moment, $200 to be on-call. But if we had someone else to be supervised as well ... [we wonder] would [it] be worth it." 009_GP(LM).

But using prevocational doctors to go ahead to an on-call situation, at restricted scope, was also noted to be an efficient use of time:
"... if I'm on-call ... I can send the intern over in advance, and he can make sure the line's in, he's done the ECG and all those things that you actually don't get paid for anyway. And that's all done. And then you come over and it actually makes you more efficient..." 191_GP(Hume).

One of the key determinants for successful supervision of learners with the needs of the PGY2s was dedicated teaching time, even if this was not funded:
"Once a week there is time with the supervisor of prevocational training for education but also a check in and a wellbeing perspective..." 177_BHS(BSW).

Further, they encourage access to and use of wider professional networks:
"We put them in the chat group on Facebook." 036_GP(LM).

A learning culture

A moderate theme for enabling supervision of PGY2s was an effective learning culture based on the range of learners in both general practice and hospital settings:
"[What we have in our practice is] a very familiar workforce with learners … they've got nurses, educators, reception staff and cleaners there, and security staff at the night clinic, they're all really familiar with students. They are really familiar with that environment, so it's an environment that encourages learners, and as such I think that will be very nourishing." 129_GP(BSW).

Practices that integrated whole-of-practice learning sessions were strongly enabled to host RG2s:
"We do have a weekly teaching session on Fridays for all the doctors…we have two hours blocked away just to do that. One of the things that we do, and the doctors have termed it as cautionary tales…we go through all the near misses, much like an M&M meeting at a hospital." 123_GP(LM).

Another GP noted this extended to informal interactive learning sessions that were hosted in the community:
"[We] have a weekly meeting on a Friday morning, which is an informal meeting but basically part of the learning. We used to call it … coffee and croissants … it's a collegiate sort of case presentation kind of thing but with no structure..." which was done *"To sort of, let our juniors know that even senior people pick the brains of their colleagues, to create that open … phone a friend, ask a friend [culture] … an enabler of learning and supervision, even if it's informal."* 129_GP(BSW).

Quality improvement and safety oversight

A moderate enabler of supervised learning was having quality improvement and safety oversight of prevocational doctors:
"…having a really good governance and monitoring sort of process, I think, assists with the safety … so are we seeing this person doing things…?" 177_BHS(BSW).

Emphasis was placed on needing structured processes to monitor the quality of learning and both learner and patient safety:
"We absolutely need to know about if they've got a 2 [a progress score on their mid-term]. And then we've given the supervisors some really basic things to do to start the conversation... just to check in to really understand is there an issue ... that's where having some people behind the scenes who are administering the system." 177_BHS(BSW). This health service noted: *"We send out a survey [to junior doctors] at the end of the term … we literally ask them five questions: what's working well, people that you want to recognise and why, one or two things to improve, any safety concerns any quality concerns that you need to address."* 177_BHS(BSW).

This was notable where doctors, including registrars, may lack insight as to where they might need help:
"…there's people who … you want to be there because they're very enthusiastic and may not be necessarily good at recognising when they need to ask for help … having a good process for getting feedback from others." 188_ST(LM).

"We absolutely need to know about if they've got a 2 [a progress score on their mid-term]. And then we've given the supervisors some really basic things to do to start the conversation ... just to check in to really understand is there an issue ... that's where having some people behind the scenes who are administering the system."

Space in the practice

A minor theme was that practices with more physical space were better able to host and supervise prevocational doctors:
"Our clinic is pretty big ... we've got 52 consulting rooms in the clinic ... there's a whole heap of stuff going on down here." 123_GP(LM); *"We have 16 consulting rooms. Four nursing areas with a total of seven nursing beds. Yeah, in the building, there's a cafe, radiology, pathology and pharmacy, and a dentist."* 101_GP(Hume).

Others found that space could be negotiated depending on the timing of learners arriving or leaving and sessions that the GPs worked:
"I've got the floor plan for next year and that does accommodate the PGY2 and first year registrars. We shuffle the rooms round a little bit, a bit, do a bit of room sharing. But yeah, then we're topped out where we've maximised our room capability." 221_GP(BSW).

Enough space was seen as a core enabler to hosting prevocational learners in addition to registrars:
"…key things that you need to make a placement successful, and that is a supervisor, clinic space, and housing, and a lot of the communities are already busy with GP registrars ... it means that they'll have to give up a GP registrar, like something has to give." 084_ST(EXT).

Funding for supervision

A major theme enabling supervision was funding for the supervision of PGY2 learners. One GP reflected that payment was a way of promoting quality:
"To get good supervisors, they have … to pay them … at the moment we get $120 or $125 an hour for PGY1s. That's way under what we would earn per hour..." 101_GP(Hume). This was reiterated by another GP: *"…I think that if we are really serious about making supervision a priority for these doctors … we do need to fund it because you might get what you pay for otherwise."* 067_GP(BSW).

Funding for supervision was more important in small communities with fractional general practice staff, meaning that they could not offset the costs of supervision:
"In [x], in terms of the population we've got, we're probably a 1.5 EFT GP practice ... we're talking about fractions in tiny, tiny practices - how do you make that financially viable? Because someone's got to take a hit somewhere along the line with paying the doctor who's training…" 222_HS(LM).

Several respondents proposed interesting solutions for increasing funding available for supervising the PGY2 cohort, such as returning to a model where the PGY2s could bill and refer under Medicare, as an important aspect of learning:
"When we did the PGPPP before, PGY2s could have a provider number. But under the current system, in the junior doctor thing, you're not allowed to have a provider number … they really need the opportunity to be able to transition gradually … to independent consulting, with supervision..." 189_ST(EXT).

One respondent noted that the cost of locums could offset an investment in supervised training:
"So by us stumping up, you know, $300,000 - $400,000 a year [for locums in] … this service, nobody seems to be concerned about it. And yet, if we pulled that out, there will be absolute uproar. I can quantify the cost." 222_HS(LM).

It was also proposed that supernumerary GPs would assist with the quality of supervision for rural vocational learners:
"…PGY interns or PGY2s, having a paid position to supervise those people … funding for that supervision that is almost a supernumerary GP." 127_GP(BSW).

GPs supervising across a generalist scope could also rely on supervisor reward for managing learners in the hospital setting:
"If a trainee is seeing someone in the urgent care department, and they require me to come in and help them so for example, interpret an x-ray or do something that's not a life-threatening thing, only one person can bill Medicare for that." 191_GP(Hume). One GP noted that: *"Very occasionally, the hospital would pay a full extra service for things like cardiac arrests and, you know, lifesaving trauma interventions where we actually needed [all] hands-on deck."* 082_GP(LM).

BARRIERS IN THE REGIONS: SUMMARY OF THEMES

Theme	Sub-theme
Health system	• Reliance on rotational staff. • Preference for retrieval rather than local treatment/centralisation of specialty services. • Siloed service, training, and employment planning. • Employment of junior doctors.
Local governance	• Limited or fragile procedural caseload. • Reducing VMO-led services. • Design of on-call models.
Recruitment and retention	• Limited doctors. • Unattractive to trainees.
General practice/ hospital	• Disengaged with the PGY2s cohort. • Financial viability of practices when adding the cost of supervision. • Space for the learners (in practice). • Medico-legal concerns. • Insufficient supervisors to meet the requirements. • Limitations of technology. • Burnout from number of learners and supervision needs. • PGY2 learning needs poorly vetted.

These themes and sub-themes are presented individually.

BARRIER: HEALTH SYSTEM

- **Reliance on rotational staff**
- **Preference for retrieval rather than local treatment/centralisation of specialty services**
- **Siloed service, training, and employment planning**
- **Employment of junior doctors**

Reliance on rotational staff

A major deterrent to supervising doctors at generalist scope was the fact that rural towns were using registrars and prevocational learners via rotational systems, and they were not necessarily dedicated to the area: *"The hospital increasingly employs registrars even at a more senior level who just rotate in and out of here from a city-based service … it's not helping us, and I think our practice would have a low (level of interest),"* 207_GP(LM). Whereas there was interest in local trainees attached to a longitudinal model of training in the region: *"…we want a sustainable workforce … we're really much more engaged with doctors who are on a pathway to long term commitment to our town."* 207_GP(LM).

Additionally, there was high use of locums and fly-in, fly-out staff which did not provide a consistent supervisor base:
"For [x], they basically have a fly-in-fly-out GP workforce. I don't think they have enough on-site consistency to supervise someone to the degree that I would be comfortable with." 110_BHS(LM).

Such staff could have limited local investment in training systems:
"Some locums are actually really good with a keen interest in teaching. But that's probably the exception rather than the rule … I think we do have to recognise locums are there to work and get money and not sort of be your best friends forever." 200_HS(Hume).

Rotational staff used in some hospital units, made it hard to designate a supervisor:
"…we've got …areas where the supervisors are not rotating so people can have a designated supervisor, but they're not always rostered. Particularly in some of the rotations that work ... two weeks on, and then quite a lot of weeks off ... continuity is a challenge." 177_BHS(BSW).

Rotational training pathways were complicated by COVID-19-enforced quarantine:
"… to go down to Melbourne [from the other side of the Murray River], then they have to quarantine. So that's adding complexity." 137_BHS(Hume).

Preference for retrieval rather than local treatment /centralisation of specialty services

A minor theme for some participants was that patient retrieval was increasingly common, which reduced the volume and complexity of services they were doing and therefore their ability to supervise at core generalist scope:
"…there's more ambulances flying out of [x] now than there ever was before … every day, if not multiple times a day..." 207_GP(LM).

Patients of retrieval were distributed across nearby regional centres and cities depending on the area of care:
"We're actually closer to … [x], but [y regional centre] is a bigger hospital. So, a lot of patients may end up in [y] … there are some qualifiers [depending on the area of care]..." 200_HS(Hume).

This was considered part of surviving in the current healthcare market:
"[In our region] … health services have already basically downgraded or shut and merged … it's very attractive to centralise because everything's a little bit cheaper…" 200_HS(Hume); but this was seen as a dis-service to rural patients: *"… you come to urgent care and if you're transferred to [x] from urgent care, then you've got to pay for that ambulance service … the $1,800 bill to [x] from here that people have to pay ... [that ends up a complaint for the health service to deal with]."* 021_HS_(BSW).

Siloed service, training, and employment planning

A moderate theme was that the Victorian context presented a unique set of challenges for growing training for rural doctors because both hospitals and general practice operated independently, and therefore regionalised models for training and employment were hard to achieve. One noted:
"…the training organisations live their lives in isolation from the health system … I think there's about 17 or 18 training organisations and 81 hospitals that need to sit around a table and be part of the management of what's happening." 060_HS(Hume) Another said: *"We're paying for 80-odd health services to do exactly the same … if we keep on doing the same thing, we will get the same result…"* 021_HS(BSW).

Opportunities to build training within and between towns, and between hospitals and the community, were missed not because of lack of leadership, but mainly due to a lack of collaboration.
"…I contacted the health service [in another town] … I contacted the GPs ... it was so condescending … [they said] we don't think it would be worth our while … doing an M&M with them .... sort of "we're okay, here, we just don't want to be involved. There's too much effort." 060_HS(Hume).

"…if I've got a practice, say, that's got one supervisor wanting a solo leave plan, I've said to the practice, 'You've got this practice, this practice, and this practice all within close vicinity to you … I feel like we need to convince these practices in more remote and rural areas that [for] the longevity of their town … they need to be more collaborative." 165_ST(LM).

It was suggested that hospital boards of nearby towns:
"Should be put together in a more logical way." 060_HS(Hume), minimising the urge to compete for service scope, lists and patients.

The need for regionalised service/training planning was viewed as becoming more urgent as procedural services were becoming more distributed:
"I'm still doing antenatal care, and still doing postnatal care … the low risk go to [x] and the high risk go to [y] - it's 50/50. We do [u], [v], [w], all their antenatal care comes to us." 009_GP(LM).

Independent hospital governance and responsibilities for travel, housing and supervision made co-employment complex for health services to negotiate and share. In one VMO-led hospital this could be overcome if the GP clinic employed learners:
"But the GP clinic [would have to] work out how to make it work." 201_HS(BSW). But having multiple practices sharing a registrar was also noted as a risk as it could *"Potentially move your patient base … at the end of the day that's their revenue base."* 157_HS(Hume).

Some hospital executives noted that, while hosting primary care clinics within hospitals could enable a public private training models for rural generalist training, this model may not align with GPs' interest in practice autonomy including their decisions to be involved in training:
"My GPs here won't be interested in participating in a lot of these models … they're an independent business and [it] actually isn't in their business' interest to support us adopting these training models." 022_HS(BSW).

Employment of junior doctors

A minor theme was employment for PGY2s and the nature of hospital employment contracts potentially presenting a barrier to them getting supervised rural experience. One health service noted avoiding employing PGY2s because of their limited competency and full-time supervision requirements. This resulted in them only employing interns and PGY3+ because of the increased supervision requirements around the PGY2 group:
"A few years ago, we decided not to progress with PGY2s … because of the supervision requirements that were being imposed at that time … so we went from PGY2s to now only having PGY1s, threes, fours, fives, and sixes." 064_HS(BSW).

If PGY2 employment in rural hospitals is not enabled, then the prevocational step in rural generalist training will mainly rely on general practices. PGY2 contracts with hospitals were also suggested to prevent them from getting wider exposure to procedural caseload outside of their rostered hours:
"There's so many restrictions on how many hours they're allowed to work, [if] something's happened at 11.30 at night, and you've got to race off and do something on-call, you can't call that PGY2 to go along with you, because it's outside of their hours..." 009_GP(LM).

A final issue was that junior doctors were being employed on single year contracts, not linked to a training pathway:
"Single contracts. No continuity." which was at odds with other specialist training programs:
"If I'm a doctor, and I go and do anaesthetic training … this is a straight [x] stream. I know where I'm going to be for the next five years, I've got predictability. I don't have to apply for a job every year because this is the pathway through." 021_HS(BSW).

"There's so many restrictions on how many hours they're allowed to work, [if] something's happened at 11.30 at night, and you've got to race off and do something on-call, you can't call that PGY2 to go along with you, because it's outside of their hours..."

BARRIER: LOCAL GOVERNANCE

- **Limited or fragile procedural caseload**
- **Reducing VMO-led services**
- **Design of on-call models**

Limited or fragile procedural caseload

A minor theme which affected supervised learning in PGY2 was the limited or fragile procedural caseload which could affect the sustainability of any training post. This happened due to poor retention of specialists: *"…we had I think a period of around about a month or two where we didn't have a specific specialist anaesthetist to support some of those more complex surgical procedures … [this] has a knock-on effect to all of the surgeons that you have … in some ways, your entire service becomes affected."* 064_HS(BSW); *"We used to have … a gynaecologist come as well, but she stopped practising and no one else wanted to come this far."* 201_HS(BSW).

It was also seen as a broad response to the focus in Victoria on hospital safety and quality standards "phasing out of theatre and alignment with the Safer Care Victoria", but it was noted that there were still rich learning opportunities in non-procedural areas:
"…we have all the complexities of a GP clinic, and aged care and palliative and rehab…" 201_HS(BSW).

Reducing VMO-led services

Another moderate theme was that VMO-led services were in decline, reducing opportunities for supervised training across a rural generalist scope of work. The VMO-led model was at risk from hospitals staffing themselves with HMOs or centralising their services:
"…increasingly, these hospitals are either too small or getting shut down, or they're so large that they have a full cohort of RMOs that can exclude generalists." 207_GP(LM).

In some cases, the VMO-led model failed when the hospital and GP relationship also failed:
"…one of the most important things in the small to medium rural health service is having access to [VMOs] within the local context for supervision … and what we're seeing is that when the relationship breaks down between the health service and the rural GPs in the region, these models of supervision have fundamentally become unworkable." 188_ST(LM).

Other times, it was because the local GPs were not interested because it was too much pressure:
"There's an awful lot of pressure on the GP workforce to provide that primary care and also then provide the acute care within the acute facilities." 133_HS(Hume); or there were not enough GPs: *"…[X doctor] has cut back significantly [and] we've probably had four senior VMOs - some have multiple skill sets, anaesthetics and obstetrics and ED, who have retired and … we haven't yet grown the youngsters."* 176_HS(LM).

In some cases, the VMO model was being replaced by non-GP specialists, and the hospitals embedded a culture of being specialist-led:
"So, you might today look at my own position, I work at [x] hospital, I have for 20 years. In that time, it's gone from six GPAs, only 10 years ago, to now 18 specialists and I'm the last GPA standing..." 036_GP(LM).

Design of on-call models

The design of the on-call models was a minor theme, but it threatened the sustainability of emergency services in some rural towns, and therefore supervised learning opportunities for PGY2 doctors. The model failed when hours-of-service expectations and payment systems did not suit practices:
"…the rural hospital used to have the clinics provide the doctors, and you had to be in the two places at once. It was a recipe for burnout … through significant different negotiations and then lots of doctors ending up leaving, the hospital currently has a locum set up." 101_GP(Hume).

One health service executive noted the importance of health services and GPs working together to design on-call models:
"So how do we partner with our GPs, to develop a workaround to keep them engaged? Do we actually need to be saying, well, if you can't do on-call overnight anymore, how can we provide a service to ensure that we can maintain some clinical service … in as safe ways that we can?" 157_HS(Hume).

In another health service, the on-call roster was considered sustainable during the day, but there were insufficient locals supporting the nightly on-call roster, highlighting the need for more rural generalists in the town to service the roster:
"We have had fairly good success with being able to staff the roster, the remuneration is, I think, appropriate … [but] a lot of people are happy to come up [from Melbourne] and provide the service during the day, but then it's hard to find them to be on-call…" 048_HS(Hume).

BARRIER: RECRUITMENT AND RETENTION

- **Limited doctors**
- **Unattractive to trainees**

Limited doctors

A major theme was despondency about the money and time wasted trying to attract rural doctors with limited results affecting supervision capacity. One health service noted:
"We spent about $20,000 on industry advertising. Guess how many inquiries it netted? Not one inquiry." 222_HS(LM); and another noted *"...they're just not interested ... I've got practices that have had ads for two years that can't get doctors."* 165_ST(LM).

This fuelled a reliance on locum staff, clashing with the agenda of building training pathways:
"…the market has failed in our area. There are no GPs. So, the health service runs the medical clinics. And we run the medical clinics with largely a locum GP workforce." 222_HS(LM).

One health service executive commented on the negative effects of using short-term workforce solutions on achieving a sustainable training pathway:
"The health services can often be looking for a workforce solution without fully understanding what's required to create the best possible training solution" 188_ST(LM).

Retention problems were also common including doctors who were scaling back hours and planning to retire. One noted:
"…as time goes by … people are getting older or effectively semi retiring, moving to the larger towns and back to the city and working part-time, which is leaving." 200_GP(Hume).

The losses could be extreme:
"We've just lost 7 GPs in [x] since Christmas ... [so] people are driving over 100 kilometres to see a GP." 067_GP(BSW).

Even in situations where models of care were applied to attract/retain staff, it was difficult:
"We have a partnership arrangement with the Royal Flying Doctor Service .... we thought … we'll ride on the coat-tails of RFDS, see if they can recruit anybody. They did a nationwide advertising campaign, guess how many doctors they recruited? … one. And they stayed for about eight months." 222_HS(LM); and the retention of RGs also impacted rural workforce and scope of services: *"…he was an excellent clinician. He was a GPA. Everybody loved him, the GP registrars loved him, all that sort of stuff. But he said, I just can't keep working like this. I'm that burnt out."* 021_HS(BSW).

The quality of schooling and available housing were key reasons that doctors were perceived unlikely to move to or stay in some rural towns:
"…a frustration with schooling for the kids ... we go through the guilt of choosing to work in a practice or an area … potentially affecting [my children's] schooling or their sporting options … [for this reason] we just had two doctors leave in the last couple of weeks." 101_GP(Hume).

Unattractive to trainees

A major theme that most respondents mentioned was the personal investment they had made in developing accredited training options in their town only for this to rarely translate into trainees on-boarding. The lack of succession impacted supervisors' enthusiasm:
"You know, it's hard to year after year after year, train people to have them leave. And we went through … about six to seven years where every registrar that we trained … during that time. Every one of them left." 039_GP(Hume).

The inability to attract trainees despite considerable effort was strongly de-motivating for supervisors:
"Even if the GPs are super enthusiastic, all of them, to be supervisors … it becomes a bit demoralising for our GPs … they're going to make the commitment but they're still not getting the people interested in coming." 200_HS(Hume).

They were also conscious that they were having trouble attracting registrars, let alone more junior doctors:
"…we can't even attract, in the last couple of years, registrar placements." 207_GP(LM).

This lent to further scepticism about novel supervision models being able to overcome this:
"If they can't get the trainees, you can have the most innovative model ever invented, but if trainees aren't interested in going to some of our tougher to place districts, people aren't going to want to know about other models of supervision." 188_ST(EXT).

Scepticism was also noted as to whether giving junior doctors rural exposure would attract them to the community longer term, including due to the lack of a clear pathway. This included lamenting the loss of formative pathways to rural general practice careers:
"…the combination of losing PGPPP and the Medicare freeze, those were the two big things, I think, that put the first couple of nails into the coffin of general practice and rural in particular." 082_GP(LM).

It was noted that the financial squeeze on rural general practice could also be a deterrent:
"Until such time as Medicare lifts the level of rebates for the doctors that are in the rural towns … that is a prohibitive factor as well." 165_ST(LM).

The breadth of services and extended hours in rural general practice was also considered a contributor:
"Unless he's prepared to do his bit with the others, as [x] said, we can't take him. We can't do anything else … because doctors in this generation don't want to do that." 021_HS(BSW).

As a result, there was a high dependence on overseas-trained doctors:
"[For eight positions] I have received more than 700 applications … more than 700 applications. How many of those applications were from somebody who has trained and graduated from an Australian medical school?" 007_HS(BSW).

Relying on overseas-trained doctors to fill places required some rural supervisors to oversee the caseload of learners at a very holistic level, which was demanding:
"…supervising IMGs [overseas-trained doctors] who have not been properly selected, they may not have worked for the last 4 years in medicine, and I have to supervise them." 227_HS(LM); *"[IMGs] … they're in a PGY2 position, but they don't have any experience in the Australian healthcare system."* 176_HS(LM).

Some health services felt their services were not stimulating enough to attract learners:
"I honestly don't know what it is that we can do with a GPY2 … that they get enough entertaining and interesting stuff." 201_HS(BSW).

And junior doctors who were meant to be coming to their service may not turn up:
"We have two doctors kind of lined up. So, if they don't disappear somewhere, they should be starting with us next year." 007_HS(BSW).

It was noted it might be hard in terms of *"sinking or swimming"* depending on whether *"they've got a good skillset that they've developed"* and *"a lot of resilience."*

But rural hospitals were not considered the right place for junior doctors:
"Who were anxious at the outset, or may doubt their own clinical capability." 064_HS(BSW).

The social aspect of rural life was not necessarily attractive to junior doctors:
"It can be very difficult because there is no social life … a small town is different from big towns, there is nothing much." 226_GP(LM). One noted: *"Isolation and distance from their family and friends"* was an issue, *"Except, on the rare occasions when the trainees are actually born and bred in that region."* 200_HS(Hume).

BARRIER: RURAL GENERAL PRACTICE/HOSPITAL

- **Disengaged with the PGY2s cohort**
- **Financial viability given the cost of supervising**
- **Space for the learners (in practice)**
- **Medico-legal concerns**
- **Insufficient supervisors to meet the requirements**
- **Limitations of technology**
- **Burnout from number of learners and their supervision needs**
- **PGY2 learning needs poorly vetted**

Disengaged with the PGY2 cohort

A major theme was that general practices and hospitals were disengaged with the prevocational group of doctors, including since the PGPPP (a pre-existing prevocational general practice training experience) was ceased:
"We used to have the medical student placement, the PGPPP … I think, you know, you felt a little bit more comfortable with them, because they sort of know their own scope of practice…" 084_ST(EXT).

Disengaging with this group was also part of coping with a high clinical workload in an environment where GPs were under-staffed:
"In terms of doctors that need one-on-one supervision, we've tended to step away from that in the last couple of years, just because it's too intensive in terms of the busy-ness of the practice … we can't really take on that one-on-one clinical supervision." 207_GP(LM).

Re-engaging with PGY2s was noted to:
"Be very, very difficult" as *"Our consulting times would blow out"* mainly because *"Second years … need very, very close, ongoing supervision, [and] that would not fly in all likelihood."* 116_GP_(BSW).

It was further noted that the rural generalist's own workload was becoming more complex, making it harder to build PGY2s into the model:
"…intensity of the load is so high because the complexity of patients - dealing with pregnant women and children [when working in GP obstetrics] was much simpler than dealing with older people [now]." 207_GP(LM).

The RJDTIF program was not a well-known program. This made it hard for practices to assess it as an opportunity:
"[RJDTIF] with a PGY2, I haven't … had … experience with that, they're full-time in general practice for a period of so many weeks or something?" 039_GP(Hume).

Interns and registrars were also viewed as riskier because of the variable quality of the doctor:
"We've been having interns since PGPPP … we didn't have PGY2s ... I still would struggle … just because [of] the diversity of quality [of PGY2s]." 082_GP(LM). Another commented: *"…to me a PGY2 is a completely undifferentiated new graduate ... you might have to supervise 10 years with PGY2s to get one to come back your way."* 116_GP_(BSW).

Health services also perceived little to gain from this group:
"…PGY2 level, it's not like the health service really gets any benefit from them in any of those areas." 048_HS(Hume). VMO-led hospitals viewed them as risky and reliant on GP supervision: *"I would want them to be working with the VMO GP in the unit at the same time … we get some challenging presentations … [and PGY2s are] a doctor without a lot of experience."* 048_HS(Hume).

Financial viability given the cost of supervising

A major theme was the major financial barriers to supervising the PGY2 group, including in general practice where they had no provider number. Compared with registrars, the PGY2 did not generate practice income: *"…you don't expect to make money out of PGY2, you expect to train them … you're supervising and training them, so they'll be safe."* And taking them on required practices to consider *"How you'd work it out, and how you fund it."* 009_GP(LM).

A health service executive reiterated that supervising junior doctors was costly for GPs compared with PGY3s and, apart from loss of earnings, the practice may be left with managing longer waiting lists and unhappy patients:
"[The GP's] not going to smash through 40 people a day if they've got an intern with them ... a PGY3 will make it faster … [with interns] they slow down their billing … they're going to push out a six week wait to eight, they will potentially disturb the patient relationship." 201_HS(BSW).

One health service asked with respect to supervising in the rural generalist pathway:
"How do we cost recover … how can I do it? A lot of it comes back to this: how do we incentivise? How do we value it?" 021_HS(BSW).

The capacity to offset the cost of supervising was limited in rural settings where bulk billing services were needed:
"…you're dealing with a rural population who find it really unfair to have to pay gaps." 101_GP(Hume).

A health service executive commented of potential GP posts:
"Their profit margin line is so fine that … it's very hard for them to take on anything extra [in terms of supervision roles]." 110_BHS(LM).

Rural hospitals commented that funding would also be needed to support PGY2 supervision, in line with the funding that follows PGY1s:
"There are very few opportunities for small rural health services to be funded and supported to train HMO2s and HMO3s, PGY2s and PGY3s. We can do PGY1s, that's funded." 200_HS(Hume).

Space for the learners (in practice)

A minor theme for general practitioners who were supervising different doctors was the lack of space in the practice for more doctors:
"We couldn't have more learners added in the building at once. We … have run out of rooms … so there's actually some days that not everyone can parallel consult because we don't have enough room for them." 191_GP(Hume).

"…we may not have rooms - certainly not full-time." 039_GP(Hume).

One GP supervisor described the problem as a game of Tetris:
"Our biggest problem presently is space … and where would you put them at the moment - we're trying to master the art of Tetris to get as many doctors in the building ... 15 doctors in 12 rooms." 129_GP(BSW).

Medico-legal concerns

The medico-legal concerns of hosting PGY2 doctors was a major theme. Some of the GPs noted the fact that the rural setting is harder to navigate, warranting stronger oversight by the supervisor. This related to the PGY2 group's level of:
"…knowledge and familiarity with working in the community ... they … struggle with being on their own in the room with a patient … it could be a medical legal nightmare." 039_GP(Hume).

There was a strong theme of unconscious incompetency of junior doctors:
"That situation of people having more confidence than is warranted, that's a dangerous situation when they don't know what they don't know…" 082_GP(LM); *"They're very enthusiastic and may not be necessarily good at recognising when they need to ask for help."* 177_BHS(BSW).

One GP articulated the risk of the PGY2 group would be hard to oversee with the ratio of doctors to supervisees in rural towns:
"…there's not quite enough supervisors to make a really safe net if that makes sense … at the moment even our HMO3+ residents, you have to really nail into them, please ring the GP, put a call in for support." 079_GP(BSW).

It was noted that their level of skill was mismatched with the unpredictable caseload in rural communities and the lack of staff, ancillary services and immediate back-up:
"…they're not in a major regional (centre). You get your farming accidents, you get your AMI, you get all that sort of stuff. But there's not an emergency doctor behind you." 021_HS(BSW).

The impact on a PGY2's career could be long-lasting:
"There's no extra pharmacy to go get it from; ultimately it might just be down pumping on that chest for 55 minutes praying to God that they come back to life … it's all fine until … a PGY2 is the only person in here for 20 minutes and someone comes in when they've cut their leg off with a chainsaw and there's only two junior nurses. And then that person dies. You traumatise that PGY2 for life…" 201_HS(BSW).

It was widely accepted that:
"Most of the time, nothing bad will happen" but this did not allay fear for supervisors that *"If something bad happens … was I really in the room with them when I said I would be? Well, no, I wasn't. I was saving someone's life down the hallway…"* 201_HS(BSW).

The risk appetite varied by setting and hospital executives mentioned the PGY2 group would need clear escalation processes:
"I couldn't have PGY2s in urgent care centre … [without] equipping the PGY2 to feel supported, to be operating and working within their scope, and [knowing] that they have an immediate escalation process." 157_HS(Hume); *"…you can either "phone a friend", or … know what your escalation pathway is."* 177_BHS(BSW) .

The de-skilling of some small rural healthcare teams was another contextual risk for having PGY2s in rural hospitals:
"Our nurses don't intubate people regularly reliably ... so, when it comes to emergency, how am I going to tube someone … because I haven't done it in three years." 201_HS(BSW).

Insufficient supervisors to meet the requirements

Without a fellowed medical workforce it was not possible to supervise to the requirements of some learners:
"…for IMGs [overseas-trained doctors], there are requirements about how many can you supervise at a time … let's say, three IMGs [overseas-trained doctors] at level one supervision, which is the same as an intern supervision, then we are talking about three specialists. Where do I get them?" 007_HS(BSW).

This was heightened by how much overseas-trained doctor recruitment was used:
"We … employ a large number of international medical graduates … our second-year doctors, we probably have 50% potentially who are international medical graduates." 046_HS(BSW).

In some cases, there were insufficient fellowed doctors in general practice to qualify as supervisors:
"We have 4.1 EFT of general practice and of that 4.1 we only have 1.6 FTE who are fellowed at the Royal Australian College of General Practitioners." 060_HS(Hume).

Another barrier was having enough GPs but not enough who were willing to supervise:
"And there seems to be quite a lot of apathy amongst the GPs as far as we can tell in terms of getting them engaged in education … I think it's a very small number." 110_BHS(LM).

The shortage of rural doctors was also leading rural health services and GP clinics to target more senior learners over the PGY2 group:
"We take a GPT3 every now and then … because they don't need to be supervised as much and it takes the burden off the clinic." 201_HS(BSW).

One health service executive recognised that supervision was not something to push if it meant keeping her GPs happy to provide ongoing VMO services:
"And so when our supervisor says he doesn't want to take a PGY2, I'm like, cool. I get it. I'm not going to force you because I need you." 201_HS(BSW).

Limitations of technology

A minor theme was the limitations of technology for supporting the level of supervision and back up that PGY2 level learners may need. Health services noted using My Emergency Doctor, but this was considered over-subscribed and inadequate for oversighting of a PGY2:
"I predict My Emergency Doctor is going to fall over eventually, because every single service in Australia is beginning to use them … you might wait up to four hours for an emergency call with them." 060_HS(Hume).

Further, other executives had trialled telephone supervision models coupled with local nurse practitioner supports, but doctors could not be overseen by nurses:
"We obviously had a lot of GP issues, and worked heavily to try and recreate the model of supervision … we had an innovative model there around how we can get telephone supervision but that escalation to the 1 nurse practitioner was met with the resistance of, you know, a GP can't learn from a nurse." 099_HS(BSW).

Burnout from number of learners and their supervision needs

A moderate theme was the barriers of supervisor burnout based on managing a large number of learners and their needs:
"…that supervisor burnout factor. Too many heads for too little people…" 129_GP(BSW).

This could lead to supervisor attrition:
"Last year, we took on a doctor who eventually got into the PEP programme, but he needed level one supervision … really intense, and he really did need level one supervision … he was just like a med student, I needed to parallel consult every single consult. And I did that for six months over COVID … I just got exhausted and couldn't do it anymore." 067_GP(BSW).

The number of learners in general practice also created a burden, including managing how they affected patients:
"There are many learners. And in the past, we had been one of the practices that, well, we would be a remediation practice and that sort of started to wear a bit thin for some of the patients as well." 082_GP(LM), and there was a point at which longstanding rural supervisors decided to cease supervision and look after themselves: *"It's been 40 years and I've been doing on-call, and the numbers of people on the roster - and yeah, there's lots of people my age and older who are just having to [say] Okay, now you have to start looking after yourself."* 082_GP(LM).

The range of work they covered added to the supervisor burden:
"[Of] those that have actually done the supervision education, [I've got] one. So, she's the supervisor of training for our HMOs. She also works with [GP] … so multiple hats. We're flogging people." 021_HS(BSW).

Time pressures associated with managing patients and multiple learners led one GP to comment:
"We just would not have the time to review most of the patients to second guess them. Yeah, we're pretty much supervised out." 116_GP(BSW). It was also noted that supervision was more than just seeing every patient, but also a lot of time on other things related to supporting the learner.

"We cannot just see every single patient that you see … you have to help them on multiple levels like it was a full-on duty..." 226_GP(LM) .

"In the context of rural health there was a sense that "the workload is excessive and growing. And so, there's really very limited capacity to spend time to train." 200_HS(Hume).

PGY2 learning needs poorly vetted

A minor theme was that the learning needs of the PGY2 group, including doctors related to the VRGP, was poorly understood:
"When they first start off, [we need to know] what should they be learning, do they need to be doing suturing or plasters, or want to learn how to get basic x-rays or IV lines or IV sedation, we really need to know what things they need to learn." 009_GP(LM).

Health service executives also commented that tools and resources may assist:
"Having some sort of assessment - and formal assessment - is really useful because it keeps both parties on track in terms of what are the domains we're looking at, and … what's the plan for improvement and those sorts of things." 177_BHS(BSW).

CHAPTER 5:
Interviews - Blended/Remote Supervision

GPSA aimed to explore the principles behind blended/remote supervision models, by interviewing stakeholders with experience of these models. This model was defined as one where learners are not necessarily always face-to-face with supervisors and may need to contact the supervisor through another method if assistance is required. GPSA identified relevant stakeholders from their known contacts across government, industry, and academia, including those involved in the independent program, RVTS, remote and rural training organisations and supervisors and academics with expert practical knowledge of working in these models. The sample was invited to participate by email and phone (SMS), consenting after reading the explanatory statement before being interviewed (schedule in Appendix 7). Overall, 14 interviews were completed representing around 32% of all those invited (Table 11). Additionally selected GPs and health service executives interviewed for Chapter 4, also commented about their experience with these models.

Table 11: Stakeholders Interviewed About Blended/remote Supervision

Stakeholders	Invited	Completed
Knowledge and experience of blended/remote supervision models	44	14 (32%)

PRINCIPLES: BLENDED/REMOTE SUPERVISION

Theme	Sub-theme
Governance	• Agreed roles and responsibilities. • Trainee communication systems clear. • Escalation methods clear. • Quality improvement system around the system model. • Ability to pivot quickly. • Accreditation processes that are streamlined.
Setting	• Opportunities to learn from the whole team. • Community of practice and social supports for the learner. • The scope amenable to remote supervision.
Supervisor	• Medico-legal risk. • Knowledge of the community. • Comfortable with some uncertainty. • Assurance of trainee's skills. • Reward. • Community of practice for remote supervisors. • Blended model (part remote, part FTF). • Learning systems and resources fit the model.
Trainee	• Stage of formative development and knowledge of the community. • Invested in training in the location. • Learning style, reflection and confidence. • Trust between trainee and supervisors.

PRINCIPLE: GOVERNANCE

- **Agreed roles and responsibilities**
- **Trainee communication systems clear**
- **Escalation methods clear**
- **Quality improvement system around the system model**
- **Ability to pivot the model quickly**
- **Accreditation processes that are streamlined**
- **Supervisor employed to support a catchment**

Agreed roles and responsibilities

A major theme enabling blended/remote supervision models was having agreed roles and responsibilities: *"With the roles and responsibilities … matching the supervisor availability with when the registrar is working … you sort of try to get some consistency with that."* 228_ST(BSW).

This meant you needed to:
"Have absolute clarity around what the off-site supervisor is actually going to do." including *"A position description for the off-site supervisor"* and having others on-site with the trainee *"Even though they're not their supervisor … [so] there is someone that they can ask clinical advice of regardless."* 172_ST(Hume).

Some respondents thought it was important to document the various components of the supervision and educational process:
"There's the educational aspects and then there's career advice and mentoring and so many different parts to it … I think it's about really articulating what those things are... there's clinical supervision, educational supervision, or mentoring … [in] a remote supervision model, you're breaking up all those different activities … who's fulfilling what role and some of those will be remote, and some will be not remote..." 175_ST(EXT).

Considerable weight was given to back-up for the off-site supervisor and the roles and responsibilities around this aspect of the supervision model:
"It involves the agreement from the employer to provide formal back-up supervision as the main model … what happens if the supervisor is on leave, unwell, those kinds of things like, who is your point of call and what happens if for some reason they don't answer their phone. Where's your next step of contact?" 228_ST(BSW).

"We will probably have to use more than one off-site supervisor in that setting to make sure that someone is always available." 172_ST(Hume).

Trainee communication systems clear

A major theme was that supervisor-trainee communication systems were clear, and tailored to the formative stage of the learner and accounted for both incidental and formal learning needs:
"If I had a registrar that wasn't asking me for help, I'd be worried, so the fact that they do contact you often, mine will just send a text and say, if you're free to talk to me about … I just always tell them if you need me to call you straight away…" 062_ST(EXT).

The level of contact for registrars was minimal:
"…they'd just phone me with [any questions] or sometimes they'd just debrief me when they were back the next day" whereas PGY2 learners were accompanied by experienced nurses in the remote context and would: *"Come back at the end of the day to debrief me and I'd give them my feedback. End of day… post presentation debriefing … and of course, at the start, you would get them to present nearly everything."* 038_ST(EXT).

One respondent noted the need for a triage system for remote communication:
"If I was setting it up, now, I would have a system of cards … this is a yellow card; this is a red card or a green card, you know, I can wait [versus 'it's an emergency'] ... it's not only the content, but it's the Why am I asking? And what sort of response am I wanting?" 206_ST(EXT).

It was widely acknowledged that different levels of communication applied according to the individual trainees' situations: location, level of experience, access to and quality of on-site back-up, and the scope and complexity of care needing to be delivered:
"I speak with my registrar each week - I'm paid an hour a week. And we would do … a little bit more than that, because she's usually got a few questions, but I get an occasional WhatsApp question about something ... but not every day or anything like that. Because … I think she's quite well supported in the practice." 082_GP(LM).

For some remote supervisors, being proactive about communicating with the trainee was essential:
"Because sometimes you phone up and you actually find that they're in a pickle, and they haven't felt able to let anyone know, or there's something unsafe in the community." 206_ST(EXT).

Escalation methods clear

A major theme was having methods used for trainees to escalate issues: customised by the location of the post, the patient's needs, access to back-up, and the learner's expectations:
"…in some of the small towns, it's having a plan for getting out of trouble. So, who do you call? Who do you normally refer to? Where's your retrieval site? It's looking at those types of things. Partly it's being aware of what facilities there are in the location ... nursing staff back-up … how do you get onto your retrieval people? And where do you send people?" 071_ST(Hume).

In smaller towns, it was essential that learners identified an emergency and escalated the response immediately:
"If there's a genuine emergency, you'd call the ambulance - no point in bringing them from one tiny town to the next tiny town ... In some ways, things flow easier once you realise it is an emergency. Most doctors are geared up for that." 038_ST(EXT).

Proximity to a base hospital also changed things:
"[Town x] is two and a half hours from the nearest hospitals … if someone had a life-threatening illness, you'd never get anyone to them, we had to manage the first two and a half or three hours…"; *"[For town y] the base hospital is, you know, 20 minutes away or half an hour away, then that's the usual wait time for an ambulance anyway in a lot of places. So that's … more straightforward. You can do this and get going."* 038_ST(EXT).

The method for accessing more support also mattered:
"I think you need specialist support, I just think, because realistically they could ring, say, [x] district health, or [x Base Hospital], but they're only getting the same level if they're talking to a registrar." 046_ST(EXT).

Quality improvement systems around the supervision model

A major theme was that quality improvement systems were essential for blended/remote supervision models:
"You definitely need some sort of process … particularly for poor supervision, which would usually be just lack of supervision as in lazy supervision, and I think that's bad, and then occasionally, some more serious problem." 038_ST(EXT).

Exploring the model for its support of restorative supervision was also valued:
"So we have a system within independent pathway, every registrar has a medical educator and a training officer. So the training officer is full-time, based in [state capital], and the first touch point for registrars, so often they're the ones who are aware of the registrar's life problems … do a bit of mentoring and pastoral care and those types of things." 071_ST(Hume); noting that this often relied on someone other than the primary supervisor: *"If there are any concerns around that there needs to be a strategy or a plan put in place to be able to help a registrar, with particular strategies and referral points, stress management, that's not just the supervisor because they might not be the expert in that restorative process."* 099_ST(Hume).

Quality improvement also needed to monitor whether the learner was safely and effectively learning under the blended/remote supervision model, and this needed to be fairly holistic, rather than learner driven. This involved:
"Somebody going out to them every so often as well, just so they can go through their files and their notes or having that ability on Zoom or whatever to share your screen … getting up their notes if they've got electronic files or things … [to] give you sort of that random knowledge rather than what's been brought to you." 228_ST(BSW).

Having an external agency managing the remote supervision model made it easier to respond to near misses and remove a trainee if warranted:
"Reflecting on what works, what doesn't … it's constantly reviewed. And at any point if it is questionable … there's an opportunity to remove or withdraw. Yeah, sometimes you just don't know until you're in there." 099_ST(Hume).

Ability to pivot the model quickly

A moderate theme was having the ability to adapt the blended/remote supervision model as required if conditions on the ground changed rapidly. This is because blended/remote supervision is often provided in fragile settings where there may be major changes to working conditions or staffing:
"In the remote posts, things change really, really rapidly and people leave at short notice or things happen. And so, you do have to have a toolkit that you go to and understand that these are the things that we can do. So, what are some of the things that we can do? ... so, when an issue is done, all balled up, we've got all the people that would action the toolkit." 084_ST(EXT).

Scenarios included:
"Supervisor had to leave at very short notice", whereby a locum was used, the trainee did some courses and, *"There was some phone supervision that could be done at the same time when their clinics weren't super busy."* 084_ST(EXT). Another health service explained a situation where: *"A couple of doctors or staff in general resign, and then the whole place sort of falls to pieces, and you get them back again."* 175_ST(EXT).

Pivoting quickly was only possible because relationships between the RTO and the health services and clinicians in the region was strong:

The remote supervision model required buffering of *"Solo leave plans"* including *"If a remote supervisor isn't available, it could be as much as well the registrar's got to take leave while their supervisor takes leave, if there is no back-up, and they're very strict on that."* 165_ST(LM).

Where possible, the remote model needed to be designed for resilience, and:
"Shouldn't rely on individuals, they should be a system … I think most of the success stories are because there are really incredible individuals that have driven things. And then when they leave, it doesn't always continue." 175_ST(EXT).

Accreditation processes that are streamlined

A minor theme was the need for scaling up an accreditation process for blended/remote supervision by considering the similarities across the model no matter where it is managed, and having a group who is in charge of this:
"…I think then doubling up and stuff would be silly really, as long as … there is an organisation who really wants pretty much the same boxes ticked as that, and the obvious one is the RTO, then, I think, just use their accreditation." 038_ST(EXT).

Respondents working for the RTOs noted that remote supervision models could not be streamlined under a one-size-fits-all accreditation process due to the nuances specific to the locations and learners:
"Accrediting them is … a really individualised process … it's not like you design a model and then go Yeah cool, that'll be fine for anywhere. It's … collaboration between the supervisor who's providing that remote supervision, the supervising practice that's providing that remote supervision, and the location of the actual post." 228_ST(BSW).

It was considered:
"There is a real quality assurance and compliance methodology used when you're ... [accrediting] ... it's ... what does that plan of supervision look like? How often, when, how do you know if it's an emergency? What is your contact? That needs to be put in place, the same way you're doing it on-site, but I think there's an extra level, and it needs a Plan B and a Plan C..." 099_ST(Hume) It was also noted: *"Now, with the remote supervision model it's usually that practice has already been accredited that we're just looking at an individual remote supervision model for a registrar, in a year ... [it] takes time...it took us four months to set [one] ... up."* 165_ST(LM).

Supervisor employed to support a catchment

A minor theme was an innovation where a supervisor provides 24/7 advice for a whole catchment:
"I've been a DMO (district medical officer) and the system there is that, after-hours, the nurses or doctors call you for advice - usually the nurses will read through the history, although it helps that these days we've got the same IT platform so you can actually log into it from home ... they run things past you and you give them advice so yeah I mean that's a very similar system ... they cover 50 clinics..." 038_ST(EXT).

This depended on the GP not being required to see their own patients at the same time as playing the role of supervisor:
"For a GP to be supervising they're not seeing their own patients at all, just sort of sitting next to a computer or the phone. That's what I envisage." 038_ST(EXT).

PRINCIPLE: SETTING

- **Opportunities to learn from the whole team**
- **Community of practice and social supports for the learner**
- **The scope amenable to remote supervision**

Opportunities to learn from the whole team

A minor theme was that the training post was organised as a whole multidisciplinary team learning model with a variety of learning and feedback opportunities:
"It's important to have feedback from people around the trainee, so ... the supervisor's having that close connection maybe with other doctors that are working in the environment, or ... the nurses who are working with them, and having some sort of multisource feedback." 228_ST(BSW).

One respondent noted that it was relevant to learn from local specialist nurses and understand the team model:
"Whatever the RAN says, that's the way that you're going. She's the one that runs the show and the ship. And so, listen to her vast experience along with the clinic manager because they've been there before. And they understand the groundwork ... you're a team and you should act as a team." 084_ST(EXT).

Learning from patients was also exemplified:
"I'd send them [junior doctors] out to the outstations for example, which is a long day of driving with, a fairly low patient load ... they had nursing staff with them and I would say, you know, just listen to the patient's story, do what you think is reasonable, be pragmatic, and come back and let me know." 038_ST(EXT).

Multi-learner practices were also valued for being:
"Part of the teaching and learning process ... they can pass on knowledge, and they can pass on an understanding." 189_ST(EXT).

Community of practice and social supports for the learner

A major theme was setting up a community of practice and social supports for the learner. This included:
"Introducing them to the social events, engaging them to the local services … as a mentor you should be doing [that]." 226_GP(LM).

For stakeholders more familiar with remote supervision in far flung places, this was a fundamental part of the trainee's overall experience:
"It's not just about what happens in the practice, it's about, you know, this doctor is probably going to be living in this community. So, what social supports are there, how are they going to be integrated into the community?" 175_ST(EXT).

Encouraging the learner to develop their own mentorship connections and networks was considered necessary:
"…developing that community of practice online ... I actually think GPs Down Under does that a little bit as well." 206_ST(EXT).

"These are all things that I think are really important when you're [using] remote rural models … I think a lot of our role is as mentor … and that's something that I didn't experience myself … I look back and I really would have would have loved to have had that ." 062_ST(EXT).

The scope amenable to remote supervision

A minor theme was that emergency and non-procedural services were more suited to a blended/remote supervision model:
"Emergency you could do off-site, but you would need good support … admitting patients to hospital, I think if you've got support in your third year, most will be comfortable around that … rehab, mental health/psychiatry probably could be remote supervision." 046_HS(BSW).

Others commented that the rural generalist scope was not fit for remote supervision:
"I haven't heard of any remote supervision for rural generalists. I haven't heard of any remote supervision that's workable to really support RG trainees." 188_ST(LM).

The range of care was so wide that the remote supervision needed to be tailored to a diverse scope:
"You might last night have been the junior doctor, helping the senior with an MVA. But tomorrow, you're doing coughs and colds." 206_ST(EXT) .

For other procedural areas, remote supervision was not considered viable:
"Obstetrics and gynaecology, I think that would be fairly important to have face-to-face, and anaesthetics and retrieval I think again would need to be face-to-face." 046_HS(BSW).

The wider scope In procedural areas certainly increased the perception of risk for the learner to be working beyond their level of safety:
"I'm just looking at the likelihood of things going wrong. So, it's probably that on-call, paediatrics, obstetrics. And certainly, general surgery; if you're labelled as a supervisor, there's some inherent risk there." 071_ST(Hume).

"It's not just about what happens in the practice, it's about, you know, this doctor is probably going to be living in this community. So, what social supports are there, how are they going to be integrated into the community?"

"Introducing them to the social events, engaging them to the local services … as a mentor you should be doing [that]."

PRINCIPLE: SUPERVISOR

- **Medico-legal risk perceived as the same**
- **Knowledge of the community**
- **Relationship with the learner**
- **Blended model (part remote, part face-to-face)**
- **Assurance of trainee's skills**
- **Learning systems and resources fit the model**
- **Comfortable with some uncertainty**
- **Reward**
- **Community of practice for remote supervisors**

Medico-legal risk perceived as the same

A moderate theme was that blended/remote supervision was regarded having similar medico-legal risks as an on-site supervision context but assessing the safety and quality of learners depended on some face-to-face observation:
"…I think that it's not specific to off-site supervisors. It's something that happens with on-site supervisors as well, where you might pick things up that aren't safe only when you're actually sitting with a trainee or observing them in practice." 228_ST(BSW). Another commented: *"Last year, we had an issue in our practice in [city]. And you'd have thought it's not very remote, but the next-door room can be remote if nobody goes through the door to look what's happening. And a child, the registrar reported the clinical signs differently to what was actually there because it was a condition they'd never seen."* 206_ST(EXT).

This highlighted that all general practice supervisors face medico-legal risk from physical barriers to observation:
"Even if you're a supervisor with the registrar next door, you don't actually know what's going on in that room unless they call you ... I think there can be potential near misses or even disasters happening, even if there's a supervisor next door." 071_ST(Hume).

The design of some remote models made off-site supervision more attractive for supervisors because their areas of responsibility were restricted to education, so they could focus on the role of supervising without being the employer:
"[Remote supervision can enable] having somewhere that you can actually discuss safety concerns without it directly impacting on your employment, so sort of having that feedback, sort of place to raise concerns because it removes those conflict-of-interest things." 228_ST(BSW).

Knowledge of the community

A moderate theme was that supervisors needed good knowledge of the community in which their trainee was working in order to support their learning:
"It's really hard if you've got a registrar in an isolated MM7 town and they've got a supervisor that's urban based." 071_ST(Hume); *"I think knowing this setting, I don't think I could have done that if I'd never lived in [x] … I'm not going to suggest you get a CT scan, because I know that there isn't a CT scanner in town."* 206_ST(EXT). *"Just say that we're doing something, doing procedural or advanced skill. Having a supervisor who is a city doctor or city specialist … If you don't understand the context, you cannot provide the appropriate level of supervision."* 099_ST(Hume).

The graduates who emerged from remote supervision models in similar regions where they were supervising remotely were more comfortable with the model, potentially due to familiarity with context:
"…the younger supervisors came up through those models, because they're GP trainees in the [region], I think they're more comfortable with it." 084_ST(EXT). Another noted it helped if: *"…the off-site supervisor [had an] understanding [of] the environment specifically that the registrar was working in."* 172_ST(Hume).

Remote supervisors noted that having knowledge of the area assisted with restorative supervision as well:
"As I have extensive experience as a rural doctor, I understand very well the pressures that come with the job. This experience helps me to understand well the challenges she faces and provide relevant advice and support." 109_ST(Hume).

Relationship with the learner

A minor theme was that remote supervisors needed to develop a strong rapport with their trainees for the model to be successful. This included:
"Making sure to be absolutely certain that the registrar is well acquainted with the off-site supervisor, they've got supports on-site, you know, those things because they tend to be the biggest things that had come out of that evaluation." 172_ST(Hume).

Relationships were developed through face-to-face time with learners:
"I spent lots of time with [learner] when she'd just come back from working for [x]. So, I actually, I'd never set out to be her remote supervisor. I was just a listening ear when she got back from that. So, we had that relationship. And so that, you know, she'd chosen me." 206_ST(EXT).

This was not always on-site at the clinic, but also at educational events and other situations where they could share stories:
"Meet[ing] up with them and try and meet up with their family … ideally in their own town … or face-to-face on a Zoom so that you know we've got that connection … and share my background so there's that comfort, shared experience." 062_ST(EXT).

Supervisors being responsive and regular in communication also built relationships:
"Establishing that trust is so important and making yourself available and being responsive. Being clear about the best way to contact me and keeping communicating." 062_ST(EXT).

Blended model (part remote/part face-to-face)

A moderate theme was that and off-site supervision models should include some face-to-face supervision (a blended model) because this enabled learning of:
"Ethics and the norms. If you're not monkey see, monkey do - and I know it's not always the right way … professionalism comes in lots of different ways, the way you speak to people, the way you deal with other people, that sort of thing, and I think you actually do need to come in under the umbrella, basically, and do some training F2F." 046_HS(BSW).

This included supervising learners about the realm of acceptable language when communicating with patients with one stakeholder mentioning that:
"Occasionally there's somebody that will say something that reveals their cultural heritage, that is no longer appropriate for Australia ... so there needs to be some sort of normative ethical, professional normative process that occurs." 206_ST(EXT).

This was particularly relevant in rural areas where culturally inappropriate practice could have widespread ramifications:
"When you've got small numbers in small towns, it [communication/professional norms] can all get a bit skewed." 206_ST(EXT).

Being face-to-face allowed more opportunity to oversee procedural work and to check on safety:
"I was really surprised at how far people could get in training and be really, really unsafe, with simple things. And I think that that's sort of where that direct observation at some level, by somebody with skills, is really essential." 228_ST(BSW).

"I was really surprised at how far people could get in training and be really, really unsafe, with simple things. And I think that that's sort of where that direct observation at some level, by somebody with skills, is really essential."

Assurance of trainee's skills

A strong theme was that blended/remote supervision models were enabled where supervisors had a strong sense as to the trainee's skill levels, relative to the scope of the role they were doing. This involved having a process to observe them before they started training under a remote supervision model: *"Absolutely watching them at the beginning, like a hawk."* 206_ST(EXT). Others reiterated this: *"I think it's that early review of a registrar's skills and competence. That's probably the top two [on a list of top three things]"* 071_ST(Hume). *"You would need to have an assessment, as soon as they come in, so you've got a baseline, and you'd need to be looking within that baseline."* 046_HS(BSW).

In the blended/remote supervision model, supervisors aimed for a lot more contact from trainees in the first stage of training in a rural area: *"At the beginning, there needs to be some discussion about every single patient … it's set up so that the supervisor knows, has a really good opportunity to see what the scope is and that some of that is direct observation."* 206_ST(EXT).

The development of the learner's ability, and the supervisor's confidence in the learner, gradually developed, and was linked to the stage and competence of the learner in the setting: *"…towards the end [of PGY2s participating in nurse-led outreach models], as I got a bit more comfortable, you know, you just leave it to them..."* 038_ST(EXT).

Some supervisors looked for signs that the trainee's skills were at a certain level: *"Correlation … between what they're telling me and what's written in the notes … and what receptionists say, when they're getting lots of repeat bookings [that's when they're ready for more independence]."* 206_ST(EXT).

Part of assuring themselves of a learner's competency involved upskilling trainees: *"We'd make sure that anyone going to any of the challenging locations where you had to do overnight on-call in the hospital … without significant emergency experience … were all put through the rural emergency skills training course before those placements."* 228_ST(BSW). Others also mentioned: *"Remote orientation day"* when they *"Do things about self-care, those types of things. But then we also do a retrieval scenario, things that they need to understand who they call, you know, [in] those types of emergency types of situations."* 084_ST(EXT).

Tracking skills development over time was considered important where: *"If you're remote, if you're not looking every now and then to assess what tasks you see after six months to offer any remediation, you've really lost a lot of time."* 046_HS(BSW).

Learning systems and resources fit the model

A strong theme was having learning systems and resources tailored to the blended/remote supervision model. Systems included: *"…the supervisor having access to the practice records, being able to do things via Zoom, or WhatsApp or whatever you may be getting, [or] if you can't do that, getting the registrar to video some consults and send them through."* 206_ST(EXT). Others mentioned: *"Through the Zoom link you share the computer screen so you can see their notes as they go and also with a patient, they can use one or two devices … to be filming. Depending on the computer setup that they have, you can always use a second device [to] join the Zoom [call] and have that camera facing the patient."* 062_ST(EXT).

The ready access to technologies facilitating information sharing and learning was seen as a major benefit to off-site supervision models: *"MS Teams and SharePoint … we're just using standard stuff that's out there. Because I know, in the past, when they used to try and set things up, people would have to buy, you know, different devices, but now everyone's got phones."* 175_ST(EXT).

Learning systems also included formal structured education sessions with the supervisor. Additionally, using: *"A weekly webinar, and of course if you can't make it there's a recording always … two workshops each year…sit down and they have a very clear structure … documentation … all parties complete in a learning plan that's reviewed."* 062_ST(EXT).

Remote supervisors were seen to be better able to support quality improvement by:
"Having their own little toolkit that they can refer the registrar to, being able to be reflective … but also say well it may not work … [and trying] different strategies and different connections." 099_ST(Hume).

In assessing their registrars, remote supervisors used methods to gather feedback from a variety of sources:
"Getting triangulated feedback, so that everybody's getting the same message. Not one person sending that message using multi sources and feedback." 099_ST(Hume).

Comfortable with some uncertainty

A minor theme was that remote supervisors were comfortable with some uncertainty about what they could add:
"I think the biggest barrier for supervision and people engaging in supervision is that idea that they have to be a fountain of all knowledge and they have to know the answer to everything. Medicine is full of uncertainty … teaching that uncertainty and using the learner's quite extensive evolving knowledge and empowering them to use it." 189_ST(EXT).

Reward

A minor theme was that remote supervisors saw wider value than financial reward for supervising but they equally like having some funding to recognise their effort:
"You have to ask what's in it for the supervisor, I mean there has to be something, it doesn't necessarily need to be money in it, but if it's not money, it's got to be some other thing that makes it worthwhile for them spending their time and emotional effort…" 038_ST(EXT).

A remote supervisor found that actively supervising a trainee was fairly seamless when they were not working clinically and were based in a salaried role with time to think:
"I was actually working as [a salaried role], and I was then being asked to supervise somebody 300 kilometres away … I didn't actually mind being interrupted. And it was quite nice to suddenly think about something different. And I had time to sort of formulate an answer, work out who else might be able to help. I think the standard of my response was infinitely better than the standard of response that I gave to the registrar who phoned me yesterday, in the middle of me doing a really complex consult [in general practice]" 206_ST(EXT).

Limited funding for remote supervision was considered a risk for delivering low quality training, with one supervisor related to the Independent Pathway commenting:
"…the thing with the independent pathway is that we don't have funding for supervisors. So even though we have our standards and expected things that supervisors do, in reality they don't always [do them] because they're not being funded for it." 071_ST(Hume).

Community of practice for remote supervisors

A minor theme was that remote supervisors valued a community of practice to share reflections about their experiences:
"Because you can easily be isolated, but you've got a network that reaches across Australia of other supervisors … and having connectivity, you know, as a supervisor - so I feel very comfortable finding another supervisor or emailing saying can I chat to you about a problem if I needed to or talking something through." 062_ST(EXT).

Another respondent mentioned they used:
"A blended off-site supervisor workshop for supervisor support … and a mentoring program so that they'll have back-up with people that have already been involved in off-site supervision in the past…"
with mentoring: *"Helpful because I think they'll [remote supervisors] probably need to be debriefing and understanding where and how their role fits in with this."* 172_ST(Hume).

PRINCIPLE: TRAINEE

- **Formative stage, skills, and knowledge of the community**
- **Invested in training in the location**
- **Learning style, reflection, and confidence**
- **Trust between trainee and supervisor**

Formative stage, skills, and knowledge of the community

A major theme reflected that the formative stage of the learner and their skills and knowledge were essential. A blended/remote supervision model required trainees to:
"Have a skillset or a level of skill, where they know when they can deal with something and when they can't so that's kind of part of that: so, it's actually making sure that we have the right people in the right place." 172_ST(Hume).

This was particularly important in relation to the complexity of presentations trainees may encounter with limited local back-up:
"With the Aboriginal Health [part remotely supervised placement], you know, because we have the problem with the remote supervision, and the more complex cohort of patients, we don't put ones and twos into those posts, they have to be three and four." 165_ST(LM).

Knowledge of the community was considered as important as having technical medical skills:
"If you have been in [this region] before, so if you've done your medical training [here], or you grew up [here], or you may have been in a very similar context before, they may consider you [as GPT1]. But if you're coming fresh out of Sydney, or Adelaide, wanting to do a GPT1 remote, the chances are the training post won't take you on." 084_ST(EXT).

Contextualising the alignment of trainee skills with the scope of rural or remote work was an important consideration:
"The supervision is appropriate for the level of experience of the registrar and what it means in context, rather than level of experience. I think PGY2/3/4/5/6 whatever, because we are also conscious that a number of doctors, may not have done a lot of primary care, or been in a rural hospital, so what is their experience in that particular medical context." 099_ST(Hume).

Invested in training in the location

A minor theme was that blended/remote supervision was enabled if trainees were invested in training in the location. One supervisor noted:
"They all wanted to be there, and we were understaffed… The ones who bothered applying for three months in [x] tended to be pretty enthusiastic and would last the three months easily." 038_ST(EXT).

Learning style, reflection, and confidence

A moderate theme was the trainee's learning style and confidence levels and their fit to the blended/remote supervision model:
"Different people have different skills and learn differently. So, I think offering different ways to learn is beneficial. Some people will succeed. Some people won't." 046_HS(BSW).

Making sure the learner was the right fit for a supervisor and training post was often determined by their level of confidence coupled with risk aversion:
"So I think, generally before they work well for the right learner and the right supervisor in the right setting … the learner having a degree of confidence in and autonomy themselves, but also, awareness of their own limitations." 071_ST(Hume). Another reiterated that the: *"Level of confidence really needs to be right. Sometimes they can be overconfident, sometimes that confidence … if somebody is overconfident that can be risky and if somebody is under confident that might also impact their judgement…"* 099_ST(Hume).

Indeed, the learner's personality type could also determine the success, or otherwise, of their experience under any supervision model, but especially remote:
"You're going to have a lot of personality differences between trainees…some who, if you put them in a remote supervision model, are going to be so anxious and feel really unsupported ... they may actually require more support early on to make sure they don't have an awful experience and want to give it all up." 228_ST(BSW).

One stakeholder also noted that blended/remote supervision models depended on systems to manage learners who lacked self-awareness:
"When RVTS started using 360-degree feedback ... we had a couple of registrars who refused to believe the feedback. Because they thought they were wonderful ... and they're still beautifully deluded about their brilliance … I think trying to persuade somebody that they're not up to scratch, when you're at a distance, is really difficult." 206_ST(EXT).

A GP remotely supervising under the RVTS also noted they:
"Really struggled" with one registrar who ultimately *"Dropped out of the RVTS program"* because he *"Was not really interested in listening to anybody ... really not interested in taking any advice, and to the point where he did the APLS … he failed the assessment … it was them that were wrong, and not that he needed to perhaps have a think about what he'd learned and resit the assessment."* 082_GP(LM).

Trust between trainee and supervisor

A minor theme was about the dual trust between learner and supervisor within a blended/remote supervision model, whilst promoting independent practice:
"My philosophy here, with all my registrars, is to train them how to think, where to turn to for advice, it isn't always me … in that first six months, or first three months, might have been … calling to talk through patients and give advice. What I personally generally feel is like as a supervisor, I'm there, not to take responsibility for hospital work but to help her integrate and use the hospital ... systems." 062_ST(EXT).

Likewise, from the trainee's perspective, being able to rely on an "unofficial" on-site supervisor to offer assurance and guidance as a supplement to that provided by the remote supervisor was vital:
"I requested from her that one of my conditions in my [RVTS] contract was that she is not going to leave me alone, that she will hold my hand till I become a fellow. And … before even moving here I had 17 years of working experience as a doctor. Most of that experience was in emergency surgery and general medicine ... but still moving remotely that was my first concern." 181_ST(EXT).

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CHAPTER 6: A Supervision Roadmap

The project advisory group considered the findings of each chapter to inform the Supervision Roadmap. The findings whilst not exhaustive, were considered to provide a systematic and comprehensive perspective of the capacity, enablers and barriers to expanding supervised learning at the RG2 level. Supervision capacity was noted to be strongly tied to systems issues of recruitment, retention, accreditation, and funding. Further, encouraging supervision of RG2s relies on awareness of the busy clinical workload of the small number of fellowed doctors willing to supervise the next generation, many of whom have 24/7 cover of multiple services across the community. The findings of this project, whilst specific to RG2, may cross-inform the wider expansion of supervised learning on the VRGP.

AGGREGATE RESULTS

The aggregate findings showed:

- There is broad literature about rural supervision, but it mainly relates to registrars, with minimal material about RG2 supervision across a core generalist curriculum. The curriculum that RG2s train across is relatively wide and may be complex to achieve in an efficient way in the Victorian context.
- The literature highlights a range of tools, resources and guide to support supervisors and the accreditation system.
- RG1 and RG2 trainees have strong interests in procedural training, with few seeking non-procedural skills at the early stages of their training. This may be related to the curriculum demands within core generalist training and the traditional professional ideation that an RG is a procedural doctor in traditional fields like GP obstetrics.
- There are multiple GP-based training programs including some which target the rural prevocational level. They have variable focus on supervision and education for the prevocational learner and only some include funding for supervision. All pay less than practices might gain from hosting a registrar.
- Supervision capacity in the three regions is highly variable, more mature in the Hume, and perhaps less so in the Loddon Mallee and Barwon South West regions. This comparative underdevelopment of supervision capacity in Loddon Mallee and Barwon South West is mainly due to recruitment and retention issues in the former and, coupled with this, a reliance on rotational workforce in the latter.
- In many cases, the supervision workforce is relatively burnt out and working at capacity with few fellowed clinicians invested in education, and able to take up supervision of RG2s atop of an increasingly busy rural workload, particularly when dealing with more complex care.
- Overall, the RG2s are generally viewed as an unappealing cohort to host. They are considered of variable quality and many GPs, with little to no understanding of the Rural Junior Doctor Training Innovation Fund (RJDTIF), were more comfortable taking on registrars who could contribute to practice income than junior doctors that had no Medicare provider number and could increase their workload. Prospective supervisors, having lost a sense of the opportunities to host the PGY2 group since the PGPPP funding ceased, faced other pressures on time and income that made supervision of RG2s seem untenable.
- RG2s compete for physical space in practices that are already hosting interns, registrars, and medical students.
- There are selective examples, including in the Hume region where practices have developed good models for supervising prevocational learners that are viable for the practice. These have emerged over a long history of engaging with RCIT intern supervision and where graduates had stayed on to continue training and working in the region. These practices built collaborative team-based supervision models, nested within a strong learning culture (with senior and more junior supervisors sharing supervision work) and quality improvement processes that benefit RG learning.
- Many clinicians will engage with the RG2 cohort, but only if the learners had a commitment to the region or were from the region. This is because several long-time supervisors nearing retirement feel both exhausted from continually investing in training people who didn't stay and demoralised and had a lot of trouble attracting learners to their town/service/clinic. Supervisors are also motivated by learners that show adequate competency and capacity for self-reflection.

- The clash between workforce and training agendas is evident, particularly in the Loddon Mallee and Barwon South West where there is strong reliance on overseas trained and locum doctors. This counteracted the ability to unlock supervision capacity, adding to the burden with the requirement of level 1 supervision. Locum doctors and trainees tend to be of high quality, but locums are not necessarily invested in training local staff. In the Barwon South West one service noted taking their time to select the right doctor to fit their health service culture which was deemed as critical for fostering the local health service culture. Getting the right trainee for the right place also helped supervisors to engage.
- Hospitals and health services in all regions are interested in expanding training opportunities. However, they walk a precarious line of encouraging this, because they want to keep their GPs happy so as not to compromise the VMO services to the hospital. Many hospitals have inadequate funding and capacity to employ RG2s (they did not come with funding that interns did) and rely on GP VMOs for RG2 supervision.
- All regions face the same range of external systems pressures that are reducing opportunities for supervised learning opportunities across procedural work. Opportunities exist where hospitals are invested in VMO rosters and local care, rather than specialist-led care and retrieval. Towns that were closer to regional and metropolitan centres and attractive to visit may not be suitable locations for RG2 procedural training. Also, VMO-led models failed where serviced by few RGs who are retiring, boards were responding to Safer Care Standards or other factors.
- There are a wide range of learning opportunities across generalist scope where RG2s could work in specialist-led outreach and telehealth clinics, across general medicine, aged and palliative care and urgent care in the community and hospital. These areas seemed highly relevant to the needs of the community and therefore potential more sustainable as learning opportunities in the regions. The areas that RG1 and RG2 trainees want to get training in may clash with the wider non-procedural opportunities in the regions, highlighting the need to be clear about the vision for the endpoint of rural generalist training in each region and matching trainees carefully.
- The dislocated planning of training and employment pathways across multiple independent health services and practices in Victoria places a strong pressure on those in leadership roles to find attractive avenues of collaboration while managing competition between services and towns. The prevailing message is that the whole training and employment system needs to be better aligned and there needs to be networked training to capture the range of generalist training opportunities across distributed nearby communities for an RG2 trainee's benefit. It was in the Hume region that there has been great success from longer-term vision around rural generalist workforce training and development coupled with consistent regional planning and action. The recognition of the need for longer-term regional planning is evident in the other regions too, where there were many champions of rural generalist training and grow your own philosophies that have started to expand accredited training opportunities by working across communities and with key stakeholders.
- Some locations are more attractive to RG2s, including coastal areas like Barwon South West, whereas other areas need to sell attributes like the social amenity of their town, access to schooling, housing, and community spirit to attract trainees. Otherwise even the most novel and high-quality training models may not achieve uptake, and this can strongly demotivate supervisors and stakeholders who spend months on accrediting and advertising training opportunities.
- There are a range of principles which emerge from the interviews about blended/remote supervision which can inform innovative solutions to building the supervision capacity for the VRGP. Supervision that is not face-to-face was considered potentially applicable in emergency and non-procedural fields rather than procedural areas. Across a generalist scope of work in rural areas, with less experienced doctors, there are more nuanced considerations including the need for any off-site supervisor to know the context of the rural setting the learner is in and have clear roles and responsibilities.
- Stakeholders mentioned that blended/remote supervision could work well if the learner had been carefully selected and was given clear escalation methods, communication routes and support of a local, skilled clinical team among other things.

A STRENGTHS-BASED APPROACH

This Supervision Roadmap has been developed by applying a strengths-based approach, after considering all the requirements, interests, barriers, and enablers related to supervising PGY2 doctors on the VRGP.

It focuses on six main points:

1. Where to build supervision capacity
2. What supervision capacity to build
3. Promoting the uptake of supervision
4. Influencing the systems level
5. Considering roving supervision
6. Committing to a gradual build

These are described below.

Where to build supervision capacity

Thinking about where to build supervision is important to ensure sustainability. There are some guiding principles to consider when choosing these.

- In locations where workforce is locally recruited, rather than rotational.
- In locations of reasonable amenity and where trainee's social interests can be pursued.
- Where there is reasonable chance of recruitment and retention of doctors (based on figures around the current attraction/retention rates of local staff and stability of outreach services).
- Where hospitals employ RG2 doctors under medical supervision and will release these doctors to smaller towns and community general practices for broader scope of experience and where they have engagement with these practices (hopefully in the same region and proximal for building relationships). This should be underpinned by appropriate formal agreements and a commitment to building a skilled regionalised RG workforce to reduce burden on regional hospitals/retrieval services).
- Where there are RG champions and critical mass practices, with experience in team-based supervision models for prevocational learners and practices that can offset loss of income for other (marginal) gains of hosting prevocational learners committed to an RG career. The supervisor needs to be motivated by the mission and goals of the RG2 group, in their region, relative to hosting a registrar that would contribute to practice income.
- In practices that have space for more learners.
- In practices and health services accustomed to hosting prevocational doctors on a learning pathway (e.g., RCIT-related).
- Where services/practices have quality improvement systems and a learning culture which is maturing or already mature.
- Where a training cluster can be fostered, providing opportunities for learners to experience a broader scope of work over a range of towns and services that agree to a co-employment and training model. This needs to include supervision roles and responsibilities in a team-based supervision model. Clusters could draw from VMO-models, outreach, telehealth, extended scope in general practice, urgent care rosters/first responder networks and nursing homes among other opportunities.

What supervision capacity to build

Supervision capacity in any one distinct procedural field is not going to be the solution for covering CGT training at the RG2 level in Victoria's rural regions, but more integrated learning opportunities in a mix of procedural and non-procedural areas is likely to work better. The type of supervision capacity to build relates strongly to the question about what the sustainable and attractive practice endpoints are for the VRGP in the different rural regions. If these are mostly non-procedural in nature, then the VRGP may need to promote a shift in the mindset about what constitutes a rural generalist. Supervision capacity development might consider:

- RG specialty fields that are needed by the community, and which match the scope of current and future RG work and therefore are more likely to be stable. The nature of core generalist curriculum, including what is expected of an PGY2 level learner across procedural areas, may not align very well with the supervised learning opportunities at the RG2 level in some of Victoria's small rural communities. In several communities, retrieval/patient transport, specialist-led services and less VMO rostering are used over RG-led care. As such, it might be worth considering the value of the current RG curriculum relative to the goals of building sustainable training opportunities in Victoria's regions. Victoria's RG models may need to map to an PGY2+ curriculum that is more focused on emergency care, general medicine, aged care, palliative care, mental health, and Indigenous Health.
- What procedural fields and where these should be pursued relative to current demand as well as supervision and service capacity. If procedural fields remain a focus, then the VRGP may need to consider giving RG2s more time to develop enough experience, in various locations, meaning that RG2 may need to be pursued over a longer period in some regions of Victoria than they would in a place like Queensland, where training can be hosted mainly in rural hospitals under a single employer.

Promoting the uptake of supervision

Many of the keys to promoting the uptake of RG2 supervision rely on building up the concept of the RG2 group and their learning needs as well as considering the up skilling that this group may need to contribute to small rural towns at the RG2 step of the pathway. This includes the VRGP emphasising:

- The quality and experience of the RG2 group (as they are perceived as a mixed quality of learner and therefore high-risk). The practice may need some involvement in determining which trainees that they select to take on and processes to remove them from the practice if things go awry.
- The supervision expectations of the VRGP in the specific rural region, relative to the scope and stage of the prevocational learner, and how these align with core generalist curriculum standards and the VRGP training endpoint in the specific region.
- A process for demonstrating the experience of learners in the RG2 group and the role that the VRGP has played in upskilling the learner to prepare to work in the setting.
- Information about ways that RG2 supervision can be viably done around a busy practice workload – various models and methods for practices that have challenges around their time and money. There were examples of a number of higher volume specialist-linked general practices working at generalist scope (with fellowed generalists) who had strong interest in hosting the PGY2 cohort and perceived they had the critical mass and systems to do this viably, including in the Hume region.
- Tools and resources and guides for supervisors to support learning of the RG2 group, including a logbook, learning plans, guides for new supervisors. This also includes engaging supervisors in skill-development around their supervision role, such as linking them with supervisor professional development opportunities, which are currently more targeted to supervisors of vocational learners.
- Create a sense of recognition for supervisors who commit to training doctors on the pathway, by developing an awards system and providing opportunities for supervisors to share stories and informally network.
- Support for quality improvement of supervision models (including regular quality appraisal) or engagement of other groups who will support this.
- Information about the RJDTIF fund and clarity about how it differs from PGPPP including what support/funding it avails, and how it can be used effectively by practices.
- Communications with the RG2 about the VRGP rural specific endpoints of training and how these are being linked with accredited training places.

Influencing the systems level

Many components that are needed to unlock supervision capacity rest outside the remit of the VRGP and will rely on the VRGP partnering with others to advocate:

- A regional model of supervised training that can be accredited for RG2s that are in GP training or yet to enrol with longer-term certainty about employment and training opportunities in the same region in RG3 and beyond.
- Funding for small rural health services to participate in PGY2 training via employment of RJDTIF learners across local practices whose GPs provide VMO services to the hospital.
- The need for a funding model under the RJDTIF that will suit practices (consider whether the current model will work, or whether to pursue a Medicare billing number) and the capacity to fit the RJFTIF model with smaller VMO-led hospitals (who don't employ PGY2s so can't receive RJDTIF funding but rely on and want to engage with VRGP training).
- Alignment between the goals of RJDTIF, MDRAP and PEP, to inform a sensible supervised prevocational training pathway for rural generalists that is appropriately funded for scale and quality. The level of funding should be able to compete with the level of reward for supervising medical students or registrars.
- Reducing rotational staffing models in regions that are relying on them and connecting the RG2 step with end-to-end medical training and RCIT training in the regions.
- The colleges and RTOs extending on their current remit over vocational training, to also support leadership of quality improvement of prevocational RG learning and engage with RG supervisors.
- The role of agencies like the Primary Health Networks and the Rural Workforce Agencies in assessing regional service need, and supporting rural doctors and their practice models, to enable supervision capacity.
- Developing RG-specific supervision tools and resources including working with GPSA to provide orientation and training for new RG supervisors.
- Providing RG2s enrolled in GP fellowship training access to funding such as the Rural Generalist Training and Education Grants (currently eligible at RG3), as there is limited educational funding for the supervised advanced skills training of RG2s in small rural health services.

Considering roving supervision

In some regions, particularly the Barwon South West and Loddon Mallee, RG2 supervision systems are relatively under-developed. These communities may yet be able to expand their supervision capacity (on the ground) by building as off-site supervision back up via a roving supervision model, with appropriate governance, setting, supervisor and trainee considerations working in alignments learning from the principles of the remote/blended supervision models informs this:

- Roving supervisors could be supernumerary to the regional employment model, who support each rural region's on-the-ground supervisory team's capacity and who work with the VRGP. Having these roles as salaried roles will attract people who are not juggling education against their practice income through fee-for-service. It may also work to involve doctors who know the regions/towns where learners are placed, who are soon to retire/retired and willing to contribute. Funding for this may stem from current considerations by the GP colleges to expand remote supervision as they assume control of GP training.
- Roving supervision would need to be set up using best practice principles backing up the local practice/hospital with supervisory and mentorship capacity for the RG2 learner. Note, this roving supervisor does not replace the need for local supervisory capacity (i.e., a local fellowed doctor and roles of a multidisciplinary supervision team on the ground).
- The principles that the roving supervision model need to align with the evidence found in this project, and other industry standards, which suggest there should be agreed roles and responsibilities, trainee communication systems, escalation methods, quality improvement systems, the ability to pivot the model quickly if conditions change, opportunities for the learner to learn from the whole team, a community of practice and social supports for the learner and supervisor, and clarity about the scope of services suitable to be supervised remotely and how. The roving supervisor would need to be tolerant of the medico-legal risk, ideally know the community, be comfortable with uncertainty, have a means of being assured of a trainee's skills, be paid, be part of a remote supervision community of practice, be available to visit on-site, and avail learning resources fit to the model.
- Roving supervision could expediate accreditation processes by streamlining an immediate supervision resource across all rural regions, including regions like the Hume where supervision opportunities are strong, but there is a desire to expand these to other towns to meet training demand.

Committing to a gradual build

Given that different regions are at different stages of development and unlocking supervision capability for the RG2 group is so multi-level, complex and tied to both direct action and intense collaboration across regions, it is advisable that the VRGP commits to a gradual build of supervision. The achievements in the Hume region which has had the longest standing RCIT is an example of the outcomes that are possible with consistent long-term regional commitment and effort. It is suggested that the VRGP develops a stepwise implementation process for expanding RG2 training that involves working within realistic parameters of engaging supervision capacity over a 2–20 year timeframe.

In the short-term:

- Convene the VRGP Regional Networks to discuss the Supervision Roadmap and decide on a course of action that is fit for each region and realistic to achieve.
- Agree the endpoint for RG practice that is sustainable and attractive in each region and how this articulates with RG2 learning.
- Draw on the practices familiar with the RCIT program, PGPPP or RJDTIF, and that have a critical mass of supervisors and willingness to see the RG2 as part of a new grow your own pathway to RG practice in Victoria's regions.
- Supervisor education and direct supports for practices can be developed relatively quickly as can supervision guidelines/curriculum expectations and toolkits to appraise community training opportunities that could be built into clustered training options.

In the medium-term:

- Work on key barriers like recruitment of fellowed doctors and increasing the critical mass of supervisors in practices.
- Implement a supervision community of practice around the VRGP and rural generalists in Victoria.
- Build partnerships for needs assessment, accreditation, credentialing, and local recruitment options for sustainable training systems (moving away from retrieval etc.)
- Try to source funding to pilot supervision novel and relevant models and build positive case studies of high-quality supervision around RG-practice demands.
- Start to progress systems-level changes like multi-year contracts for training and employment.
- Expand training practices and hospitals attached to the program, and formal governance around regionalised training.

In the longer-term:

- Systems levels changes like policy and practice, including funding for supervision that aligns with the effort required and support from colleges and other GP training organisations.
- Exemplars of best practice published.

CONCLUSION

This exploratory project engaged with a breadth of stakeholders in three very distinct regions and beyond, to unravel some of the nuances of supervised learning for the RG2 step of rural generalist training in Victoria's regions. The findings show the complexity that is involved. By considering the 5 Chapters of findings and Chapter 6, the Supervision Roadmap, the VRGP is likely to have a range of material to inform the next steps of the VRGP's development of high-quality supervised learning to grow a fit for purpose RG workforce for Victoria.

REFERENCES

1. Australian College of Rural and Remote Medicine. Fellowship Training Program Handbook. Brisbane: ACRRM; 2021. p. 1-41.
2. Martin P, Kumar S, Lizarondo L. When I say...clinical supervision. Medical Education. 2017;51(9):890-1.
3. Milne D. An empirical definition of clinical supervision. British Journal of Clinical Psychology. 2007;46(4).
4. Launer J. Chapter 8 Supervision, mentoring and coaching. Swanwick T, editor. London, United Kingdom: John WIley & Sons Ltd.; 2014 2014.
5. Ingham G, Fry J. A blended supervision model in Australian general practice training. Australian Family Physician. 2016;45(4):343-6.
6. Australian Government 2019, *Modified Monash Model*, Department of Health (Canberra) Available from: https://www.health.gov.au/health-workforce/health-workforce-classifications/modified-monash-model. Accessed on 27/08/2021.
7. Russell D, McGrail M. How does the workload and work activities of procedural GPs compare to non-procedural GPs? Australian Journal of Rural Health. 2016;25(4):219-26.
8. Worley P, O'Sullivan B, Ellis R. From locum-led outposts to locally-led continuous regional learning networks: the National Rural Generalist Pathway. Medical Journal of Australia. 2019;211(2):57-60.
9. Postgraduate Medical Council of Victoria. Accreditation guidelines for intern and PGY2 training. Melbourne: PMCV; 2021.
10. Medical Board of Australia. Interns: Australian and New Zealand medical graduates undertaking an accredited internship in Australia Canberra: MBA; 2021. Available from: https://www.medicalboard.gov.au/registration/interns.aspx. Accessed on 27/08/2021.
11. Best J, Phillips J, Welch T, Boyer S, DeLacy C, MColl G. The Murray to the Mountains Intern Training Program. Medical Journal of Australia. 2015;203(6):249.
12. Best J, Boyer S, DeLacy C, PHillips J, Welch T, McColl G. Murray to the Mountains intern training program: involvement of small health services. Medical Journal of Australia. 2014;200(7):378-80.
13. Australian Government 2020, *General Practice training in Australia: the guide*, Department of Health (Canberra). p. 1-44. Available from: https://www.health.gov.au/sites/default/files/documents/2020/02/general-practice-training-in-australia-the-guide.pdf. Accessed on 20/08/2021.
14. Postgraduate Medical Council of Victoria. Clinical learning for junior doctors guidelines. Melbourne: PMCV; 2021. p. 1-8.
15. Royal Australasian College of General Practitioners. Standards for general practice training 3rd dition. East Melbourne: RACGP; 2021. p. 1-73.
16. Australian College of Rural and Remote Medicine. Supervisor Guide. Brisbane: ACRRM; 2020. p. 1-29.
17. Australian College of Rural and Remote Medicine. Supervisors and training posts standards. Brisbane: ACRRM; 2020. p. 1-9.
18. Royal Australasian College of General Practitioners. Applications to trial an alternative process. East Melbourne: RACGP; 2021.
19. Postgraduate Medical Council of Victoria. Performance management guidelines ofr junior doctors. Melbourne: PMCV; 2021. p. 1-4.
20. Wearne S, Dornan T, Teunissen PW, Skinner T. Twelve tips on how to set up postgraduate training via remote clinical supervision. Medical Teacher. 2013;35(11):891-4.
21. General Practice Registrars Australia. The new supervisor guide. Bendigo: GPSA; 2020. p. 1-23.
22. General Practice Registrars Australia. Supervision in after-hours environments. Bendigo: GPSA; 2018. p. 1-19.
23. O'Sullivan B, Hickson H, Kippen R, Cohen D, Cohen P, Wallace G. A framework to guide the implementation of best practice clinical learning environments in community general practice: Australia. Int J Environ Res Public Health. 2021;18(1482):1-12.
24. O'Sullivan, B., Hickson, H., Kippen, R. et al. Exploring attributes of high-quality clinical supervision in general practice through interviews with peer-recognised GP supervisors. BMC Med Educ 21, 441 (2021). https://doi.org/10.1186/s12909-021-02882-7.
25. General Practice Supervisors Australia. On-call myths Bendigo: GPSA; 2021. Available from: https://gpsupervisorsaustralia.org.au/employment-resources/on-call-myths/. Accessed on 27/08/2021.
26. General Practice Supervisors Australia. develop a registrar learning plan Bendigo: GPSA; 2021 [Available from: https://gpsupervisorsaustralia.org.au/develop-a-registrar-learning-plan/.

27. General Practice Supervisors Australia. Teaching plans Bendigo: GPSA; 2021. Available from: https://gpsupervisorsaustralia.org.au/teaching-plans/. Accessed on 27/08/2021.
28. Lennon M, O'Sullivan B, McGrail M, Russell D, Suttie J, Preddy J. Attracting junior doctors to rural centres: A national study of work-life conditions and satisfaction. AJRH. 2019;27(6):482-8.
29. Medical Board of Australia. Supervised practice for international medical graduates guidelines Canberra: MBA; 2021. Available from: https://www.medicalboard.gov.au/codes-guidelines-policies/supervised-practice-guidelines.aspx. Accessed on 27/08/2021.
30. O'Sullivan B, Russell D, McGrail M, Sampson M, Warrington A, Wallace G, et al. Factors related to rural general practitioners supervising general practice registrars in Australia A national cross-sectional study. Australian Journal of General Practice. 2019;48(1-2):66-71.
31. Couch D, O'Sullivan B, Russell D, McGrail M, Wallace G, Bentley M. An exploration of the experiences of GP registrar supervisors in small rural communities: a qualitative study. BMC Health Services Research. 2020;20(1):834.
32. Couch D, O'Sullivan B, Russell D, McGrail M. It's so rich, you know, what they could be experiencing': rural places for general practitioner learning. Health Sociology Review. 2019;29(1)76-91.
33. Young L, Peel R, O'Sullivan B, Reeve C. Building general practice training capacity in rural and remote Australia with underserved primary care services: A qualitative investigation. BMC Health Services Research. 2019;19(338):1-10.
34. O'Sullivan B, Gurney T, McGrail M. Selection, training and employment to encourage early- career doctors to pursue a rural postgraduate training pathway. Australian Journal of Rural Health. 2021:1-5.
35. Konkin J, Grave L, Cockburn E, Couper I, Stewart RA, Campbell D, et al. Exploration of rural physicians' lived experience of practising outside their usual scope of practice ot provide access to essential medical care (clinical courage): an international phenomenological study. BMJ Open. 2020;10(e037705).
36. Campbell AM, Brown J, Simon DR, Young S, Kinsman L. Leading the rebirth of the rural obstetrician. Med J Aust. 2014;201(11):667-70.
37. Martin P, Lizarondo L, Kumar S, Snowdon D. Impact of clinical supervision on healthcare organisational outcomes: a mixed methods systematic review. PLOSOne (under review). 2021.
38. Braun V, Clark V, Hayfield N, Terry G. Thematic analysis. In: Liamputtong P, editor. Handbook of research methods in health social sciences. Singapore: Springer Nature; 2019. p. 843-60.
39. Hanson D, Carey E, Harte J, Manahan D, O'Connor P. Prevocational integrated extended rural clinical experience (PIERCE): cutting through the barriers to prevocational rural medical education. Rural and Remote Health. 2020;20(5437):1-11.

APPENDICES

APPENDIX 1: SERVICE MAPPING SUMMARY

Issues	Training post priorities
Hume	
• Meeting the prerequisites for GP training at RG2 including in anaesthetics, obstetrics and gynaecology and paediatrics is challenging. • Sustainability of supervision, policy and funding for training posts is a concern. • Meaningful employment at the completion of training is required and doing training that matches the community need also essential. • Addressing the long-term program outcomes requires commitment and collaboration between many services. • Working with small rural health services and their medical specialist outreach services is an option, as specialist outreach can be a common model. • Many health services with recruitment issues - supervision seen as critical enabler which underpins whether positions will be filled.	• An accredited training in a networked model - networking with services at Kilmore, Seymour, Alexandra where patients flow on to Northern Health and Eastern Health. • Ongoing connection to the region and linkages with multiple services in that region during training need to be promoted across the training pathway. • Models with multiple external rotations so that trainees remain connected to a region across their RG training pathway. Consider PIERCE model or joint appointments or rotations that involve working in multiple settings in the same discipline (39). Options like RG2 or RG advanced training plans with fortnightly visits with a specialist to small rural health services for outpatient clinics doing antenatal or paediatric care. • Supervision support frameworks and a mentoring system that has clear processes for trainee and mentor. • Longer service contracts.

Issues	Training post priorities
Loddon Mallee	
Obstetrics • Ten health services reported providing maternity services, of which eight were birthing services. With one exception, the six Level 2 and Level 3 health services relied solely on local GP. This group reported a current shortfall of 9 GP Obstetricians (Obs) and demand (due to growth or anticipated retirements) for an additional 13 over the next 5 years. • Only two health services providing accredited training for GP Obstetrics resulting in a regional capacity to train three Advanced Dip Obs candidates and four to six Dip Obs candidates per year. • Recruitment to the Advanced Dip Obs and Dip Obs positions has had variable success recently. **Anaesthetics** • The two health services with the lowest levels of activity reported having a GP Anaesthetist medical workforce model. All other sites utilised a mix of GP Anaesthetists and Specialist Anaesthetists (most drawing on CVAS), or Specialist Anaesthetists alone (Bendigo Health only). • Pools of local GP Anaesthetists ranged from 1 to 6 and the total size of the mixed Anaesthetics on-call pool ranged from 2 to 14 (excluding Bendigo Health). • Only two health services providing JCCA training and reported capacity to train a total of two candidates per year. No issues with recruitment for JCCA training positions were reported. **Paediatrics** • There were mixed perspectives on the demand for GP-RG (Paediatrics). While most indicated a need for GP VMOs to have a good level of capability in managing children presenting to the Urgent Care Centre, smaller health services preferred to transfer children who might deteriorate to health services at higher capability levels. Concerns were raised about potential maintenance of skills issues for a GP-RG (Paediatrics) in locations with infrequent paediatric presentations. • Only one small health service, not actively recruiting, indicated a current need for GP with advanced paediatric skills. A second larger health service could see future demand for a GP-RG (Paediatrics) as part of the development of their Paediatric services and within a mixed Specialist Paediatrician/GP-RG (Paediatrics) model. **Emergency** • Except for the two largest Emergency Departments in the region, all emergency and urgent care services relied on GPs within their medical workforce model. Only two of these health services reported that their GPs had qualifications in advanced emergency skills (either through ACEM or ACRRM).	**Obstetrics** • GP Obs VMOs needed in locations with small after-hours on-call pools. Level 2 and 3 maternity services need GP Obs where rosters are small (1 in 3) (n=11). **Anaesthetics** • Mixed FANZCA and GP Anaesthetist models are common, but a local GP Anaesthetist workforce is important when 24/7 on-call is required (shortfall n=17, spanning epidurals and eye blocks). Eleven health services reported providing surgical services in the region with annual theatre cases ranging from 160 to 13,000. **Paediatrics** • Increased GP basic paediatric skills needed in current GP VMO workforce. May in some cases need advanced skills but not frequently as paediatric cases typically transferred. Only one rural health service reported having GPs with advanced paediatric skills. • Only one Advanced training position for GP-RG (Paediatrics) existing within the region. **Emergency** • Increased emergency skills capability needed in current GP VMO workforce. May in some cases need ACEM EMC level capabilities. In future more GPs will need emergency training to look after the urgent care centres (n=7). • All small health services thought that GP general emergency skills and confidence to manage emergency presentations in the urgent care setting were important but hard to maintain. • Most small health services wanted more GP VMOs participating in the on-call roster for their Urgent Care Centre. • Advanced emergency skills highly regarded but not mandatory. • Future demand for an additional 12 GP VMOs (due to growth or anticipated attrition) across the region. Again, it was preferable but not mandatory that these GPs had advanced emergency skills. • Three health services had the supervisory capacity to provide accredited training in ACEM Certificate or Diploma.

Issues	Training post priorities
Barwon South West	
• Cyclic retention of rural interns is problematic. • Challenges recruiting to RG2 and advanced skills posts, whereby overseas-trained doctors are recruited and have trouble getting registration and provider numbers. • High reliance on seconded positions in small rural towns and seconded doctors not returning to work at the rotational sites (26 accredited registrar positions were being filled by secondees from other health services). • Use of secondments from other health services to fill 11 intern positions at Western District Health Service and 14 HMO positions at Portland District Health, Colac Area Health and Western District Health Service. • Competition between health services for JMOs and increased PGPY2/PGPY3 positions in tertiary centres drawing people into the city (Geelong). • Protracted difficulty recruiting the ones they get in small rural areas. Many HMO positions vacant for 12 months. 4 vacant HMO positions in 2019. Low demand from GP registrars wishing to undertake advanced skills training. Restricted HMO2 training options that will meet ACRRM and RACGP requirements. Lack of PGY2 rotations in the region including into general practice. Particular towns where limited rotations are Warrnambool, Colac, Hamilton, Terang, Camperdown and Timboon. GP registrar positions available now are mainly procedural and may not address mental health and geriatrics needs of the community. • Interns turning over. **Anaesthetics** • No HMO positions. **Psychiatry and palliative care** • Only one rotation. **Paediatrics** • 5 positions at HMO. **Obstetrics** • 6 HMO obstetrics, and they are all in 2 health services. **Primary care** • No GP clinic rotations for HMOs in the region.	• Training rotations that meet RG2 in small communities using networked and telehealth models of supervision of good quality. Shift away from secondments and make pathways localised to the region. Develop rotations into larger health services for interns and JMOs to gain experience. • Purchase roving supports to assist with accreditation of RG posts in a networked training model. • Expand rotations in Warrnambool, Colac, Hamilton, Terang, Camperdown and Timboon. • Nonprocedural additional skills posts, to meet all the needs of the communities e.g., mental health. • Existing supervision capacity for advanced skills. **Obstetrics** • Barwon Health, South West Healthcare and Portland District Health. **Anaesthetics** • Barwon Health, South West Healthcare and Portland District Health and Western District Health Service. **Emergency** • Barwon Health, South West Healthcare, Colac and Portland. Has the highest existing training capacity of 36 positions. ICU has 24 positions accredited. **Paediatric** • Barwon Health, South West Healthcare, Colac Area Health and Portland District Health. **Internal medicine** • Barwon Health, South West Healthcare and Portland and Western District Health Service. 2nd highest training capacity with 28 positions.

APPENDIX 2: THE RACGP FORM TO ACCREDIT AN ALTERNATIVE TRAINING MODEL

RACGP
Royal Australian College *of* General Practitioners

Application to trial an alternative process for general practice training

Trial of process

STAGE 1

Please fill out the details of the proposed process for which you are seeking approval by the **relevant Censor**.

One-off situations that are designed to meet the needs of just one registrar, in one context for one term need to be sent to the relevant Censor for approval with a copy sent to **vtstandards@racgp.org.au**

Please ensure that you submit this application form to the **relevant Censor** with a copy to **vtstandards@racgp.org.au** a minimum of 2 months in advance of your planned implementation date.

Contact details

Training provider

Contact person

Phone

Email

Standard outcome number

Standard criterion number

Please select the category for approval

1. Training post ☐ 2. Supervision (remote/team/Aboriginal health) ☐

3. Alternatives to hospital training ☐ 4. Other – please specify

Continued on page 2

Clarifying information

1. What is the process you want to trial? Describe the context in which the process will be used.

2. Why is the alternative process necessary compared to your existing arrangements? What issues will it address?

3. Who has been involved in the planning of this process? (List all relevant stakeholders)

4. What outcomes will you expect to see?

5. When do you plan to commence the process?

Once the initial trial is completed and evaluated, and you decide to repeat the process, you will need to apply to the *RACGP using the extension of an alternative process for general practice training form.*

Continued on page 3

6. What risks are associated with implementing the process? How will the risks be mitigated?

7. How will you select the registrar/s? Outline the selection criteria. What is the selection process? Who is involved?

8. What stage of training/level of competence will the registrar/s have reached to be eligible to be involved in the process?

10. For alternate models of supervision, please answer the following questions.

a. Who is the lead supervisor (whether on or off site)?
b. Who have you identified as the supervision team? What are their roles?
c. If an Aboriginal Medical service, describe how Aboriginal people have been and will be involved.
d. Describe ways in which the registrar can seek and receive support when needed.
e. Who is the contact person if the registrars have a problem with the process?
f. What contingencies are in place if the supervisor cannot be reached?

Continued on page 4

11. Describe how this process will be monitored? How often and by whom?

12. What alternative arrangements have you made for the registrar if the process breaks down?

13. Other information. Please attach any documentation, including those referred to in this application, or provide any other comments you think may support your application. In the box please list any documentation that you have attached.

Declaration

The RTO agrees that any repeatable, RACGP approved process may be de-identified and published for use by others.

APPENDIX 3: TEACHING AND SUPERVISION FRAMEWORK FOR IMPLEMENTING BLENDED SUPERVISION MODELS

The supervision team	• Who is the principal supervisor? • Who are the other accredited general practice supervisors? • Who are the other members of the supervision team (e.g., non-accredited GPs, practice manager, Aboriginal health worker, allied health staff)? • How are concerns about the registrar communicated between team members? • How is information collated so the registrar can receive feedback?
Clinical supervision	• How do you orientate the registrar into your practice? • What is the roster for in-hours and after-hours supervision? • Is the supervisor able to attend on-site 100% of the time the registrar is consulting or on-call? • How is the supervisor to be contacted? • What is the plan for when the supervisor is on leave? • How is patient safety monitored? • Does the practice have clinical meetings or other governance processes that the registrar will attend, and which will look at practice systems with a view to maximising safety? • How are registrar critical incidents handled?
Educational supervision (teaching)	• What is the teaching and learning philosophy of your practice? • How will you identify registrar learning needs? • When will a learning plan be created and how often will it be reviewed? • How often does a registrar receive face-to-face teaching and what is the duration of the teaching session? • When does the teaching occur and who provides the teaching? • What activities are typically undertaken during teaching sessions? • Do you conduct teaching sessions concurrently with other learners such as medical students or other registrars? • What educational opportunities are available in your practice? • Will the registrar see a broad range of patients in your practice? • What assessment activities will be undertaken during the registrar's term?
Supervisor education and professional development	• What training have members of your supervision team attended? • How do you communicate knowledge and share skills gained from attending supervisor education among the team? • How do you evaluate your supervision and teaching? • Can you outline an example of how you have changed your teaching practice in response to either registrar or educator feedback, or attendance at an educational event?

APPENDIX 4: LEARNING CONSIDERATIONS FOR WORKING IN AFTER-HOURS ENVIRONMENTS

	Training need	Issues to consider	Education activities to address
Populations	• Communication skills.	• Access to translators, communication impairments, culturally appropriate, and distressed patients and/or family.	• Review the resources in the Communication Skills Toolbox to assist with this.
	• Patient demographic.	• Patients and presentations not usually seen by the doctor in their 'daytime' patient demographic.	• Use Random Case Analysis to explore how different patient demographics might present and be managed.
	• The re-presenting patient.	• Dealing with 'frequent flyers' – the patients who use the after-hours service as their GP.	• During a teaching session, discuss with the registrar why this situation occurs, and plan on how they can address the issue with the patient.
Presentations	• Acute and serious illness management.	• Management of patients independently in a non-clinical environment.	• Simulation during teaching time is a great way to both assess your GP Registrar's skills and provide upskilling. • ALS and similar courses are important to keep updated.
	• Using the 'Doctor's Bag'.	• Doctor's bag supplies are infrequently used, and many GP registrars are unfamiliar with the medications.	• In a teaching session, review emergency medications, and other equipment and supplies that should be in a 'Doctor's Bag'. • Australian Prescriber: The Doctor's Bag App. • Prescriber Bag supplies
	• Scope of practice and triage.	• Patient's may be inaccurately triaged or require tertiary management.	• Make an agreement with the GP registrar regarding which conditions you would like to be contacted about every time (if you are supervising) and/or which conditions should always be referred (e.g. chest pain, infants < 6 months old). This is the same process that should occur on orientation of a registrar. • Use the Reducing Diagnostic Error Teaching Plan to improve your GP registrar's approach.
Processes	• Appropriate test ordering.	• Access to pathology services	• Use the Rational Test Ordering Teaching Plan to discuss his issue.
	• Access to guidelines and resources.	• Differing access to patient information and handouts which may impact upon consent.	• Identify useful medical apps that can assist. • Encourage the GP registrar to identify key resources and keep paper copies to provide (e.g. rehydration in children), or save to a USB.
	• Billing and remuneration.	• Advising patients re billing and out of pocket costs. • Appropriate use of item numbers • Remuneration for the doctor.	• Work through the Navigating Medicare Teaching Plan, with a particular emphasis on after-hours item numbers. • The On-Call Myths resource can help to define obligations.

	Training need	Issues to consider	Education activities to address
Processes	• Clinical autonomy.	• The GP registrar may not be comfortable with the independence required.	• Direct observation to assess unconscious incompetence. • With the registrar, create a 'risk register' – what clinical areas and situations may incur an increased patient safety risk. • Managing Uncertainty in General Practice Guide.
	• Consent.	• To refuse care, or to gain a second opinion from their GP, to have a chaperone (may not be easily accessible), consent (if unable).	• Ask your GP registrar to identify cases in which they have had difficulty obtaining consent and discuss.
	• Interprofessional communication and clinical handover.	• Especially with regards to patient follow-up by their regular GP. • Phone and email communication to ensure continuity of care. • Follow-up of serious or life-threatening results.	• Discuss the importance of clinical handover to avoid delayed treatment, unnecessary test repeating, medication errors, legal action, and for the follow-up of significant test results. • Review the systems that the practice has in place to manage this in-hours, and how these processes work after-hours.
	• Fatigue Management.	• Working too many hours or too late at night. • Managing breaks, illness, appointment times.	• Review the Identifying and Supporting GP Registrars at Risk Guide. • Discuss with your GP registrar what strategies they have in place to manage fatigue.
	• Governance.	• Who is answerable to whom and what if there is a problem?	• Team Leadership in General Practice Guide.
	• Managing third parties.	• Relatives, friends, carers, interpreters, other health staff, chaperones, drivers. (Especially with respect to decision-making and confidentiality).	• Role plays are a great way to develop practical approaches to managing communication issues. Use the Doctor Talk Flashcards to prompt your role plays.
	• Medical record keeping.	• Often hybrid models of computerised and paper-based notes.	• Using Chart Audit, look at correspondence received from after-hours providers, or that the GP registrar has written, and identify strengths and areas for improvement.
	• Patient complaints.	• Management at the time, documentation, follow-up.	• Review the Practice Complaints Policy and consider how this should be implemented in an after-hours setting.
	• Personal safety.	• Risks in home environments. • Steps for managing violence.	• Duress alarms, transport, emergency contacts. • Ask the GP registrar to develop a Risk Registrar for their after-hours work and develop a mitigation for each risk.

APPENDIX 5: MYTHS RELATED TO ON-CALL EMPLOYMENT AND SUPERVISION

My registrar signs an employment agreement with the practice and a contractor agreement with the hospital, but isn't engaging a registrar as a contractor illegal?

No. It is not 'illegal' to engage a registrar as a contractor. This is a poor choice of words and something that is factually incorrect. The reason the NTCER requires registrars to be engaged in an employment arrangement is because registrars do not fit the definition of a contractor for payroll tax, income tax and superannuation. Therefore, if a practice engages a registrar as a contractor and does not pay payroll tax, income tax and superannuation, the practice may find themselves in breach of legislation and may pay a penalty as a result. However, in most on-call circumstances the on-call component of the registrar's work is covered by the employment contract in place with the training practice. Thereafter, the income related to on-call, after-hours work is generally paid to the practice by the hospital and released with appropriate payment of taxes and superannuation to the registrar. If your practice is paying appropriate tax, insurances and super on all income related to the registrar, inclusive of their on-call work, then your legal obligations in this regard are satisfied.

My registrar will be uninsured because of the contractor agreement in place for on-call work.

No. Your registrar will be covered by their workers compensation insurance, medical defence insurance and public liability insurances of both the practice and the hospital they are performing on-call work for. The scope of practice does not change for the registrar whether they are performing after-hours or in-hours consults. They will still be confined to the scope for which their supervisor is qualified or for which they have appropriate qualifications such as advanced qualifications in anaesthetics for example. There is no problem of being uninsured where an appropriate employment agreement and contractor agreement are in place. This has been checked with multiple Medical Defence Organisations and consistently confirmed. For peace of mind, we encourage all registrars to check that they are adequately covered by their MDO insurer for after-hours on-call work.

If the registrar's supervisor does not have anaesthetic qualifications, but the registrar does then the registrar cannot perform anaesthetist functions as their scope of practice is limited to that of their supervising GP.

No. If a registrar has an appropriate advanced qualification in a specific discipline, that qualification appropriately extends their scope of practice beyond that of their GP supervisor should the supervisor not have the same qualification. As such the registrar will be covered by all of the appropriate insurances. For peace of mind all registrars should check that they are adequately covered by their MDO insurer for their specific scope of practice.

Once the registrar is officially on-call, the legal and insurance risk becomes the responsibility of the hospital.

No. The GP registrar must have adequate supervision and normally this supervision will be provided by the same supervisor(s) as during in practice consults. While the supervision tends to be more remote/via phone, the supervision support must still be in place and available to the registrar throughout the duration of their on-call work. As such, while the hospital's liability insurances will come into play if something goes wrong during an on-call shift, the registrar's supervision needs, and the role of the supervisor may well come into relevance. At this time a supervisors own insurances and those of the practice will likely be required – jointly and severally. (25)

APPENDIX 6: RESPONSIBILITIES OF THE SUPERVISOR OF AN IMG (OVERSEAS-TRAINED DOCTOR) UNDER THE MEDICAL BOARD

Supervision in general practice positions - It is preferred that IMGs with limited or provisional registration work in general practices that are currently accredited to the RACGP Standards for general practices (latest edition). If the practice is not accredited, the supervisor must satisfy the Board that they have structures in place to support safe practice by the IMG.

- Ensure as far as is possible, that the IMG is practising safely and is not placing the public at risk.
- Observe the IMG's work, conduct case reviews, periodically conduct performance reviews and provide constructive feedback.
- Address any problems that are identified.
- Notify the Board immediately if they have concerns that the IMG's performance, conduct or health is placing the public at risk.
- Notify the Board immediately if the IMG is not complying with conditions imposed or undertakings accepted by the Board or is in breach of any requirements on registration.
- Verify that the IMG is practising in accordance with work arrangements approved by the Board and report to the Board if the IMG is not doing so.
- Ensure that approval of the Board has been obtained for any proposed changes to supervision arrangements, registration conditions or requirements before they are implemented.
- Inform the Board if they are no longer able or willing to provide supervision.
- Provide an orientation for the IMG and provide an orientation report to the Board three months after initial registration.
- Provide work performance reports to the Board in the approved form at intervals determined by the Board.
- Agree to provide supervision at a level determined by the Board.
- Be clear about how they can be contacted by the IMG when the IMG is practising, during working hours and after-hours.

Responsibilities of the employer include to:

- Ensure supervision is provided according to the Supervised practice plan and supervisor's agreement.
- Facilitate the provision of protected time for the IMG and supervisor to enable the formal supervision requirements. to be met.
- Ensure the IMG is adequately oriented to organisational policies and procedures.
- Advise the Board of any concerns about the IMG if they form the opinion that there is a risk to the public that they cannot adequately address by implementing local measures. (29)

Levels of IMG supervision

- Level 1 supervision - The supervisor takes direct and principal responsibility for each individual patient.

  The supervisor must be physically present at the workplace at all times when the IMG is providing clinical care. The IMG must consult their supervisor about the management of all patients at the time of the consultation and before the patient leaves the practice. Supervision via telephone contact or other telecommunications is not permitted.
- Level 2 supervision - The supervisor shares with the IMG, responsibility for each individual patient. The supervisor must ensure that the level of responsibility that the IMG is allowed to take for patient management is based on the supervisor's assessment of the IMG's knowledge and competence.

  Supervision must be primarily in person - the supervisor must be physically present at the workplace a minimum of 80% of the time that the IMG is practising. Where the supervisor is not physically present, they must always be accessible by telephone or video link. The IMG must inform their supervisor on a daily basis about the management of individual patients.
- Level 3 supervision - The IMG takes primary responsibility for each individual patient. The supervisor must ensure that there are mechanisms in place for monitoring whether the IMG is practising safely. The IMG is permitted to work alone provided that the supervisor is contactable by telephone or video link.
- Level 4 supervision - The IMG takes full responsibility for each individual patient. The supervisor must oversee the IMG's practice. The supervisor must be available for consultation if the IMG requires assistance. The supervisor must periodically conduct a review of the IMG's practice (29).

APPENDIX 7: SURVEY AND QUESTION TEMPLATES

Trainee Survey

CURRENT SITUATION

1. Where are you currently working?
   a. Town name
   b. Hospital or health service
2. What are your current position details?
   - ☐ HMO1
   - ☐ HMO2
   - ☐ HMO3+
3. What is your current stream or position title?
4. What is your current postgraduate year?
   - ☐ PGY1
   - ☐ PGY2
   - ☐ PGY3
   - ☐ PGY4+

COMMUNITY ROTATIONS

5. What community rotations (primary care/GP) are you doing/have you done this year?
   a. Town name
   b. GP practice name
   c. Hospital or health service name
6. What community rotations did you complete last year?
   a. Town name
   b. GP practice name
   c. Hospital or health service name

SKILLS AREAS AND TRAINING ROTATIONS /REQUIREMENTS:

General practice *Anaesthetics* *Emergency* *General medicine* *General surgery*
Paediatrics *Obstetrics and gynaecology* *Psychiatry* *Rehabilitation* *Palliative care*

7. What skills areas do you want to practise when you are qualified?
8. What training rotations are you meeting in the current year?
9. What training requirements do you still need to meet next year?

NEXT YEAR'S SITUATION

10. Where do you plan to work next year?
    a. Town name
    b. GP practice name
    c. Hospital or health service name
11. What community rotations (primary care/GP) do you plan to do next year?
    a. Town name
    b. GP practice name
    c. Hospital or health service name

TRAINING PARTICULARS

12. What is your current status?

- ☐ RCIT
- ☐ In a funded RG2 position
- ☐ Registered with the VRGP and waiting on an RG2 position
- ☐ Enrolled in the Independent Pathway with ACRRM
- ☐ Enrolled in the Remote Vocational Training Scheme
- ☐ Enrolled in the Australian General Practice Training (ACRRM or RACGP)
- ☐ Other

13. What is your training plan for next year?

- ☐ Start GP training
- ☐ Continue GP training and do my advanced skills year of training
- ☐ Get more hospital experience before entering GP training later
- ☐ Start GP training and move to general practice
- ☐ Other

14. Which college are you planning on or currently enrolled with?

- ☐ ACRRM
- ☐ RACGP-FARGP
- ☐ Both colleges
- ☐ Other

15. Do you intend to continue training to become a rural generalist?

- ☐ Yes
- ☐ No

General Practice Interviews: Enablers and Barriers to Supervision

Participant name	
Region	
Town	
Practice name	
Employed position in practice	
Practice size (doctors employed, full or part-time)	
Practice linkages with local health service (i.e.: employed as part of district health service or not)	

1. Tell me a bit about yourself. [Prompt: age/career stage/registration status]. How long have you worked in rural/remote general practice across your career?
2. What do you most enjoy about your job?
3. What do you find challenging about your job?
4. Tell me a bit about your practice? [Prompt: from practice details anything you want to expand on]
5. What qualifications do the doctors in your practice have?
6. Apart from comprehensive primary care, what additional services does your practice provide? I am going to take you through some prompts to make sure I gather this information carefully.
7. Is your practice providing any urgent care or emergency services? (Prompt: on-call ratios, duration of shifts, in an emergency department with 24-hour cover, how are you contracted for this? What proportion is paediatrics caseload?)
8. Is your practice providing any paediatrics services including outreach services? (Prompt: >25% paediatrics caseload, approximately how many cases per week? How are you contracted for this?)
9. Is your practice providing any obstetrics and gynaecology services? (Prompt: what proportion is your O&G work per week, approximately how many cases, antenatal and postnatal breakdown? How are you contracted for this?)
10. Is your practice providing and anaesthetics services (Prompt: anaesthetics-related clinics like combined emergency department, ICU or retrieval services? What proportion is your anaesthetics work per week, and roughly how many cases per week. How often do you work and what is the duration of shifts? How are you contracted for this?)
11. Is your practice providing inpatient services? (What proportion is your inpatient work per week, what range of inpatients do you cover? Do you have qualifications and training for this? How are you contracted for this?)
12. To what extent do you plan to keep working in the current practice at the scope you're working at, compared with retiring or winding back?
13. What about other doctors in the practice?
14. Is your practice an accredited teaching practice? [Prompt: AGPT, other programs, PMCV]. If not, why not? If yes, why?
15. Do you or others in your practice currently supervise medical students AND/OR junior doctors AND/OR registrars? [Prompt: are you also involved in RJDTIF, MDRAP, RVTS or AGPT programs?]
16. If so, what are the supervision structure and processes you use?

17. And what are the barriers and enablers of supervising doctors at different stages/on these programs? [Prompt: managing restorative supervision to help with coping strategies, stress management, burnout, debriefing and supervision for formative skills and knowledge development and learning guidelines, ethics and norms.]
18. Do you or others in your practice currently supervise doctors across the additional services at a rural generalist scope of work (emergency, paediatrics, O&G, anaesthetics, inpatient care etc.)?
19. If so, how do you manage the supervision arrangements/how do you triage supervision for these areas? [Prompt: what is the supervision structure and process?]
20. How do you supervise these additional areas so that you know patients are safe?
21. How do you supervise these areas so that the doctors are learning what they need to know in both GP but also, the additional services you provide?
22. Specifically, for PGY2, what are the current barriers to supervising doctors at this stage, across a wider scope? [Prompt: particular service areas, where harder and why.]
23. What are the current enablers to supervising PGY2 level doctors across a wider scope? [Prompt: particular service areas, where easier, and why.]
24. To what extent could your practice engage more with PGY2 learners, in particular areas you work across? And why, why not? [Prompt: is there anything that would make a difference/help you, including being involved but not as an accredited teaching practice?]
25. Would you consider supervising PGY2 level doctors working in nearby communities, using a blended or remote supervision model? [Prompt: where the roles and responsibilities were clearly defined.]
26. What would the barriers and enablers to this be?
27. How do you engage and attract new junior doctors to your practice? [Prompt - and encourage them to stay.]
28. Do you have anything else to add?

Small Rural Health Service Interviews: Enablers and Barriers to Supervision

Participant name	
Hospital name	
Position title	
Region	
Town	
Hospital size (beds)	
General practice(s) attached to the hospital	

1. Tell me a bit about yourself. How long have you worked in rural health services management across your career?
2. What do you most enjoy about your job?
3. What do you find challenging about your job?
4. Tell me a bit about your health service? What are your current priorities for medical service provision? What range of services do you provide?
5. Is your service providing any **urgent care or emergency services**? [Prompt: on-call ratios, duration of shifts, in an emergency department with 24-hour cover, how are doctors contracted for this if it is doctor-led?]
6. Is your service providing any **paediatrics services** or paediatric outreach services? [Prompt: >25% paediatrics caseload and roughly how many cases? How are doctors contracted for these?]
7. Is your service providing any **O&G services**? [Prompt: what proportion is your O&G work per week, and approximately how many cases, antenatal and postnatal breakdown. How are doctors contracted for this?]
8. Is your service providing any **anaesthetics services** [Prompt: anaesthetics-related clinics like combined emergency department, ICU or retrieval services? What proportion is your anaesthetics work per week and how many cases, what are the duration of shifts. How are doctors contracted for this?]
9. To what extent do you want the health service to maintain the current scope of services, compared with winding them back and why? [Prompt: GP/RG involvement expected to the same/more into the future.]
10. Is your health service an accredited training post or planning to become one, for junior doctors or registrars enrolled in GP training? [Prompt: AGPT, other programs, PMCV]. If not, why not? If so, why? If accredited or pursuing accreditations, what supervision models have been applied to become accredited?
11. Does your health service currently supervise medical students AND/OR junior doctors AND/OR registrars? [Prompt: are you also involved in RJDTIF, MDRAP, RVTS or AGPT programs?]
12. If so, what are the supervision structure and processes you use?
13. And what are the barriers and enablers of supervising doctors at different stages/on these programs? [Prompt: managing restorative supervision to help with coping strategies, stress management, burnout, debriefing and supervision for formative skills and knowledge development and learning guidelines, ethics and norms.]
14. How do you manage the supervision arrangements/how do you triage supervision for doctors? [Prompt: what is the supervision structure and process.] [Prompt: Restorative supervision to help with coping strategies, stress management, burnout, debriefing and supervision for formative skills and knowledge development and learning guidelines, ethics and norms.]
15. How do you supervise the rural generalist scope of additional specialist areas the doctors may be working in so that you know patients are safe?
16. How do you supervise these areas so that the doctors are learning what they need to know across the scope of work your service provides?

17. What are the current **barriers** to supervising junior doctors across the rural generalist scope? [Prompt: particular service areas, where harder, and why.]
18. What are the current **enablers** to supervising junior doctors across the rural generalist scope? [Prompt: particular service areas, where easier, and why.]
19. To what extent could your health service engage more with rural generalist junior doctor learners? And why, why not? [Prompt: particular areas of care and is there anything that would make a difference?]
20. How would you employ PGY2 doctors for these services? [Prompt e.g., through an MoU with the general practices.]
21. Would your health service consider getting involved in supervising rural generalist doctors in PGY2, working in nearby communities, using a blended or remote supervision model. [Prompt where the roles and responsibilities were clearly defined.]
22. What would **the barriers and enablers** to this be?
23. How do you engage and attract new junior doctors to your health service? [Prompt - and encourage them to stay.]
24. Do you have anything else to add?
25. Would you like me to forward you the contact details for the Regional Coordinators so you can discuss how the VRGP might be able to work with your service?

Large Regional Health Service Interviews: Enablers and Barriers to Supervision

Participant name	
Organisation	
Position title	
Contact email	
Contact number	
Region	
Town	
Hospital size (beds)	

1. Does your health service already support supervised training for PGY2 doctors based in small rural communities, who are building skills to pursue rural generalist careers (GPs with additional skills), in any way that you know about? This includes for the following services:
   - Anaesthetics
   - Emergency
   - General practice
   - General medicine
   - General surgery
   - Paediatrics
   - Obstetrics and gynaecology
   - Rehabilitation
   - Palliative care
   - Psychiatry
   - Other, please state?
2. If not, why? If so, how? [Prompt: what is the supervision structure and process] [Prompt: How do you manage the restorative supervision to help with coping strategies, stress management, burnout, debriefing. How do you manage the supervision for formative skills and knowledge development and learning guidelines, ethics and norms?]
3. What are the barriers to providing remote supervision for this group? (If learners were selected and had done Advanced Life Support training and the roles and responsibilities of the supervisor were clearly defined) [Prompt: learner, supervisor, service level factors.]

   [Prompt: in terms of learner safety, the supervisor may have the role of orientating learners, being available to respond to a registrar's clinical questions during consulting hours, conducting audits of registrar patient care, such as random case analysis, responding to critical incidents and complaints. In terms of learning, supervisors would also be responsible for developing and reviewing the learning plan, facilitating educational opportunities that evolve from clinical work, providing registrar tutorials.]
4. What are the **enablers** to providing remote supervision for this group (if roles and responsibilities were clearly defined? [Different parts of the RG scope.]
5. What are the **barriers** to providing remote supervision for this group? [Different parts of the RG scope.]
6. How do you attract or engage junior doctors in your health service? [Prompt - and encourage them to stay.]
7. Would you be interested in being involved in a pilot of remote supervision?
8. Is there anything else you would like to add?
9. Would you like me to forward you the contact details for the Regional Coordinators so you can discuss how the VRGP might be able to work with your service?

Stakeholder Interviews: Learning About Blended/Remote Supervision Models

Stakeholder name	
Organisation	
Position title	

1. What is your experience with rural supervision models and where the trainees and supervisors may work across multiple sites and supervision is not necessarily occurring face-to-face? Where, when were you involved in these models?
2. Have you applied these models training rural generalist doctors (scope of general practice, admitting to hospital, seeing inpatients, and doing emergency on-call)?
3. If so, what was the scope of supervision you are aware that could be supported remotely? [Prompt: caseload per week, frequency/duration spent on rosters.]
    - On-call services/emergency.
    - Paediatrics, paediatrics outreach.
    - Obstetrics and gynaecology (prenatal, intrapartum, post-partum).
    - Anaesthetics, ICU, retrieval .
    - Admitting patients to hospital and inpatient care/general medicine.
    - General surgery.
    - Rehabilitation.
    - Palliative care.
    - Psychiatry.
    - Other.
4. What part was supported face-to-face? [Of the above scope]
5. What level of back-up was used if the doctor needed help?
6. How were roles and responsibilities defined?
7. What educational supports were used?
8. How was technology used, for example, phone or video, or document sharing, to connect with the trainee?
9. More specifically, how did you manage restorative supervision to help with coping strategies, stress management, burnout, debriefing?
10. And how did you manage supervision for formative skills and knowledge development and learning guidelines, ethics and norms?
11. What aspects of these models worked well and in what context (learner, supervisor, service, setting)?
12. How did you know that the patient was safe? [Prompt: In terms of learner safety, the supervisor may have the role of orientating learners, being available to respond to a registrar's clinical questions during consulting hours, conducting audits of registrar patient care, such as random case analysis, responding to critical incidents and complaints.]
13. How did you know that the learner was learning? [Prompt: In terms of learning, supervisors would also be responsible for developing and reviewing the learning plan, facilitating educational opportunities that evolve from clinical work, and providing tutorials.]
14. Did you have any near misses whilst using rural supervision models? If so, what happened and what did you learn from these?
15. How were the models evaluated and what were the outcomes (satisfaction by learners, supervisors, impact on patient care)?
16. How easy were these models to accredit – do you have any tips there?
17. In summary, what are your three top tips for enhancing the effectiveness of rural supervision models for those that are new to this?
18. Is there anything else to note that might inform whether these could work in the VRGP?

GPSA

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