Recent Developments in Rural Hospital Medicine I:

Rural Hospital Medicine Special Scope

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Introduction

This year (2008) has produced several significant events for rural hospital medicine in New Zealand.

At its April meeting, the Medical Council of New Zealand (MCNZ) recognised Rural Hospital Medicine (RHM) as a new scope of practice. This marked the culmination of three years of hard work on the part of those who put together the application.

At the same time the new Royal New Zealand College of General Practitioners (RNZCGP) Division of Rural Hospital Medicine held its first general meeting and elections for its governing body. Later this year the first doctors will be 'grandparented' to Fellowship and become vocationally registered. Finally we will see the first registrars enter the new training programme in December 2008.

The formation of the RNZCGP Division of Rural Hospital Medicine marks several important firsts. It is the first time a group of doctors with a scope other than general practice will sit within the RNZCGP; it is the first new scope to be recognised by the MCNZ since the moratorium on new scopes was lifted in 2004 and since the introduction of the Heath Practitioners Competency Act; it is the first generalist scope of practice since the recognition of Accident and Medical in 2001.

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These are important steps towards securing a future for our rural hospitals as providers of high quality care for their communities. Doctors working in these hospitals will finally be recognised for the set of specialist skills and knowledge they have and new doctors entering the branch will be supported as they work to develop their skills and knowledge to these recognised standards. We are optimistic that rural hospital medicine can become an attractive career choice for young doctors and that this will contribute to a healthy, more stable rural workforce in the near future.

The professional body for this new scope, the Division of Rural Hospital Medicine will sit within the rural faculty of the RNZCGP. Given the close ties and overlap with rural general practice, this is its logical home. As a result, many doctors will avoid the need to join two colleges and the rural faculty provides an excellent forum in which to advance rural medical issues generally. Although the Division sits within the College, it is a semi-autonomous body: it will 'own' the scope of RHM and report directly to the MCNZ as the branch advisory body. At an operational level the Division's activities will be 'normalised' within the RNZCGP; the same College staff administering education, assessment and quality programmes for both general practice and RHM. This will allow the programmes to be closely aligned and should minimise compliance issues for doctors working in both general practice and RHM. It also gives the Division access to a level of expertise that would not be possible if it had to support a separate operational structure.

What does all this mean for doctors working in rural hospitals?

Full-time rural hospital doctors or medical officers, special scale (MOSSs)

General registrants have traditionally manned many of our rural hospitals. These doctors come from a variety of backgrounds. Many are overseas trained. They work on the MOSS scale and require a collegial relationship. Some of these doctors will experience the greatest changes. For the first time they will have the opportunity to become vocationally registered in their discipline. As Fellows they will be able to work independently, enrol in a Maintenance of Professional Standards (MOPS) programme, join their own professional body and be remunerated as vocationally registered doctors. Perhaps, most importantly, they and the rural hospital workforce generally will gain a level of recognition and status that has long been expected in other branches of medicine in New Zealand.

At the same time we expect some doctors will opt to continue as general registrants and that this group will remain a large and essential part of the rural hospital workforce. While less will change for these doctors they will still see some benefits. They will be able to have a more relevant collegial relationship with a rural hospital generalist (rural hospital doctors currently often rely on an urban-based specialist to provide this relationship – a doctor who works in only part of their scope and in a different urban context). They can also become active members of the Division of Rural Hospital Medicine. The Division has decided to offer general registrants working in rural hospitals access to its MOPS programme. This will further strengthen their collegial relationships by providing a structure for the continuing professional development this relationship is designed to monitor.

General registrants should also benefit from an increase in professional and educational activities. There will be regular national meetings and at a local level, Fellows will start to organise Peer Review Groups and continuing medical education (CME) as part of their MOPS, and the hospitals will become accredited to the standards required to train registrars in rural hospital medicine.

General practitioners (GPs)

We have received many questions from rural GPs who work part-time in rural hospitals. Some of these doctors have valid concerns about the potential complications of dual fellowship, raising for them the spectre of increased compliance and costs.

GPs make up half the rural hospital workforce, usually with part-time hospital appointments. Many of these doctors, especially those who have worked for many years in rural hospitals, see their hospital practice as a seamless part of the care they offer their patients and consider it part of their general practice, covered by their vocational registration in that scope. Increasingly, however, younger doctors who have undertaken GP training find that the hospital part of their work falls outside the scope of what is now defined as general practice. Many of these doctors feel poorly prepared, and hence vulnerable, when expected to undertake rural hospital work. The new possibility of dual fellowship in both GP and RHM will fill that gap, giving GPs working in rural hospitals options for relevant training, CME, and supervision. They are likely to feel more confident and supported in providing the full spectrum of care across the primary–secondary care interface and at the same time gain recognition of the full scope of their practice.

With their experience in rural hospital work combined with a FRNZCGP, many rural GPs are eligible for grandparenting. Indeed many may find this easier than the full-time hospital MOSSs who, despite their years of experience, often lack a relevant qualification such as a fellowship or postgraduate diploma. A large number of applications have already been received from GPs. (The details of grandparenting into rural hospital medicine are covered in a second article in this journal).

As is the case with many MOSSs, we expect many GPs who have rural hospital appointments will continue with their current registration arrangements. At the same time we are optimistic that many will see value in seeking and maintaining dual registration in both general practice and rural hospital medicine.

Fellows in other branches

There will be at least one other significant group of doctors who consider dual fellowship – those who are also vocationally registered in Accident and Medical Practice. Many of the doctors working in our larger rural hospitals, particularly hospitals with an emergency department, are Fellows of Accident and Medical Practice (FAMPA). FAMPA is recognised by the RHM Division as one of the qualifications to grandparenting and there is some alignment with its training programme. Work needs to be done to ensure the MOPS reporting is kept as straightforward as possible for these doctors.

There may also be small numbers of doctors who maintain dual registration in other branches such as emergency medicine; they will face similar issues. Most of these doctors will need to be members of two professional colleges.

MOPS

The Division is working with the RNZCGP to align the GP and RHM MOPS programmes. The current RNZCGP MOPS programme is generic and flexible enough to be suitable for doctors working in either or both of these scopes. We need to ensure that there is no doubling up of the reporting processes.

The RHM programme has some additional requirements. The first is the maintenance of certificates in

acute cardiac, trauma and paediatric care (EMST and ACLS level 7 and APLS). The second is a requirement to spend one week a year (or three weeks per triennium) maintaining or developing skills at a base hospital. This is already standard in many rural hospitals and we believe those who do not currently have access to this will welcome the opportunity. By making it a compulsory part of the MOPS programme we hope that its facilitation will become the responsibility of the rural hospital, rather than that of the individual doctor.

Training

The RHM training programme that has been approved by the MCNZ has a much higher recognition of prior learning than that of any other College. This includes recognition of Primex and the Part 1 examinations of several other Colleges. It is sufficiently flexible, including enough elective time, that it will be possible to complete dual fellowship with GP training at the same time. We expect many trainees to take this option. Others may choose to use their elective time to work towards another fellowship such as FAMPA or develop a specific set of hospital-based skills. Discussions are continuing with the Australasian College of Anaesthetists (ANZCA) about offering an optional one year of anaesthetics training based on the rural Australian model.

Conclusion

Dr Pat Farry, who was one of the first to promote the concept of a scope of rural hospital medicine, initially stressed the importance of finding a solution that would work equally well for all rural hospital generalists, GPs and MOSSs. This has remained a fundamental principle that has guided the development of the RHM scope. We believe the future of our rural hospitals depends on the active involvement of both groups. We have worked hard to bring the workforce together and believe we will have failed if it divides.

Competing interests

None declared.

Shared Clinical Records

'Many technical glitches and operational problems occurred with the [Shared Clinical Record] SCR and the technical infrastructure that supports it. This is not surprising in a project of this scale and complexity, but even relatively minor problems sometimes led to long delays and considerable frustration in all participating organisations. This occurred in a context in which [there was] pressure from government to redress a "worrying lack of progress" on the national programme for information technology. Non-participation of general practices in the programme ranged from 7% to 42% across the early adopter sites. This was due to a variety of reasons, including doubts about the benefits of the SCR, insufficient reimbursement, competing priorities, inadequate data quality, incompatibility of their software system, and ethical concerns.'

Greenhalgh T, Stramer K, Bratan T, Byrne E, et al. Introduction of shared electronic records: multi-site case study using diffusion of innovation theory. BMJ 2008; 337:a1786

Primary care research

'We must nurture our strengths, retaining strong links to practice, clinicians and patient organisations and championing inter-disciplinary collaborative approaches in our work. We must expose students early to research in primary care. We must also develop ways of showcasing our achievements, assembling robust evidence of the important academic challenges in primary care, of the implications of these challenges for health and health care more widely, and of our growing capacity to address them. Our brightest undergraduates, politicians, public servants and media editors must see that primary care research is where important and exciting work is being done.'

Furler J, Cleland J, Del Mar C, Hanratty B, et al. Leaders, leadership and future primary care clinical research. BMC Fam Pract 2008; 9: 52.

Consultation time

'The median visit length was 15.7 minutes covering a median of six topics. About 5 minutes were spent on the longest topic whereas the remaining topics each received 1.1 minutes. While time spent by patient and physician on a topic responded to many factors, length of the visit overall varied little even when contents of visits varied widely. Macro factors associated with each site had more influence on visit and topic length than the nature of the problem patients presented... A highly regimented schedule might interfere with having sufficient time for patients with complex or multiple problems. Efforts to improve the quality of care need to recognize the time pressure on both patients and physicians, the effects of financial incentives, and the time costs of improving patient–physician interactions.'

Tai-Seale M, McGuire TG, Zhang W. Time allocation in primary care office visits. Health Serv Res 2007; 42:1871-94.