Doctors trading places: the Isolated Practitioner Peer Support Scheme

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ABSTRACT

- We describe the outcomes of a practice exchange in which an isolated general practitioner from a remote region traded work and living arrangements with a rural group practice GP.
- An exchange can provide an opportunity for mid- and senior-career professionals to refresh their outlook on their careers.
- Involving the rural medical workforce in practice exchanges can enable the development of peer networks that can improve retention of isolated practitioners in Australia.
- A fresh experience in a new setting can provide opportunities for practitioners to improve practice management and sharpen their clinical skills.
- Uprooting families and preparing homes for unfamiliar visitors add stress to doctors and their families on exchange.
- Patients in isolated practices could feel concerned that they may lose their doctor as a result of an exchange.
- In this instance, the benefits far outweighed the difficulties.

MJA 2009; 191: 78–80

Doctors who choose to work in rural and remote areas find great potential for personal and professional satisfaction,[1,2] but practice diversity and lifestyle have proven to be inadequate drivers for workforce recruitment and retention. Clinical pressures such as prolonged periods on call and unrealistic patient expectations often combine with life pressures and the professional and personal isolation of remote practice to produce burnout in rural medical practitioners.[3,4] Many towns are too small to provide work for the full number of doctors needed for a sustainable after-hours roster, and many rural practices are too small to provide in-house cover for annual leave,[5,6] leaving some doctors feeling trapped.[7]

Rural general practitioners who have fewer colleagues with whom to discuss professional issues are more likely to report work-related distress and to seriously consider leaving rural practice.[8] Peer support has been identified as a means of alleviating high levels of stress in a general physician population,[9] and social and psychological support programs that focus on practical interventions have been shown to improve both wellbeing and retention of rural GPs.[10] Yet these isolated settings offer few opportunities for face-to-face contact with peers, limiting the ability to establish new networks for professional and personal support.[11] Further, there remains a need for rural GPs and their families to have "time out" from their community and to gain external support for business and practice management.[12]

GPs in mature rural group practices appear largely satisfied with their communities and their opportunities to achieve professional goals,[13] and may therefore have insights to offer an isolated practice. Others seek a change of scenery, that may see them working overseas for a time.[14] A recent exchange between Irish and Australian registrars was evaluated as successful by both the registrars and their supervisors.[15] There is also a readiness to engage in short-term altruistic work that does not require a permanent move, as demonstrated by the 800 doctors who responded to the appeal for volunteers to carry out health checks as part of the Australian Government's Northern Territory intervention scheme in 2007.[16]

Here, we report the outcomes of the first placement in the Isolated Practitioner Peer Support Scheme (IPPSS), an experiment in job and life exchange in which an isolated GP (IGP) in single practice in a remote region trades positions and living arrangements with a GP in a rural group practice (RGP). The aim was to allow the IGP an opportunity to sharpen clinical skills and experience practice in a more supported environment, while allowing the RGP to experience solo practice in a remote setting.

Initiation of the exchange

The proposal for the IPPSS was initiated from small group discussions between GPs in northern New South Wales who were interested in workforce succession planning. The decision was made to trial an exchange between two practices to test the feasibility of the concept in the region. North Coast GP Training provided funding to develop and implement the proposal, including meeting costs and long-distance phone calls.

Inclusion criteria were that participating doctors had to be registered in NSW and hold visiting medical officer (VMO) positions within the area health service's public hospital system, with recent experience in emergency medicine. An IGP was defined as a solo GP in single practice in a town with a population less than 3000, with a public hospital appointment. The NSW Health website was used to obtain the names and phone numbers of small rural and remote hospitals, and their affiliated general practices were then contacted using the business telephone directory. Social networking by phone and email with colleagues in the region was used to identify any practices missed from the list. Practices were excluded from consideration if the doctor had been trained overseas and was working in an Area of Need position, due to the regulatory restrictions placed on the ability of these doctors to work in other locations. Practices outside NSW were also excluded, due to difficulties with transferring registration and hospital indemnity cover interstate.

The rural group practice selected for the exchange has a very strong socially and professionally supportive medical peer group. Care was taken to match the skills of the participants, to ensure mutual respect for professional competence by staff and patients as well as the GPs. Eight IGPs were shortlisted, with the one selected having similar family and practice circumstances to the chosen RGP, including size of practice, scope of care provided, and willingness of family members to relocate for the exchange period. Characteristics of the two participating practices and GPs are summarised in the Box.

Logistics of the exchange

Arrangements were made with the practices' respective area health services for mutual recognition of VMO appointments and clinical

Characteristics of the participating practices and general practitioners

Rural community group practice

- The GP has been a doctor in the region for nearly 30 years, including several years as hospital Director of Emergency
- Town of 8000 population, with catchment area population of 30 000
- 95-bed hospital
- Educational support includes Northern Rivers University Department of Rural Health lectures, videoconference research seminars and grand rounds linked from a major teaching hospital in Sydney, satellite broadcasts from the Rural Health Education Foundation, and library facilities
- RRMA classification 5*

Isolated community single practice

- The GP arrived as a registrar in 2001; supervisor subsequently left the area
- Town of 1300 population, with catchment area population of 4000
- 21-bed hospital
- Limited local education opportunities
- RRMA classification 5*

RRMA = Rural, Remote and Metropolitan Areas.[17]
* Rural areas with population < 10 000. ◆

credentialling. No major costs were incurred, with participants travelling by car.

Arrangements were then made with the practices, including rostering of hospital and after-hours work for the 2-week period of practice exchange. The doctors agreed to trade places instead of entering into a locum arrangement with each other's practice, to avoid unnecessary paperwork and locum fees. This also allowed the participants some flexibility in which of their swap partner's duties they chose to do. For example, a locum arrangement would have required the IGP to perform on-call hours at the rural practice; instead, other practice partners filled in for this duty.

Although the exchange was short term, a complete living arrangement swap was arranged between the doctors' families, to provide a more comfortable place to live than a hotel and to ease the disruption to family members, as well as providing the adventure of a new setting. The 2-week exchange took place in the winter of 2007, and was intended to be a pilot for future, longer-term exchanges.

Experiences of the participants

Face-to-face interviews were held with the participating GPs (J G M and L M F) 2 months and 6 months after the exchange, to record their thoughts on the experience. A further telephone interview was conducted 2 years after exchange completion to assess the long-term effects.

Both doctors rated the experience highly, although for different reasons — reflecting their different needs. Both doctors found the towns, practices and hospital staff to be "extremely friendly, welcoming, and helpful". Both felt good about helping out a colleague, and having the opportunity to gain practice tips and appreciate experiences outside of their comfort zones.

The RGP valued the opportunity to experience a new community and different practice profile, including developing relationships with hospital and community health staff. Although the actual number of after-hours calls was low, the RGP found the demand of being continuously on call to be taxing, and this was compounded by professional isolation, especially during emergency presentations. This doctor gained a "first-hand appreciation of the workload carried by these remarkable isolated doctors and their dedication and sacrifice for their community" and returned to his practice with a renewed sense of the value of collegiate support and teamwork.

The RGP also felt burdened by a sense of constant responsibility. This was reinforced by the pattern of the practice being fully booked every day, resulting in increasingly long work days as additional patients with emergency presentations were fitted in. To counter this, he instituted a half day off per week, which was continued long term on the IGP's return (although she remained on call 7 days a week), enabling her to attend her children's school functions for the first time. The RGP also recommended to the hospital staff that they reduce the after-hours demands on the IGP by making greater use of nursing staff through models of delegated authority, and by purchasing a blood chemistry analyser for the emergency department. In turn, his interest in practice-based point-of-care testing equipment was triggered by seeing how it could support quality care for patients receiving warfarin therapy in an isolated setting.

The IGP listed the principal benefits as gaining reassurance about her clinical skills and her ability to work in different environments.

> I came here as a registrar and sometimes have wondered if I needed to be better prepared before I arrived. It was very reassuring to see how my skills compared to the other GPs. It made me more aware of the areas where I was lacking and where I could improve. It has definitely made me a safer doctor. — *IGP*

She found the support and teaching offered by colleagues in the group practice valuable, and observed different methods of performing procedures.

> Peer support is very important — you can get very defensive about why you do what you do. Rural people are more deferential to their doctors. They want you to tell them what to do. It was good to see a different profile, to have people ask you questions and to see other people's practice of medicine. You do get used to doing things a particular way and it is fairly freaky to expose your level of knowledge, but we all need to be grounded in how our standard of practice compares. This is not something you can do with online medical education or by attending the occasional conference. — *IGP*

The IGP learnt new ways of team care and was influenced to recruit a registered nurse for her practice after observing nurses in the larger practice applying dressings and performing vaccinations and health screening. The group practice had a more consultative interaction with their hospital and practice staff, which enhanced the nature of team care arrangements. This enabled the IGP to appreciate the benefit of having nurses perform patient triage, thereby allowing her time to be more efficiently allocated.

This doctor also rated as highly effective the ability to socialise with other doctors and for her children to benefit through changed schooling and more time spent with their parent.

Both doctors experienced procedures and methods on their sojourn that they found valuable and instituted in their own practices on their return. For example, the fairly simple changes to booking patterns created significant benefits in patient flow and in achieving family–work balance for the IGP. The IGP was also inspired to take a more structured approach to professional

development, and a year after the exchange she became a supervisor for the Royal Australian College of General Practitioners and was able to recruit a female registrar to join the practice.

Both families found the effort of "uprooting" to be a major barrier, particularly in preparing their homes for unfamiliar people to stay. Spouse employment created some difficulty, as families were reluctant to use leave entitlements that would preclude joint holidays later, although they ultimately did so. To reduce the impact of callouts during the exchange, both doctors took on additional workloads in the weeks before and after the exchange, which made them less available to their families during the moving process. However, both families felt welcomed by their host communities and appreciated having the time away from regular commitments and routines: "The friendliness factor was great!" For the family members, the exchange was not so much a holiday as a new experience and an adventure, which can bring a sense of renewal.

An unexpected but not surprising effect was anxiety among the isolated community on seeing a new doctor. Many expressed concern that this was a precursor to the IGP leaving, and these concerns continued to be aired intermittently for several months afterward. Interviews with the IGP indicated this fear was unfounded.

> *Was there a risk that, by exposing you to the benefits of working in a group practice, you might leave solo practice and your town would lose its doctor?*
>
> IGP: No, I think there are reasons why people are attracted to this type of practice in the first place. It has to do with personality and wanting to be independent.
>
> *Do you think that participation in IPPSS has had an impact on how long you might stay in your practice?*
>
> IGP: Definitely — [it's now] more sustainable. It makes a difference to know there is someone you can ring for advice, who knows what your practice is like. I would really like my registrar to have the same experience, and I would like our practice to host another GP who is even more isolated.

Fortuitously, the RGP had seen a patient from the IGP's practice not long before the exchange, making entry to the community easier as word spread, as it does in a small country town. Local media coverage before the exchange might have further helped to avert the community's concern.

Where to next?

Contented doctors stay in rural practice longer — women by 3.5 years and men by 5.2 years — than those who are discontent.[18] Achieving job satisfaction in general practice through mental stimulation, challenge, and a variety of work, as well as balancing professional and non-professional life, are significant factors for retention of female GPs.[19] However, although the benefit in retention rates resulting from variety of scope of practice increases in significance with increasing rurality or remoteness,[20] the ease of opportunities to participate in peer-group educational activities to support this variety of practice declines with rurality.

Our experiment demonstrated that a doctor exchange can enable the development of peer networks that improve retention for isolated practitioners. As one of the participants noted, "Change is as good as a holiday". An important aspect of this project was that the usually autonomous IGP could feel confident that her patients were being cared for by a competent and qualified practitioner with a similar or superior skill set during the exchange.

The participants are now prepared to act as consultants to other regional practices considering such an exchange, to advise on how to optimise the potential the experience presents.

Acknowledgements

We thank North Coast GP Training for providing funding; and the North Coast and Hunter New England Area Health Service Medical Staff Councils, Northern Rivers University Department of Rural Health, Mt St Patrick and Tweed Valley Colleges, the Rural Doctors Association of Australia, and the Australian College of Rural and Remote Medicine for their support and encouragement.

Competing interests

None identified.

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(Received 16 Apr 2009, accepted 1 Jun 2009) ❑