



**RURAL FACULTY**  
The Royal Australian College  
of General Practitioners

# The Practice of Flexible Practice

## Discussion Paper

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## Introduction

This paper responds to issues raised by the spouses of rural general practitioners (GPs) during a recent Family Support Project (Cheney et al., 2003). The need for more flexible work arrangements so that rural GPs may balance personal and professional lives was raised during this project and indeed is a recurring theme in the field of rural medicine. Specifically, we investigate the operation of the locum system, particularly in Queensland where families in the project lived and present a range of models developed in different parts of Australia responding to the demand for flexible practice arrangements.

### *Background*

The term 'flexible practice' describes a way of addressing the needs of GPs to spend time with family or on activities outside their time at work. It has been reported that GPs spend an average of 51.4 hours working per week (CDHFS, 1996) and other data suggest that rural general practitioners work in excess of this. However, it is not just an issue of total working hours. Flexible practice also relates to issues such as quality of life, ability to take leave at short notice, the option to work part-time, ways of dispersing on-call duties between different practitioners and health services, easy entry and graceful exit from practices. Other terms used to describe flexible practice arrangements are 'sustainable practice' or 'sustainable model of practice'.

Women rural GPs, in particular, have noted that their greatest stress was the conflict between their career and their personal life (Tolhurst et al., 1998, Kilmartin et al., 2002) as they most often carry the main responsibility for the care and rearing of children (Levitt and McEwin, 2001). The three issues contributing to this stress were described as total hours worked, time on-call and not finding enough time to keep up their professional knowledge (Tolhurst et al., 1998). Women also commented that the least satisfying part of medical practice was lack of time for family and personal life. Childcare options are often very limited in rural areas, which further contributes to the problem (Tolhurst et al., 1998). In response to these issues, "flexibility was identified as the key to the development and construction of policies and programs to support female GPs in rural and remote practice" (Levitt and McEwin, 2001). Lippert (2002) re-iterates

this from her own research, noting the need for greater flexibility in practice and training arrangements and valuing varied working styles and practice arrangements.

One of the key findings of a recent report on female GPs (Levitt and McEwin, 2001) is:

*...the need for flexible practice and training opportunities. Female medical practitioners want flexible working and training arrangements, part-time and job sharing opportunities, salaried as well as private practice arrangements, on-call and after-hours arrangements which do not compete with them as the primary family carers.*

Indeed, this report notes that increasing numbers of younger males also wish to adopt more "family friendly" modes of practice (Levitt and McEwin, 2001).

Various responses have arisen from the need to decrease working hours and to increase family and personal time. Traditionally, mechanisms to enable respite from working hours focused on direct relief via locum systems. There is evidence to suggest that this mechanism has been unable to meet rural GPs' needs (Hays et al., 1997; White et al., 2002). More recently, the emphasis has been on exploring a range of different options, which largely focus on ways to restructure the dominant model of rural general practice (i.e. often a solo or shared practice that also provides its own after-hours service). Examples of both locum systems and flexible models are discussed below.

### **Locum relief: the current model for flexibility in practice**

#### *Locum services in Australia*

A common scenario is that if a rural GP requires time off, a locum (short-term relief doctor) is required. Access to and availability of locum relief has long been identified as a key factor affecting the recruitment and retention of GPs in rural and remote communities (Cameron, 1998; White et al., 2002).

Each of the State-based Rural Workforce Agencies<sup>1</sup> runs a locum service jointly funded by the Commonwealth Department of Health and Ageing. Of the funding received by the workforce

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<sup>1</sup> Rural Workforce Agency of Victoria, Western Australian Centre for Rural and Remote Medicine, Tasmanian General Practice Division Limited, Queensland Rural Medical Support Agency, Rural Doctors Workforce Agency of South Australia, New South Wales Rural Doctors Network, Northern Territory Remote Health Workforce Agency.

agencies, the largest sum supports locum relief. In general, all rural doctors are eligible for locum relief for recreational, Continuing Medical Education (CME) and sick leave. Solo practices may also be eligible for weekend relief. In each State, the allocation of locums is handled slightly differently.

In Victoria, the workforce agency provides a subsidy to the rural Divisions of Practice to provide the locum support and assistance locally (RWAV, 2003). Rural Divisions may then employ or contract locum doctors who are available to be booked by GPs in their Division during the course of the year. Divisions will also fund practices directly with subsidies to employ locums. The subsidies are only available to pay the locum, not for travel or accommodation expenses.

Western Australia conducts the locum support program jointly with the Australian Medical Association (AMA). The program assists financially with locum costs, whether the locum is provided through WACCRM or through a private agency. Solo practices are eligible for six weeks annual leave as opposed to the four weeks available to other doctors. In one area, they have directly employed a locum to service six to eight practices (WACCRM, 2003).

Some States handle locum allocation through a central register, as done by QRMSA, the workforce agency in Queensland, and as in Tasmania. The system in Queensland is described in detail below.

#### *The example of the locum system in Queensland*

##### **Locum availability**

Locums are available from a number of sources in Queensland. These include QRMSA, commercial agencies, Divisions, Queensland Health and practices themselves. Of these, the largest supplier of locums in provincial, rural and remote Queensland is Queensland Health, which maintains a pool of approximately 25 to 30 rural relievers to cover the leave requirements of State-salaried medical practitioners outside the major metropolitan centres. These relievers are normally relatively junior second or third year medical graduates.

For private practitioners in rural and remote areas (RRMA<sup>2</sup>s 4 to 7), the QRMSA is the major provider of locums. A private general practitioner employed in Queensland is entitled to four weeks

recreational leave, two weeks CME leave, two weeks sick leave and two weeks emergency leave. The locum service operates on a five-day week. On weekends, locum doctors usually travel between practices, moving to take up new locum positions in different areas. This makes the provision of weekend relief difficult.

Even in urban areas it has been reported (White *et al.* 2002), that there is an undersupply of locums in relation to demand. The situation in rural areas is far worse. For the 2000–2001 financial year, QRMSA was not able to provide nearly a third of the requests they received for locums (White *et al.*, 2002). QRMSA uses locums from two sources: overseas trained doctors (who do 3–6 month stints in Australia), and a list of city doctors available for some locum work depending on location and availability for release from their own practice (White *et al.*, 2002). The overseas trained doctors may also specify where they are willing to be placed and so there are constraints upon allocation of locums.

In a survey of Queensland GPs who had left their practice, poor access to locums was one of the contributing factors identified (Hays *et al.*, 1997). Practitioner views of locum availability explored in a recent study found that 56.9 per cent of respondents were dissatisfied with their access to and the availability of locum relief (White *et al.*, 2002). The study also indicated that 56.8 per cent of respondents were unable to take the amount of recreational leave they desired in the preceding twelve months (White *et al.*, 2002)

It appears that dissatisfaction regarding access and availability of locum relief is more pronounced among private practice (62%) compared with salaried Queensland Health practitioners, including those who also have the right to private practice (38.9%) (White *et al.*, 2002). This is almost certainly associated with the different costs and availability of locums for private as opposed to salaried practitioners.

##### **Locum quality**

QRMSA has an extensive selection process to choose overseas trained doctors based on their experience and skills. QRMSA currently uses an overseas recruitment company based in the USA, which undertakes a series of vetting processes on QRMSA's behalf. Doctors deemed suitable by the recruitment agency are assessed by a panel of

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<sup>2</sup> Rural, Remote and Metropolitan Areas

Queensland doctors to establish their suitability to rural general practice in Queensland. This quality control process has meant that most practitioners (92.6%) have been satisfied with this service, more so than when using other agencies to acquire locums (White et al., 2002).

As reported by Hoyal (1998), there is very little literature that covers the application of quality assurance principles to the evaluation of medical locums. His Queensland study of a group of overseas trained doctors found that of 53 locums, 41 were evaluated by their supervisors and given a rating of 4.5 out of 5 regarding their perceived skills and knowledge (Hoyal, 1998). This study took place on a very small scale and would need extension to a much larger group to give any useful indication about locum quality across Queensland.

#### **Cost of locums**

QRMSA provides funding to cover travel and accommodation costs between locum placements. Practice fees must be covered by the practice in which the locum is working. Doctors working in RRMA 4–7 categories are subsidised according to their leave type and RRMA category. The impact of locum costs was seen as an important barrier to the capacity of practitioners to take adequate leave (White et al., 2002) as rising costs make employment of locums economically unviable. The cost implications of accessing locum relief were found to be significantly greater for private practitioners compared with salaried practitioners (White et al., 2002).

#### **Participation by the Divisions**

At the time of the locum survey in Queensland (November, 2001), only 12.1 per cent of locums were supplied through the Divisions. As part of this project, the Divisions in Queensland were surveyed regarding their involvement and approach to provision of locum services. It was found that some Divisions employ locums to supply the practices in their region. While some practices do not directly employ locums, this is often because despite trying, they have not been able to attract a locum to their area.

#### *Shortcomings of the locum system*

The shortage of locums is one of the primary reasons the locum system is falling short of satisfying the needs of rural GPs. As a part of a review of the Rural Locum Relief Program commissioned in 2000, (Locum Relief Review Group, 2000; as cited in White et

al., 2002) it was identified that many factors influence the shortage of locums in regional, rural and remote areas:

- higher turnover of doctors in regional, rural and remote areas;
- unfilled permanent positions, particularly in public hospitals;
- provider number restrictions;
- GPs in rural areas often require greater support from locums as they are often on-call 24 hours a day, seven days a week;
- increased importance of CME which takes GPs away from their practice;
- increasing numbers of part-time GPs, which impacts on the total availability of the workforce; and
- paperwork and legislative restrictions e.g. visas for overseas doctors.

Other shortcomings of the locum system as a means to ensuring flexible practice in the full sense of the term may be identified as being that:

- the leave must be negotiated well before the time it is required, therefore there is no flexibility to obtain leave at short notice, even in the case of emergencies;
- patients are known to avoid the locum in preference for their own doctor, (in some cases it is not even understood that the term 'locum' refers to a suitably qualified doctor);
- the constant changing of the allocated locum gives no continuity to the patient; and
- the locum system is in the main focused on longer periods of leave (i.e. recreational, study or sick leave) and is not available to regularly reduce daily and after-hours workloads as would be required to ensure flexible practice outcomes.

#### **Other potential models for attaining 'flexible practice'**

It is clear that there is a need to develop innovative models of practice that satisfy the needs of rural GPs in a more complete way than the locum system is able to do. A number of different models are emerging in various contexts and projects around Australia. A selection of these practice

models is described below, including a discussion of advantages and limitations.

*The Kowanyama model—Fly in, Fly out*

This model is described by a GP about the experience of working for the Royal Flying Doctor Service (Weiland, 2000). At the time of documentation, the Kowanyama practice had two doctors (one male, one female) who worked two weeks on, two weeks off (which amounts to 80 per cent of a full-time position). Kowanyama is a town of 1500 people on the western side of Cape York in Queensland. The nearest tertiary hospital is 10 hours drive, with the roads cut off half the year by rain. The two doctors are flown in and out by the Royal Flying Doctor Service, with almost a full day for hand-over each time.

This model gives the advantages of:

- opportunity for part-time work (perhaps more accurately described as periodic full time work);
- financial viability by working 80 per cent of full-time load and because of associated travel allowances;
- providing the opportunity to attend some meetings, educational courses, social activities;
- providing more opportunity for contact with peers and professional support;
- offering some flexibility because the two GPs involved can negotiate their roster;
- providing opportunities to access health services for self;
- a salaried position, which therefore includes maternity leave;
- allowing the spouse to maintain complementary employment in a larger centre;
- allowing rest breaks, the chance to 'escape', debrief and recuperate;
- giving continuity of practice and accommodation
- reducing need for locums and related concerns about diverse locums;
- allowing older children to remain in school in a larger centre;
- both male and female doctors being available to the community.

There are however, some disadvantages to be noted:

- obligation to set up two homes for the two doctors;
- periods away from home, friends, family;
- long periods on-call;
- limited access to courses, conferences, locums if needed;
- difficult to take leave at times.

There is potential for this shared practice model to be utilised in other small towns and remote areas with solo practices. An example of this is in a small town in Victoria, where one full-time position is held by two GPs who work approximately twenty days and ten days per month respectively (RWAV, 2000).

*A three-partner shared practice*

Similar to the Kowanyama model, this model is based upon three partners each working part-time. In this model, the doctors remain in the town (unlike the Kowanyama model). However, the availability of three doctors to share the workload allows considerable flexibility. This model was described by a GP who spent several years working in this arrangement in outback Western Australia in a town of 3500 people (personal communication). The model of multiple GP practices (usually three or more) is identified as a key model with the potential to address the needs of rural female GPs (Tolhurst and Lippert 2002).

In this arrangement, the three practitioners each worked a little over half time. They were able to split the after-hours work between them, and the town benefited from the three sets of skills they were able to offer. Each practitioner had flexibility to take leave upon arrangement with the others.

The advantages of this model are:

- potential to take leave when desired and potentially at short notice;
- sharing of on-call work;
- three sets of skills (potentially complementary ones) available to a small community;
- chance to work part-time and avoid burnout and stress.

Some limitations of the model, depending on the circumstances, might be:

- difficulties getting part-time locum cover if it is needed (locums prefer to work full-time);

- family and spouse dissatisfaction in a remote centre;
- all three positions are part-time and some practitioners may desire or require full-time work and salary; and
- infrastructure burden for communities, e.g. need for multiple domestic residences. This might be problematic in communities where the local government or health department subsidises residential accommodation of private GPs in an effort to increase recruitment and retention.
- difficulties related to transferring patients between the care of different GPs; and
- GPs might have different prices and billing arrangements.

It should be noted that some regions have implemented various forms of electronic patient records to enhance access to records by rostered GPs.

#### *On-call rosters within a region*

One way to alleviate the stress of being constantly on call is establishing a mutually supporting weekend and public holiday medical on-call roster as was done in an RWAV project in Victoria (RWAV, 2000). The roster operates with doctors sharing the provision of after-hours weekend care and public holidays. A practice manager draws up and coordinates the roster and resolves any difficulties that may arise. The roster is distributed to local health services and ambulance services.

The benefits of the on-call roster are reported as:

- alleviating the constant stress of being on-call;
- allowing the doctors quality time with their families; and
- improving both recruitment and retention prospects for the area.

The main limitations of such an arrangement are that it may only operate in the situation where there is a pool of GPs to draw from, where distances are viable and therefore does not apply to solo practices or those in remote or geographically large areas.

#### *Virtual amalgamation*

The virtual amalgamation approach has been taken in Victoria through RWAV (RWAV, 2000). This cooperative model of rural general practice involves developing amalgamated, computerised clinical and management systems for different practices in nearby towns. Each practice retains a physical presence in the community. It also includes collaborative rostering of GPs across neighbouring towns.

The benefits of virtual amalgamation are seen to be as follows (RWAV, 2000):

- financial benefits that will improve the viability of each practice;
- ability to share after-hours on-call between each practice, by having electronic records available at each practice location;

#### *GP Cooperative after-hours model*

This model is used in several regions of Queensland (and is common in other parts of Australia) to share after-hours work between several practitioners. This model is described in an information paper by Queensland Divisions of General Practice (2001). There are different ways in which such a cooperative could be set up. Responsibility for the service could be taken on by either a Division, a group of GPs, a private hospital or an external company. In general, one rostered GP attends the centre, with another available for on-call back up.

Advantages of this model are:

- GPs involved with this kind of arrangement felt that there was a positive effect on their lifestyle, including fewer on-call requirements, which for some meant that they were not obliged to live so close to their practice population;
- this model encourages contact and communication between GPs in a region which increases social contact and support between practitioners; and
- enhanced patient accessibility to after-hours care, reduced response time, improved continuity of care, enables consistent management policies and increased patient satisfaction.

Limitations of this model might include:

- applicable only in regions where the distances between practices made the arrangement viable;
- changes in the availability of GPs would need to be managed;
- separate provider numbers must be sought for the service;

- ability to access all the GPs available through the separate practices, leading to a wider choice for patients;
- increased access to public hospital beds;
- increased capacity to employ a shared practice nurse with access to each practice location;
- ability to cover periods of recreational and educational leave, enhancing professional standards and quality of life (i.e. 'internal' locums);
- increased attractiveness for recruiting and retaining GPs;
- greater access to female GPs to cater for patient preference;
- networking support between GPs;
- greater flexibility for GPs to take recreational, educational and sick leave.

Some of the limitations of such a model might be:

- in some remote areas access to the Internet is unreliable which would be problematic under this model;
- the distance between towns must be conducive to the cooperative structure that is created and virtual amalgamation may not be viable in some locations.

#### *Remote centre linked to a larger nearby centre*

Another of the RWAV sustainable practice models (RWAV, 2000) relates to the operation of a 'branch' practice medical service in a small town by a large practice in a nearby town. In the case described, the community purchased the small local practice which then allowed the larger practice of seven full time equivalent GPs to provide service in the small town without incurring a large capital outlay.

The new service provides more sessions than were previously available, has a shared on-call roster, and all the participating GPs have admitting and visiting rights at the local hospital. In this way, the GPs are not required to reside or operate full-time in a smaller community. Further research is required to develop an understanding of the maximum distance between towns that would allow such an arrangement to be viable.

#### *Associateships*

The structure of the work environment has a significant impact on the opportunity for practitioners to arrange their work in a flexible manner. A traditional partnership model has several disadvantages. Partnerships usually imply equal investment towards the practice costs, work and division of income. Therefore, it discourages part-time work. Interests are not easily transferable and as the partners own the business and are directly responsible for all aspects of it, they are usually closely involved in its management and functioning. This ongoing business responsibility is not necessarily attractive to doctors seeking flexibility in their work arrangements. There is also unlimited personal liability for all damages or debt incurred by any member of the practice. Currently, the main alternative to being a practice partner is to be an employee, which is likely to be associated with fewer rights and decision making responsibilities within the business.

Associateships offer a different way of structuring a medical practice. An associate structure allows the common costs to be divided equally, whilst retaining financial independence related to an individual doctor's workload and skills. This structure also avoids the need for a practitioner to commit to the purchase of plant and equipment.

Below are comments by two GPs who work in an associate structure describing the benefits they derive from this business structure (RDAA, 2002):

*I have worked in an associateship for the last 17 years in a rural community. The associateship form of practice has allowed me great flexibility in terms of hours worked, appointment bookings, practice cost sharing and regular holidays. I think that it is an ideal arrangement for female rural doctors who wish to be part of a practice rather than employees [GP north western NSW].*

*Many doctors (both men and women) now prefer the flexibility of an associateship where they are up for a portion of costs but can choose to work as much or as little as they like without impacting financially on their colleagues. One practice here consists of three women who were previously employees. They formed their own associateship practice, which has inherent flexibility and now employs 1-2 other women and a trainee [GP WA].*



### *Cooperation with other health services and practitioners*

Close cooperation with other health services creates the potential to share the work that would otherwise be undertaken by the GP alone.

Employing practice nurses is one example of a government initiative to encourage GPs to work more closely with allied health practitioners. Practice nurses can undertake certain clinical tasks such as managing age and sex disease registers, performing health assessments, patient education, health promotion and coordinating other health services for complex or chronic conditions. The arrangement offers the GP more time to do work only they can do. A recent Commonwealth Budget initiative allocated funding to practices employing practice nurses.

Nurse practitioners constitute another form of support for GPs. A nurse practitioner extends the role of a nurse such that they may take up specified tasks normally performed by GPs. There has been some reservation expressed by GPs regarding the fragmentation of health care and level of independence appropriate for a nurse practitioner. In addition, the recruitment and retention of nurse practitioners in rural and remote areas suffers from the same difficulties as GPs.

### *After-hours nurse telephone triage service*

This initiative has been undertaken by some Divisions in rural Queensland. It involves establishing an after-hours nurse telephone triage service which covers all interested rural GPs. In the long term it aims to significantly reduce after-hours demands on GPs so they can spend more time with their families. One such program focuses on offering specific training toward increasing the capacity of existing nurse triage facilities in local hospitals (Fleming & Summer, 2003). Another project that focused on telephone nurse triage in the field of palliative care in Griffith, NSW reports that 50 per cent of all after-hours calls triaged by the nurse service were resolved without requiring GP intervention<sup>3</sup> (Griffith, 2003).

### *Urban relief for rural practices*

The possibility of an urban practitioner replacing a rural or remote practitioner at regular intervals has been established in various places throughout Australia. In Queensland such an

arrangement was instigated by the rural GP involved, with a GP in Townsville for one week in four. Such an arrangement could also be organised through formalised channels. In Tasmania, such an arrangement is encouraged through the Rural Workforce Agency (TGPD, 2003). In some cases this model is a 'sister practice' whereby a city practice 'adopts' responsibility for providing consistent locum services to a rural practice. An advantage of this model is establishing consistent locum personnel who build up knowledge of a specific community and patient list. Depending on distance between the sister practices, locum provision may include weekends and shorter periods.

### *Royal Flying Doctor Service—female clinic model*

This Western Australian model provides support to solo male rural GP practices. On a regular basis (e.g. one day each six weeks), relief is provided by a visiting female GP flown in by the RFDS.

Advantages of this model include:

- provision of a female doctor to the rural community;
- day relief for the solo rural GP; and
- opportunity to debrief with a colleague.

Although the model functions in a similar form in most States, it is only available to a limited pool of rural GPs for a limited period of time (i.e. one day every 4–6 weeks).

## **Discussion points**

The following questions seek to stimulate action on this issue. They relate to each of the parties that have interests and potential influence in relation to this issue:

### *For Practices and General Practitioners*

- what are the individual's aspirations around flexible practice?
- what opportunities are there within the practice/town/region to adopt or adapt flexible practice models?
- what resources and supports are available (e.g. local Division, Rural Workforce Agency, local, State or Commonwealth government) to assist this?

<sup>3</sup> Reported at the NRHA Conference, Hobart, March 2003 in Hobart.

- what further information, support or resources are needed?

*For Divisions, Rural Workforce Agencies and local government*

- what are the needs around increasing flexible practice within the region/State?
- where are the most critical areas of need?
- what models of flexible practice are relevant?
- where could new models be trialled?
- what funds/ resources/ support can be provided to assist in developing locally appropriate flexible practice models?
- what changes to funding/ policy need to occur to increase flexible practice?

*For State and Commonwealth Governments and services*

- where are the key areas of need regarding flexible practice?
- what policies and funds need to be developed or implemented to support the development or adoption of flexible practice models?
- what opportunities are there for existing State and/or Commonwealth funded health facilities to be involved in flexible practice arrangements?

*services, easy entry and graceful exit from practices.*

The current models supporting 'flexible practice' clearly show potential for new ways of operating. Their potential may overcome some of the difficulties associated with the locum system of relief and provide greater freedom to GPs in rural practice.

## **Conclusions**

It is critical that models addressing flexible practice be trialled and integrated into mainstream understandings of rural general practice. This could be expected to address key factors affecting recruitment and retention of rural general practitioners. In addition, it is vital that stakeholders exchange information about these models and the policies and financial supports required to make them viable in rural and remote areas.

Different approaches to general practice services need not incur excessive demands on the time and quality of life of rural GPs. We define such 'flexible practice' as:

*practice which addresses issues such as quality of life, ability to take leave at short notice, compatibility with family responsibilities, the option to work part-time, ways of dispersing the on-call duties between different practitioners and health*

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