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# Factors Positively Influencing GP Obstetricians to Remain in Rural and Remote Obstetric Practice

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## ABSTRACT

**Objective:** To explore factors that enable and encourage GP Obstetricians (GPOs) to remain in their role providing perinatal care and delivery services in rural and remote locations.

**Setting:** Rural and remote locations in North and Far North Queensland.

**Participants:** Participants were GPOs providing maternity care and delivery services. They were invited to be interviewed for the study via hospital email and snowballing.

**Design:** We conducted 11 semi-structured interviews with GPOs from July to August 2023. Interview data were coded and analysed using thematic analysis into themes and subthemes.

**Results:** We identified two overarching themes as enablers: job satisfaction and support. Job satisfaction was composed of enjoyment arising from an interest in the field and procedural work, and feelings of fulfilment deriving from serving the community. Support centred around constant, supportive interactions with midwifery and medical colleagues in the workplace, medical colleges, and staff at regional referral centres.

**Conclusion:** As GPOs who remain in rural and remote areas identify support as a key enabler, establishing strategies to improve service delivery and retention involves expanding and supporting the current system as well as implementing new approaches to support practitioners both at work and home. Skill maintenance should be tailored toward individual needs, referral centres need to have a fostering and inclusive mindset toward their rural practitioners, review systems should be inquisitive and constructive rather than punitive, and colleges should foster and support their fellows.

## 1 | Introduction

Recent rural maternity services closures have left rural women with reduced access to birthing options. These closures have affected smaller and larger centres: some permanently, whilst others go on temporary bypass due to staffing [2–4]. This leads to adverse outcomes, one being an increase in the women in Queensland (1992–2011) birthing prior to reaching hospital—by 206% following a 28% reduction in rural maternity services [5]. Other consequences include pregnant women being forced to relocate hundreds of kilometres from family and friend support, and culturally safer care [6]. Conversely, women who decide to stay face the possibility of birthing in a hospital not equipped to deal with them, causing staff to be unfairly exposed to patients they may not be comfortable to manage and damaging provider-patient and community relationships if an adverse event occurs [7]. Rural hospitals providing dedicated birthing services are safe for women and babies, and additionally increase primary care capacity, GP anaesthetics and theatre provision, which are lost if closed [1, 5].

A GPO is a general practitioner/rural generalist (RACGP and ACRRM) with advanced skills in obstetrics, trained via an advanced training pathway recognised by the Royal

**Summary**

- What is already known?
  - Rural women and families are disadvantaged by lack of birthing services in Australia.
  - The presence of suitably skilled GPOs in these communities is an integral part of solving the birthing crisis for rural Australia. Having a delivery service in town leads to fewer births prior to hospital and improves safety and outcomes for rural women [1].
  - Staffing rural and remote services has historically been and continues to be difficult [2].
  - There is limited research geared towards the reasons GPOs remain in rural and remote obstetric practice.
- What this paper adds?
  - Rather than focussing on what causes GPOs to leave communities, we decided to focus on the enablers to provide positive solutions for government and health training organisations to support those already in this role and for generations to come.
  - This research highlights several areas that could be actioned to encourage continuing GPO delivery services in rural and remote areas of Northern Queensland, Australia.
  - Specifically, improving skill and lifestyle matching and providing flexible services that cater to staff needs appears to make a difference for practitioners.
  - Exposure and support from mentors who work in the rural and rural obstetrics sphere are of benefit to enabling clinical courage, which is integral to the GPO role.
  - Support for GPOs, both before, during and after training, needs to be maintained and expanded on from current models, and requires specificity to service and clinician.
  - Systems and staff need to be supportive of the role and the people within it, and clinical courage needs to be fostered by mentors, staff and hospital systems.

Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) [8]. Necessary skills include safely managing antenatal care, low risk and complex births, instrumental and assisted births, and provision of caesarean section [8]. GPOs are an integral part of a safe rural delivery service, providing 3.9% of maternal services in Australia, with 23% of GPOs working in MMM 4–7, compared to 3% of O&G specialists [9, 10].

This study was undertaken to identify enablers for GPOs to keep providing delivery services in rural and remote Australia. Prior research focussing on why staff leave rural locations has identified career and development opportunities, conditions, leave, incentives, staffing, lifestyle, relationships, and fulfilment as factors [2]. Very little focusses on GPOs separately, or on enablers. Whilst each delivery facility is different, we aimed to identify reasons and enablers common to GPOs that kept them continuing to practise rurally. We aimed to discover information that could be used to tailor sustainable and enduring services, and to highlight areas not effectively targeted to better design and plan future birthing services.

## 2 | Method

This study is qualitative and the epistemology of this research derives from constructivism [11, 12]. It focuses on how subjects construct and make meaning of the reality of being a GPO in Northern Queensland. This method involved conducting semi-structured interviews and thematic analysis. Relevant ethics approval was obtained. Interviewees were sourced by emailing the Director of Medical Services of each birthing hospital and Queensland Health employee emails for GPOs in this region as per RANZCOG website search function. Snowballing recruitment was encouraged as it was recognised the list was likely incomplete.

There were 11 respondents to the email. Participation was voluntary, rescindable at any point, and confidential. Interviews were conducted with the respondents and female interviewer (BE) over video conference/phone in July to August 2023, ranging 20–45 min. Several respondents had worked with BE in the past, but not at the time of the interviews. BE was known to them as supportive of rural obstetrics.

A semi-structured format was chosen allowing flexibility for GPOs to explore what was truly important to them with their jobs. Five questions were posed:

- What are the reasons you chose rural practice?
- What made you train in rural obstetrics?
- What makes you stay in rural obstetric practice?
- Are there any factors that make you want to stop or seriously rethink providing rural obstetric care?
- Is there a factor which, if changed today, would have the best positive impact on your ability to continue in the role?

The interviews were not pilot tested. As a result of early interviews, a further question was added: Is there a reason you left other rural obstetric sites or something that attracted you to your current workplace?

Interviews were recorded with consent, transcribed, and analysed using Thematic Analysis [11] by two reviewers (BE and AV) who inductively analysed data into themes and subthemes utilising NVivo software [13]. Field notes were not made. There were no repeat interviews. Data saturation was reached within the first few interviews, but a decision was made to continue to interview all 11 volunteers and at the time of writing, none rescinded consent. Transcripts were not reviewed by respondents; however, additions were encouraged via email. No additions were made by respondents.

## 3 | Results

### 3.1 | Population Profile (See Table 1)

Interviewees worked in MM4-7 locations across the North and Far North Queensland area. Of 11 respondents, 73% (8) worked in MM4 locations, with 27% (3) in MM 5–7, which have been grouped for confidentiality. The majority were female (8/11) and

**TABLE 1** | Participants.

| Respondent | M/F | Age | MM location | Years rural | Years rural obstetrics | Work arrangement |
|---|---|---|---|---|---|---|
| R1 | F | 35–44 | 4 | 5 | 5 | Part time |
| R2 | F | 25–34 | 5–7 | 3 | 2 | Part time obs, full time work |
| R3 | M | 45–54 | 4 | 25 | 25 | Full time |
| R4 | F | 25–34 | 4 | 5 | 5 | Part time obs, full time work |
| R5 | F | 35–44 | 4 | 11 | 11 | Full time, decreasing to part time |
| R6 | F | 35–44 | 4 | 17 | 17 | Part time |
| R7 | F | 35–44 | 4 | 8 | 8 | Part time |
| R8 | F | 35–45 | 5–7 | 6 | 3 | Part time |
| R9 | F | 35–44 | 5–7 | 3 | 3 | Part time |
| R10 | M | 25–34 | 4 | 3 | 1 | Full time |
| R11 | M | 45–54 | 4 | 20 | 20 | Full time |

the median age group was 35–44 (6/11). Experience in rural obstetrics ranged from 1 to 25 years.

All male GPOs worked full time in their hospital providing rural obstetric cover, whilst female participants worked varying degrees of part time hours (or were decreasing to part time) or worked full time hours split across rural obstetrics hospital work and other, non-obstetric and/or non-hospital work.

It was identified during interviews that two participants worked in areas not actively birthing and had been recruited to start or continue a service in those locations. Their contributions were included as they could speak to reasons why they had stayed elsewhere and factors that would encourage them to remain when their services opened.

## 3.2 | Themes

The two overarching themes were job satisfaction and support. Subthemes of job satisfaction included enjoyment and fulfilment. Enjoyment encompassed interest in work content, variety of work and utilisation of skills. Fulfilment related to desire to assist rural women and provide a needed and appreciated community service. Ability to continue in a role initiated with interest and value in work was buttressed by support in all spheres: clinical settings, relationships (local and regional referral), consistent leadership, skill development and case support, and work-life balance conducive to family life.

### 3.2.1 | Job Satisfaction

**3.2.1.1 | Enjoyment: Interest in Obstetrics and Variety in Work.** Flexible mix of GPO, GP and hospital work was appreciated by participants, who enjoyed expanded practice 'I like full range of practice- which I think really, you need to be in a place where there's not a hundred thousand specialties to really be able to use your full range of training' (R3). Many interviewees expressed interest in obstetrics from the time of training. 'It is a really interesting skill, and very rewarding, and lots of fun' (R2). Participants valued obstetrics as patients were young, vibrant, and a usually well population at a happy time in their life. 'It's just a part of medicine that I really like, probably because it's got so much good stuff to it' (R4).

Obstetrics was identified to add to skills beyond obstetrics. 'we can do the antenatal care and the postnatal care, and that bit of gynae...So, I think that's—just being able to offer the service' (R1). Surgical skills were improved and appreciated: 'I actually found a real love for the sort of surgical component of it' (R9).

**3.2.1.2 | Enjoyment: Staffing and Flexible/Alternate Working Arrangements.** 'A critical mass of people' (R1) to 'share the burden with' (R2) was hugely important to continue in the GPO role. It directly impacts job enjoyment and had flow on effects to family life. 'When there's adequate staff around, then you get adequate down time, and when there's not, then you sort of doing repeated on calls and those longer runs and longer shifts, and unable to leave work like on fatigue if there is another emergency' (R5). When adequate staffing was not available, on-call burden increased. 'My on call can be a bit much sometimes ... when people go on leave—we're kind of a bit short staffed. So I did like 5 on call shifts over a 7 day block, which was a bit more than I'd prefer' (R10). There was no identified clear on-call burden mandate limiting how much they could possibly do, whilst other departments do have guidelines around adequate staffing and on-call. 'Having some sort of minimum standards, surely couldn't be a step backwards' (R11).

This led to GPOs feeling burnt out, with some requiring leave and/or stepping back to part time roles to be able to survive the job. 'I actually went on early ... leave because of burnout... I was doing like 5 nights straight on call and had multiple bad things happen' (R5). Needing to take leave was associated with guilt especially if the service needed to go on bypass, with the GPO feeling responsible. 'None of us like having to go on bypass. It's not good for the hospital. It's not good for the community. It's

not good for us maintaining our skills. Now, I don't know what the answer to that is. But I feel like there's not a lot of proactivity with trying to prevent it' (R2).

Integrating obstetrics with GP or other non-hospital work which did not require on-call, or decreasing FTE lessened the on-call burden and subsequent feelings of burnout. 'Part of the reason for staying was having such good roots at the general practice ... that was sort of what kept us here even when things got challenging' (R4).

**3.2.1.3 | Fulfilment: Continuity of Care.** Several respondents used the term 'cradle to grave' care to describe the service they took satisfaction in providing. 'It's that continuity... you get to see them in GP, when they're pregnant, you get to look after them. Well, they have their baby, and then you get to look after their baby afterwards as well as they grow up. So yeah, you get to do all that which, if you're an obstetrician in the city, you don't get to do' (R4). Whilst this highlights a variety in work, it also identifies the satisfaction of being connected socially to people, families and communities.

**3.2.1.4 | Fulfilment: Community Connection and Role Value.** There was agreement that being present at an important part of people's lives was a humbling experience: 'It's such a pivotal moment in these people's lives...that's a really honourable position or sort of part to play in people's lives—and it's really special, and not everyone gets that opportunity' (R5).

There was generally high job satisfaction, with respondent 3 noting tangible evidence of the benefit provided to women in the region was a driving factor: 'I guess I feel like I can see my impact. I need that kind of feedback.' Part of this was founded in a deep need to bring a service to communities traditionally underserved, such as rural women: to 'help a population that I felt might have been underrepresented' (R9). There was a strong desire to support women and an interest in women's issues. All respondents noted this, and to some extent it made them stay.

Additionally, this tied in with feeling that their presence and effort was meaningful and appreciated by patients and colleagues locally and at referral centres, and also made the community safer: 'I can think of many cases where, had I not been in town to help back somebody else up, or have we not had the service at all we would have had dead mom and dead babies like 100% for sure' (R5). All respondents found their work validating and rewarding.

**3.2.1.5 | Fulfilment—Lifestyle.** Exact town was less important than what the location offered. Work for partners, service access, good schools and appropriate accommodation were important. A sense of fitting in made a difference to whether some respondents stayed and played a role in leaving other sites. 'In [current place of work]—you're given accommodation ... whereas in [previous place of work] trying to find a rental was ridiculous' (R7). One of the biggest enablers was proximity and ease of travel to a bigger centre. All respondents within a few hours of a larger centre noted this. This had flow on effects to personal, family, social and lifestyle access, and easier utilisation of leave, including professional development leave, without life disruption. 'Connection to regional centres- travel costs and distance is a big big thing, I think, for living remotely' (R8).

### 3.2.2 | Support

> The problems that make people leave are unsupported practice—you know, being put in situations they're not comfortable to manage.
>
> (R11)

**3.2.2.1 | Support: Skills and Training.** All interviewees highlighted skill training, support, maintenance, availability and quality as critical to enabling them to fulfil their aspirations as a GPO. 'To keep people happy here—you need to keep us skilled' (R8). It was identified that more training time to develop expertise prior to practice would likely be beneficial: 'doing 18 months of obstetrics made me a much better practitioner' (R7). However, there was concern the current training logbook had been increased without meaningful action to ensure that this could and would be met: 'whilst they set these new targets, they didn't put anything in place as to how we were supposed to meet them. So, either tell me I'm gonna be doing 18 months or support us to get them in 12 months' (R10).

Another concern was emphasis on required paediatric/neonatal skills, which are often assumed once working rurally, but are not a large part of obstetrics in centres with a paediatric team. 'I think the biggest thing, the biggest shock—was looking after the babies' (R4). Plus, after focussing solely on obstetrics training for the year, GPOs felt they needed support in other areas of the rural generalist role: 'I really struggled with those initially coming back out of my obstetric term just because I didn't know how to deal with them for a ... little while... my emergency skills really went to crap' (R7).

**3.2.2.2 | Supportive Training in Local Area.** Local support for newly qualified GPOs was especially important. More experienced interviewees noted a supportive network of senior local GPOs willing to teach and help with decision making in the first few years was a factor that, if not available, would have caused them to stop. 'We had a really good team of GP Obstetricians who supported me, and particularly for the first few months, I was on call with someone else, so I always had a buddy or a backup, or even someone just to ask about the local context as well: can we do that here, should we do that here? and that was really good to sort of be supported into it. I wasn't just on call alone the first night here, or anything like that' (R4). This high level of support and mentoring by senior practitioners highlights the knowledge and skills required beyond tertiary hospital training to allow junior GPOs to grow into their role. This support was required at the home site and with access to productive upskilling and specialist clinicians. 'Sending junior obstetrician like GPOs to small obstetric units, and where they're doing very little procedural stuff ... it's just designed to fail' (R11). Doctors who remained in their role beyond this initial period felt solidified and more confident in their skills and ability to continue.

**3.2.2.3 | Support for Regular Skill Maintenance.** There was strong focus on availability and quality of skill maintenance. Respondents identified variable needs, dependent on experience and workplace exposure. It was noted places with lower birth numbers may require more comprehensive procedural maintenance, as would more junior GPOs, dependent on comfortability and experience. However, access to appropriate and quality skill support was difficult. 'I might go for 2 weeks, and then only get 2 or 3 Caesars which doesn't really help me' (R5). One respondent noted signing an agreement in a 2-week period, only one caesarean section would be guaranteed. Several noted time away from family was difficult, and one suggested for themself, a fortnightly shift with a dedicated procedural list would suit better. Several respondents noted more useful placements were often booked years in advance, and quality was incredibly variable. There was exasperation with this process and the lack of continuity across locations. Interviewees felt the colleges and regional facilities needed to 'prioritize their upskilling with their proceduralists' (R9), and 'it's incumbent upon RANZCOG or ACRRM...to keep us skilled' (R8).

Several respondents noted a time colleges had discouraged them or others from GPO training due to predicted proceduralist excess. This was heavily questioned by respondents. 'I got told not to do it ... they were encouraging people the other way...It didn't have an impact on me, but I'm sure there were lots of people that would have an impact on' (R2). Many noted current staffing issues and were frustrated with lack of foresight at this point. 'It blows my mind – because I could look almost anywhere in Queensland or Australia and find a job as a GPO' (R9).

**3.2.2.4 | Supportive Relationships and Leadership – Midwives, Doctors.** A highly cohesive work team was an integral enabler. Trust and respect underpinned these relationships, including with midwifery, nursing staff and GPO and non-GPO doctors at the facility. Staff that worked in an area longer were valued highly for knowing both how the hospital and community worked. 'I think it more does come down to the people, and those work relationships—like having a good fit with the people you work with is really important to keep people. Yeah, that's good leadership and collaborative like being able to trust your colleagues' (R4).

Having the right person in leadership positions was instrumental. They needed to be supportive, and consistent. 'There was probably a big leadership change—That's probably what else happened about 8 years ago. That's probably helped the improved—just general feel of the hospital' (R6). Respondent 5 noted that prior to appointment of an obstetrics lead there had been no clinical stewardship and felt this change had helped the team become more mutually respectful and cohesive. Conversely, respondent 4 noted: 'The toughest thing was the change in leadership' when the director of medical services had changed multiple times over a short period. What had helped her remain was consistency and support from her GP mentor, highlighting that one consistent and stable mentor can enable GPOs to remain when there is uncertainty elsewhere.

**3.2.2.5 | Supportive Relationships and Leadership—Regional Hospitals.** R6: 'Governance and accountability is really important—but I also think that you need to have that inner sense of feeling at 2 AM that if this goes bad ... they will have my back—they're not going to put me over the coals and send me out to the wolves.' The relationships staff had with referral hospitals were incredibly important and, for the most part, described as positive. Several GPOs observed this had improved over time. Most identified the relationship with regional centres as a key factor enabling continuation: both when liaising for patient care, and in the aftermath of cases with complications. It was noted that referral centre staff developing an appreciation of location and capabilities of the GPO's rural service fostered mutual respect and benefited this relationship. Regional site leadership was important. 'He's always happy to take our calls... and you know you're going to get good advice from him, and he understands the limitation of rural' (R7). It was apparent having people within the referral centre willing to teach, be readily contactable, and able to relate to the rural context were a great source of support and enablers for GPOs to continue.

**3.2.2.6 | Support—Midwifery Team.** 'You know, delegating responsibility to the midwives is a really important thing if you're gonna try and work as a team' (R11). Relationships with midwifery and nursing staff were hugely important. Practitioners needed to feel they were adequately informed about patients, not brought in last minute when things went awry. 'The doctors and the midwives, so we were kind of a team—so, we all took care of our patients and shared them. We saw everybody, even people who are going to have normal births, we'd still be involved. So even when you got called in for emergencies, you knew everybody' (R3).

Many chose their work location based on the relationship between midwifery staff and doctors, and several had left prior sites, or avoided them, for the same reason. 'Having midwives that we work with regularly, and trust is really important to provide good obstetric care' (R4). A collaborative approach was paramount and highly valued as an enabler. 'I've been very fortunate to have a great relationship with our midwives here, but that has come on the back of recognizing the importance of fostering a really close relationship and having the opportunity to work with midwives who are very open and collaborative. I've been yeah, very lucky in that sense' (R8).

**3.2.2.7 | Support From GPOs as a Larger Group.** Informal support channels included social media, email and chat groups, courses and conferences. They were a supportive environment for GPOs to compare service delivery models, approaches to difficult cases, clinical resources, rostering and staffing issues, and issues within services or within the larger obstetric/GPO community. The sharing of similar experience was valued highly. These channels were noted to build links that could be leant on when difficult cases arose. 'We've got a Whatsapp group that everyone posts things in. So, I think there's that sort of quiet background collegiality with them and I know that if I had an issue, I could call someone else and be able to have a chat to them, and we do all kind of know who each other are in the region' (R5).

**3.2.2.8 | Support When Dealing With Complicated Cases.** Support for case-based learning and debrief was important for outcome management and to improve hospital

processes but was also integral for the mental health and wellbeing of the practitioner and team involved. Formal regular support was advocated: 'I do feel like if we had formal like scheduled supports and check in sessions that actually would be very beneficial' (R5).

There was general agreement that review processes could be improved with regional centres. Some participants, having previously seen colleagues vilified for negative outcomes in the past, had re-thought providing obstetric care in rural settings. 'It'd only take one bad event to make you really question what you're doing' (R11). In addition, respondent 7 noted 'One thing that would make a big difference to keeping people in rural jobs is when you do have a bad outcome ... then you have seen how your colleague has been treated, and you just go well, if that was in a bigger hospital that would just be attributed to oh well that's just obstetrics' (R7). Having a review process which was deemed fair and supportive rather than vindictive was key, and an enabler to continue. 'If something goes wrong... it needs to be—you know—more of a constructive process rather than a blaming process ...' (R10). For the most part, it was agreed this was usually the case. '[Regional referral centre] was really supportive too—they, we had sort of various contacts with them, saying, look, if you need to talk through it, it's not nice for anyone to go through' (R6). Having a good relationship and dealing with these outcomes constructively, was an enabler. 'I wasn't directly involved in that that M+M, but mostly positive things came out of it' (R10).

**3.2.2.9 | Support From Mentors.** Most GPOs identified informal mentors who had guided and supported them, were encouraging to start and complete their training, and who remained an ongoing source of support. 'The director at the time was just so supportive, you know. You could call her. She would come in. She would teach you. It was just a fantastic care model, and she was very supportive of rural generalism as well... I think that just shows that if you have consultants and bigger hospitals who are supportive of that program ... it will encourage people going into rural obstetrics' (R7). It was noted mentors who were GPOs were helpful. Some respondents noted a formal relationship may be beneficial during training and immediate years afterwards.

### 3.2.3 | Differences Between Women and Men

Enablers and concerns remained similar between self-identified genders. However, the female respondents in this project were more likely to mention roster concerns and childcare duties than the males. Specifically, on call with children was identified as difficult. 'As a female trying to raise children. I think it's really tough unless you've got a really unusual husband who can do everything' (R6). There was a feeling amongst female respondents that to survive the GPO role, a part time allocation was needed: 'I just think of the weekend I just worked with the stuff that I got called out for, and then, if I had to then be working another 4 days, I would be completely exhausted and fatigued' (R7).

### 3.2.4 | Safety of Service

GPOs indicated the ability to provide a safe service directly enabled their willingness to continue even in challenging circumstances. There was concern about balancing women's desire to birth rurally with safety, and within the comfort levels of staff. 'So, you do stuff that's probably not entirely out of your scope, but you know, sort of pushes your boundaries... generally they [patients] prefer to take the risk of having someone with a little bit less experience ... if it means they don't have to go to a tertiary centre...' (R10). Respondents agreed preselecting low-risk patients was important. Respondents suggested clearer guidelines about what the facility would manage, and what would need to be referred on would be beneficial, and one respondent felt mandated safe staffing ratios like those of other colleges may improve safety.

## 4 | Discussion

Given current rural and remote obstetric services are at risk, this study highlights enablers for rural GPOs to continue in their role, focussing on keeping GPOs skilled, supported and confident in the safety of their service so they find deep satisfaction in their work servicing their rural and remote communities. These factors are all self-evident. They highlight the strong desire and willingness to serve communities, and utilisation of these enablers should assist stakeholders to focus their effort to improve this crisis.

Notably, whilst individual enablers were important, the combination of these factors was more so. A mix of enablers encompassing interest, fulfilment and support was instrumental in creating an enduring service. Although similar themes were uncovered in all interviews, GPOs individually had differently weighted areas of concern to enable continuation. Any group planning to tackle GPO retention requires a multipronged and flexible response.

The results were largely expected and echo previous literature. However, our area of research, enablers to stay for GPOs, has an added complexity due to the nature of the work undertaken. Rural and remote health service provision needs to support practitioners and enable flexibility and personalisation of roles. Colleges (RANZCOG, RACGP and ACRRM) play an important role in providing programmes and curricula that support procedural skills, training navigation, facilitating continued growth through well designed and individualised skill maintenance, and bolstering a network of mentors teaching the next generation of GPOs. The increase of logbook skills needs to be backed up with tangible action to ensure requirements can be met and trainees feel valued. Government support through targeted funding is instrumental to Colleges' ability to facilitate good quality training and skill maintenance as GPO enablers.

GPOs spoke of how moving beyond their comfort zone to provide obstetric services for communities—a demonstration of clinical courage [14, 15]—was instrumental in their ability to comfortably fulfil the role. Development of this courage was an enabler to remaining, and absence of it, a barrier. This was credited to supportive senior local staff, being part of a trusting and functional team and community of practising GPOs. It was strengthened by relationships and leadership at regional hospitals and founded on strong feelings of connection to the

community served. One of the highest yield target areas is focusing on bolstering a network of mentors to facilitate clinical courage in junior GPOs.

Whilst strongly highlighting enablers supporting GPOs to continue, this population was a small cohort in North and Far North Queensland. In addition, with only three male participants, comparing gender-based factors is difficult. Future research would benefit from a wider sample of GPOs, comparing with other regions and services. If interventions are instigated, it would be useful to investigate retention and satisfaction rates and detail the impact on clinical outcomes where GPOs remain in their roles for longer.

## 5 | Conclusion

Fostering and encouraging interest in obstetrics and supporting practitioners with skills maintenance and workplace relationships should be the major concern of facilities recruiting and retaining GPOs, and colleges training them. One key finding indicated support in the first few years after training in obstetrics required fortification to develop the clinical courage necessary to continue, and local mentor support was critical for this. Having more experience, although a positive enabler, needs to be more than simply a tick book of tasks and requires personalised follow-up and ongoing support. One of the most vital roles to support GPOs working in rural delivery services into the future is to foster our next generation of mentors.

This study has highlighted avenues that could be targeted to broaden supportive networks amongst GPOs, including having a clear and useful skill support process and constructive case reflection procedure. When the decision to open or retain services is made, strategies need to be specific to region and to the specific staff working in the service—with skill mix, identifying matched and productive skill maintenance opportunities, flexibility in rostering, supporting mixed roles and fostering mentoring relationships and clinical courage.

No one factor can convincingly account for enabling GPOs to continue in their role, which is fundamental to consider when addressing this issue.

### Author Contributions

Beth Exell: writing – original draft. Anna Vnuk: supervision and draft revisions. B.E. undertook these interviews and research working as an GP registrar and employee of JCU, Cairns, Queensland, with the experience and training of supervisor, A.V., who has imparted this knowledge to B.E. B.E. is now a rural generalist and was interested in this particular topic due to recent coverage of struggling and closing maternity services rurally in the region she works, as well as an interest in pursuing rural obstetrics. JCU had no role in the design or conduct of the study or interpretation of findings. There was no funding acquired for this project. This research has not been published in any way elsewhere.

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### Ethics Statement

Ethical approval was obtained from the James Cook University Human Research Ethics Committee (approval H9099).

### Conflicts of Interest

The authors declare no conflicts of interest.

### Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

### References

1. D. Tennett, L. Kearney, and M. Kynn, "Access and Outcomes of General Practitioner Obstetrician (Rural Generalist)-Supported Birthing Units in Queensland," *Australian Journal of Rural Health* 28, no. 1 (2020): 42–50, https://doi.org/10.1111/ajr.12593.

2. N. Mohammadiaghdam, L. Doshmangir, J. Babaie, R. Khabiri, and K. Ponnet, "Determining Factors in the Retention of Physicians in Rural and Underdeveloped Areas: A Systematic Review," *BMC Family Practice* 21, no. 1 (2020): 216, https://doi.org/10.1186/s12875-020-01279-7.

3. A. Kamalakanthan and S. Jackson, "Doctor Supply in Australia: Ruralurban Imbalances and Regulated Supply," *Australian Journal of Primary Health* 15, no. 1 (2009): 3–8, https://doi.org/10.1071/PY08055.

4. RDAQ, "Rural Birthing Crisis Contagious to Larger Regions," (2023), https://rdaq.com.au/_Qld/News/Current-news/Rural-Doctors-Maternity-crisis-is-contagious.aspx.

5. S. Kildea, A. C. McGhie, Y. Gao, A. Rumbold, and M. Rolfe, "Babies Born Before Arrival to Hospital and Maternity Unit Closures in Queensland and Australia," *Women and Birth* 28, no. 3 (2015): 236–245, https://doi.org/10.1016/j.wombi.2015.03.003.

6. F. Magick Dennis and H. Keedle, "Birthing as Country," *Women and Birth* 32, no. 5 (2019): 383–390, https://doi.org/10.1016/j.wombi.2019.06.005.

7. L. P. Sweet, V. A. Boon, V. Brinkworth, S. Sutton, and A. F. Werner, "Birthing in Rural South Australia: The Changing Landscape Over 20 Years," *Australian Journal of Rural Health* 23, no. 6 (2015): 332–338, https://doi.org/10.1111/ajr.12214.

8. RANZCOG, "Certificate and Procedural Training. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists," (2023), https://ranzcog.edu.au/training-topics/prospective-trainees-certificate-and-procedural-training/.

9. AIHW, "Maternity Models of Care in Australia, 2022. Web Report. Australian Government," (2022), https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care/contents/about.

10. Care DoHaA, "Australia's Future Health Workforce Report—Obstetrics and Gynaecology. Australian Government," (2024), https://www.health.gov.au/sites/default/files/documents/2021/03/obstetrics-and-gynaecology-australia-s-future-health-workforce-report.pdf.

11. M. E. Kiger and L. Varpio, "Thematic Analysis of Qualitative Data: AMEE Guide No. 131," *Medical Teacher* 42, no. 8 (2020): 846–854, https://doi.org/10.1080/0142159X.2020.1755030.

12. V. Braun and V. Clarke, "Using Thematic Analysis in Psychology," *Qualitative Research in Psychology* 3, no. 2 (2006): 77–101, https://doi.org/10.1191/1478088706qp063oa.

13. QSR International, "NVivo Version 13, R1, Released 2020," (2020).

14. J. Konkin, L. Grave, E. Cockburn, et al., "Exploration of Rural Physicians' Lived Experience of Practising Outside Their Usual Scope of Practice to Provide Access to Essential Medical Care (Clinical Courage): An International Phenomenological Study," *BMJ Open* 10, no. 8 (2020): e037705, https://doi.org/10.1136/bmjopen-2020-037705.

15. L. Walters, I. Couper, R. A. Stewart, D. G. Campbell, and J. Konkin, "The Impact of Interpersonal Relationships on Rural Doctors' Clinical Courage," *Rural and Remote Health* 21, no. 3 (2021): 6668, https://doi.org/10.22605/rrh6668.