HOBART SYMPOSIUM: PROCEDURAL RURAL MEDICINE RECOMMENDATIONS

Background

The accelerating decline in procedural practice (particularly obstetric, anaesthetic and operative surgical services offered by general practitioners) is now generally acknowledged. This factor is regretted by consumers and communities in rural areas where access to these and other health services is already limited. The loss of doctors offering procedural services therefore has a particularly heavy impact on them. For individuals and families, it can mean delayed treatment, potentially sub-optimum health outcomes and considerable social and financial costs. For communities, it means a diminished capacity to attract new people or industries, a loss of social capital and an economic drain as expenditure follows people accessing these services elsewhere. It imposes a heavier workload on the dwindling number of practicing proceduralists and can affect the viability of rural general practices and hospitals.

Maintaining procedural practice is a priority for the Rural Doctors Association of Australia (RDAA), a body formed in 1991 to give rural doctors a national voice, and the Australian College of Rural and Remote Medicine (ACRRM), which was set up in 1997 to oversight medical education and standards for rural practice. In 2001, RDAA formed a working group of rural proceduralists to address the issue. ACRRM was commissioned by the Commonwealth to investigate the retention of procedural skills as part of its Integrated Training Grant and its paper *Barriers to the maintenance of procedural skills in rural and remote medicine* was completed in July 2002.

In June 2002, RDAA and ACRRM made a presentation on procedural rural medicine to the National Rural Health Policy Subcommittee of the Australian Health Ministers Advisory Council (AHMAC). In the discussion that followed, the Subcommittee requested that the two bodies, in collaboration with other stakeholders, progress beyond analysis of the problem to proposing solutions to it.

This has been done in two stages. The first was the preparation of an evidence-based paper - *Procedural rural medicine: strategies towards solutions* – that was presented to the AHMAC Subcommittee in October 2002. The second was a multi-disciplinary symposium held in Hobart in March 2003 to determine practical ways of implementing appropriate action. Both processes recognize the need for an integrated national strategic framework within which action in the following key result areas will help to halt and reverse the decline in procedural rural medicine:[1]

- Attracting the next generation of procedural doctors: recruitment & training
- Supporting the procedural workforce: recognition & skills maintenance
- Monitoring & evaluation of current initiatives
- Identifying good working models for wider application
- Enhanced collaboration between all levels of government

[1] Although professional indemnity issues are recognized as a major factor in the decline of procedural medicine, it was excluded in view of current work in progress in this very volatile area

NATIONAL VISION

Rural communities have local access to quality procedural medical services

OBJECTIVE: To meet the need of rural communities for local quality procedural medical services in order to:

- Achieve optimum health outcomes for rural people
- Help reduce the heath differentials between rural and urban populations
- Provide equitable access to procedural medical services
- Minimize costs and disruption to rural consumers and families
- Maintain the vitality of local economies
- Support regional and rural socio-economic development
- Enhance the viability of all local health services
- Reduce the negative impact of the procedural decline on the rural medical workforce

STRATEGIC DIRECTIONS

Research, good working models and input from the 160 participants at the symposium indicates that action to address the decline in procedural rural medicine must:

- Be guided by a national, evidence-based framework for action
- Integrate work already in progress at various levels
- Acknowledge and support the role of all levels of government
- Direct organizational and professional activity in this area
- Be characterized by collaboration and flexibility
- Support all members of the procedural team including doctors, midwives and nurses
- Recognize the changing gender and ethnic composition of the medical workforce
- Encourage a professional culture and structures which value GP proceduralist
- Focus simultaneously and immediately on recruitment, training, skills maintenance and infrastructure

KEY PLAYERS

Stakeholders recognize the need for action at every level. There was a strongly expressed need for national leadership by the Commonwealth in collaboration with State/Territory and local government.

RDAA and ACRRM acknowledge their responsibility as professional organizations with a specific rural focus to prioritize support for procedural rural medicine.

1. ATTRACTING THE NEXT GENERATION OF PROCEDURALISTS

All strategies must be designed, monitored and evaluated to ensure they take into account the changing attitudes and gender and ethnic composition of the incoming medical workforce

1.1 RECRUITMENT

1. Increased procedural exposure/ experience from medical school to registrar training
2. Expanded focus on procedural practice rural clubs, scholarships and related activities
3. Collaborative recruitment strategies for rural medical, nursing and midwifery trainees
4. Increased emphasis on procedural practice in rural recruitment programs
5. Early exposure to role models, mentors, concepts and values likely to encourage procedural medicine as a career stage
6. Further research into the factors influencing career choices within medicine
7. Assistance for experienced doctors who want to take up procedural medicine

1.2 TRAINING

1. Commonwealth Department of Health and Ageing leadership in the development of an integrated national training strategy for rural proceduralists
2. Increased involvement of male and female proceduralists in curricula design and teaching in academic, hospital and practice settings
3. Rural clinical schools supported to involve students in early procedural experience and the development of ongoing mentoring networks
4. Procedural training posts better integrated with undergraduate programs and wider GP training
5. Training bodies ensure arrangements are in place for procedural registrars to work with existing rural proceduralists at the completion of their training
6. Mentorship systems and other support structures for junior proceduralists
7. Regional specialists supported to act as teachers, consultants and mentors
8. Specialist colleges involved in rural procedural initiatives
9. Development of regional hospital capacity as centres for procedural training
10. Support to encourage local hospitals engagement in procedural training
11. System developed to assess overseas trained doctors for training and support into recognized credentialed proceduralist practice.

2. SUPPORTING THE CURRENT PROCEDURAL WORKFORCE

The value of the rural GP proceduralist should be formally recognized by health authorities and colleges in awards, resource allocation, incentives, rewards and structures which acknowledge and support their important role in rural health care.

2.1 RECOGNITION

1. Programs to support and retain the rural medical workforce include a specific component for proceduralists

2. A national credentialing framework for simplified processes and streamlined models of multiple credentialing
3. Regional planning for a qualified workforce adequate to maintain procedural services for rural communities and support appropriate models of care
4. Co-coordinated regional investment in support and upskilling for all members of the procedural services team.
5. Regional health authorities maintaining rural health facilities through functional linkages between smaller centres
6. Regional health authorities and hospital boards maximize health professional and consumer input in decision making on procedural services
7. Regional health authorities provide infrastructure for safe procedural practice
8. Regional and local collaboration between professionals and services to ameliorate the on-call and after hours burden
9. Hospitals encouraged to foster collaborative innovative team arrangements
10. Child care facilitated for procedural team
11. Initiatives to encourage service providers and consumers to value and sustain local procedural services.

2.2 SKILLS MAINTENANCE

1. Financial and systemic support for male and female procedural mentors, including former proceduralists now practicing in provincial and urban centres
2. Regional organisations facilitate, subsidize and support increased local and regional training opportunities for procedural teams
3. Regional systems facilitate rural proceduralists' access to specialist links, mentorship, information and support
4. Outreach specialist programs designed, monitored and evaluated to ensure support for training and sustaining local proceduralist and specialists
5. Advanced rural skills posts supported by shared hospital positions and roles for regional specialists that include clinical work, teaching, and mentoring.
6. Commonality and transferability of CPD requirements
7. Review of strategies for the maintenance of professional standards (MOPS) by Australian trained and other doctors
8. Greater use of IT and online learning systems for the maintenance of procedural knowledge and skills

3. MONITORING AND EVALUATING CURRENT INITIATIVES

There are already various disparate strategies, large and small, planned or in progress, to support procedural rural medicine. They should be linked with this overall framework to increase their impact and evaluated in relation to both their immediate outcomes and the value they add to other initiatives and broader approaches.

1. This strategic framework collaboratively developed into a flexible national action plan supported by clear performance indicators and regular evaluation
2. National data collections and paradigms underpinning rural medical support programs include a specific component for rural procedural medicine

3. Commonwealth and state funding systems examined to identify and address any anomalies which undermine rural procedural practice
4. The implications of the changing attitudes and gender and ethnic composition of the medical workforce included in all monitoring and evaluation
5. Medical school funding designed to support rural recruitment linked to performance indicators and demonstrated success in producing rural doctors
6. Rural clubs and scholarship schemes monitored in terms of outcomes for the rural procedural workforce
7. The type of activity provided during registrar training evaluated to assess its impact on uptake of rural procedural medicine
8. The proportion of registrars moving into procedural training monitored by appropriate rural bodies
9. Cost benefit analysis to compare the costs of providing procedural services in rural areas to that of sending patients to hospitals in larger centers
10. Current evaluation and monitoring related to MSOAP used to direct the continuation of the program.

4. LEARNING FROM GOOD WORKING MODELS

The papers and group discussions at the Hobart Symposium indicated that there already a number of successful models operating at a regional level that were worthy of consideration for application on a larger scale. The Symposium also demonstrated the importance of participative and consultative processes, which can disseminate knowledge of local initiatives to a wider audience.

1. Models from medical schools that are currently producing rural proceduralists used in the design of future curricula and strategies
2. Critical success factors in the establishment of the NSW advanced skills training program should be applied to work in other States
3. A resourced showcase for outcomes of flexible, collaborative models, particularly those developed at community and regional level
4. The potential of multidisciplinary and team approaches and models emphasized in program design and advocacy and lobbying activities
5. Current Commonwealth initiatives proving effective in providing non-hospital rural experience for young doctors continued and expanded
6. Models that incorporate skills maintenance for all team members emphasized in program design and advocacy and lobbying activities
7. Expanded support for local and regional models that include medical and other health professionals in team training at the same time
8. On-going support for local and regional cooperative arrangements which facilitate access and alleviate work loads
9. Support for child care and other initiatives which help balance personal and training and service delivery responsibilities
10. Support for initiatives which facilitate open communication between health care professionals and regional and hospital authorities

5. ENHANCED COLLABORATION BETWEEN ALL LEVELS OF GOVERNMENT

The participants in the Hobart Symposium reinforced the view of other researchers and analysts that existing and future government programs and resources should be linked more efficiently to ensure a more integrated approach.

1. Collaboration between jurisdictions in the development of a flexible, integrated national action plan based on this strategic framework.
2. The Australian Healthcare Agreements include specific indicators relating to local access to procedural services
3. Commonwealth and State authorities collaborate to ensure appropriate technology and equipment is available to maintain procedural services
4. Enhanced collaboration where the Commonwealth has responsibility for GP training and the States provide the procedural training posts
5. Cross-government resourcing facilitates hospitals moving further towards team approaches and supportive structures for procedural service delivery
6. Commonwealth and State scholarships linked to proceduralist training opportunities.
7. Divisions of General Practice, local government and regional health services develop collaborative strategies to support rural procedural medicine.
8. Local government and communities lead the creation of flexible local solutions in collaboration with regional health authorities