Training and Support for Procedural Practice in Rural and Remote Medicine:

SOLUTIONS PAPER

Acknowledgements

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1. INTRODUCTION

In parallel with its recent research on the *Barriers to the Maintenance of Skills in Rural and Remote Medicine,* the Australian College of Rural and Remote Medicine (ACRRM) has sought advice and input from members, government, the community and organisations as to how we can support our existing procedural workforce and develop a workforce for the future. This report presents a resume of issues based on this advice and provides a series of points where intervention might be possible.

ACRRM has recently published a national research study on procedural medicine that provides current information on the areas that many doctors view as important and that form a clear agenda for a solutions-based approach.

The study indicates that many of the priority issues identified by doctors refer to aspects of education, training and recognition and therefore come within the purview of ACRRM programs and initiatives. In addition, there are several industrial and professional issues that rural doctors prioritise, particularly in the areas of indemnity, insurance costs, specialist and other staff support and payment structures, which have been referred to the Rural Doctors Association of Australia for further action.

In terms of the issues that ACRRM may address, doctors identify the following as requiring immediate attention:

- Maintenance of multiple standards, benchmarks and qualifications;
- Costs of upskilling versus income recovery;
- General undervaluing of the procedural GP;
- Pressures of maintaining a broad range of skills;
- Ability to take leave for training – time constraints, professional limitations;
- Access to appropriate skills programs – type, locality, cost;
- Changing preferences for combining medical and social/family life; and
- The need to achieve multiple standards and benchmarks across medical disciplines.

Female doctors rate, in addition:

- The stress and pressures of procedural practice;
- Levels of colleague or locum support when required; and
- Costs of professional memberships.

2. STRATEGIES FOR CHANGE

ACRRM's approach to finding solutions takes the form of a tiered strategy:

- Solutions that require an integrated approach with components of the same strategy implemented at each level of education and training – medical students, junior doctors, registrar and established practitioners – strategies to increase the value placed on rural proceduralists might be one example.

- Solutions geared to the needs of particular subsets of doctors – private, public or combined which require the support of Commonwealth, State or regional authorities – some of these will be more relevant to the AHMAC paper than others and some may be addressed in other programs.

- Solutions already be in place - a number of trial or pilot models that are already working on a small scale could be useful to address particular issues and capable of national application.

3. PRIORITY ISSUES

ACRRM provided a wide circulation of the issues contained in this report to members, rural organisations and government. The following is a list of the top priority issues selected by its working party:

- Credentialling and other issues related to the current complexity of maintaining recognised skills in more than one discipline –typical of rural procedural doctors;
- Greater access to regional training situations and to sufficient numbers of cases to attain and retain skills;
- Promotion of regional referral models which support GP proceduralists, through the greater use of available GP services by regional colleagues;
- Models of support for the training and upskilling of female proceduralists;
- Training needs in practices where key procedural partnerships are in place and where changes to the capacity of procedural care will ensue from doctors' requirements to take leave to upskill;
- Financial and bridging issues of part time doctors of both genders wishing to re-train as proceduralists;
- Cost versus income issues related to training and indemnity expenses; and
- Active support for future proceduralists and recruitment to this area of practice.

4. SUGGESTED AREAS FOR ACTION

4.1 Recruitment – medical students

If appropriately structured, there are points within the medical degree where medical students can be introduced to the challenges and rewards of procedural medicine and be given an opportunity to value and appreciate the work of rural proceduralists. The following strategies were suggested:

Introducing medical students to the issues

> Promote better strategic planning to ensure medical students are introduced to the concept of community based, procedural training and careers. More focused links are required with medical schools in order to gain a better appreciation of where and how rural and procedural medicine can be incorporated into the curriculum and to experiential terms, including greater input by rural medical teachers. It would be helpful to develop data on whether, and at which points in the course, a high value is placed on rural medical role models, in line with RUSC guidelines.

Greater understanding of the needs of rural communities

Consider means to develop a greater understanding within medical schools of the requirements of rural communities - exposing medical students to the concept of community based procedural training - particularly in practices with anaesthetic, obstetric and surgical profiles – reinforcing the influence of early exposure to challenging practice and to role models in medical practice and teaching.

A better understanding of rural service delivery

Ensure medical schools provide experience that allows students to 'track' the movement of people through the medical community and appreciate how they are managed by different services. Gaining a better feel for the common clinical problems of a community and appreciating the special challenges for rural doctors.

Understanding the dynamics of discipline and career choice

Identify particular streams where progression to a procedural career is most likely. It would be useful in terms of a potential rural training cohort, to obtain more accurate data on the career choices of subsets of medical students in order to develop programs of information and encouragement which would supplement the work of the rural clubs and scholarships.

Examine patterns and links between enrolment in medical education and ultimate workforce results. In view of the cost of medical training, further data may be useful on the links between enrolment in medical training and its outcomes in filling particular subsets of the workforce.

Recruitment and support of procedural mentors

The recruitment of more mentors to promote procedural work is now pressing. The role could be enlarged for ex rural proceduralists currently working in urban and provincial settings. A study of the preferences for involvement of this group has recently been published by ACRRM. In addition we have the means to address the shortage of 'mentors', by providing greater incentives for the engagement of doctors practicing near the regional coastal cities and with a strong interest in rural medicine.

4.2 Training – Junior doctors and Registrars

It is evident from ACRRM data gained through its junior doctor programs that a continuity of experience in rural and procedural medicine is a major factor in the retention of interest and commitment in specific lines of practice. The following issues have been flagged in both junior doctor and registrar training opportunities to nurture an interest in procedural medicine.

4.2.1 Junior doctors

Getting more interns into rural community attachments

Further develop intern positions in Regional Hospitals, to address the current practice of interns being basically limited to city hospitals, with short rural rotations to rural hospitals. This would promote a progression of rural training from undergraduate, through intern and PGY 2 to regional registrar levels, whether that is GP or specialist training. In addition a greater proportion of community terms and Rural and Remote Area Placement Program (RRAPP) positions are suggested for junior doctors, co-ordinating with the Rural Training Networks.

Ensuring good procedural mentors and role models

Further community training options could be provided for junior doctors that enable them to reflect on the scope of procedural practice and to have terms of high quality training and mentoring from proceduralists. A continuity of experience in rural and procedural medicine is a major factor in influencing thinking about possible career tracks, building on the interest raised at medical student levels.

Understanding the factors that influence vocation and career choice

Develop data that provides a better understanding of the career aspirations and support requirements of the new generation of graduates.

4.2.2 Vocational training

Realising the potential of the regional hospitals in training

Further support for, and refinement of, the concept of advanced training for generalists. In terms of recruitment into procedural practice, the place of the regional hospitals is crucial - the main teaching hospitals concentrate on experience for training registrars. Smaller hospitals, without that competition, have the potential to form an ideal training environment for the interested 'generalist'. This is a basis for both the generation of initial interest and the maintenance of skills. Obviously many of these people gravitate to the specialties, but if there was a specific program, this action could result in the recruitment of more procedural rural doctors.

Ensuring an optimal role for regional teachers and mentors

Further development of models of support for regionally based specialists as teachers and supporters of rural proceduralists and means to ensure generalist teachers of procedures are recognised, supported and rewarded.

Further development of models of support for, and recognition of, rural mentors.

Understanding the aspirations of the new generation of doctors.

Further consideration of ways to understand the needs of the new generation of doctors and find the means to encourage them to value procedural medicine as a career and to appreciate its contribution to rural medicine.

Curtailment of costs to trainees – for entry to examinations.

Understanding the role of procedural training in the new regional arrangements

Clarification and documentation of the position of, and options for, procedural training in the new training arrangements including means to ensure that advanced and procedural training is well represented.

Examination of the role of selection processes in the matching of Registrars to training posts in order to ensure procedural training is available to doctors most likely to benefit from and use such options.

Registrars require training options that meet the needs and aspirations of the new generation of doctors and of female doctors.

Emphasise the strong link between community needs and training as a basis for support of procedural training, particularly in the rural consortia.

Formulation of new models of the purchase of regional procedural training options for consortia, in order to gain access to a secure number of training places for rural trainees.

Recognition that procedural medicine is a team activity

Support for local hospital administrators and nursing staff to take on board and to benefit from training for procedural work.

4.3 Maintenance of Skills – established rural and remote doctors

Addressing complexities in credentialling

Provide arrangements that promote easier and less complex means of maintaining multiple credentialling and recognition by more than one Specialist College.

Design and implement flexible professional models for part-time practitioners and others that recognise prior experience in a more realistic way.

Differential needs of subsets of the medical workforce

One approach to training and support is not appropriate for all doctors. Sub-sets of the workforce identify different needs and approaches – female practitioners, new generation doctors, OMPs, OTDs. Professional arrangements for obtaining and maintaining procedural skills and methods used to teach procedures should be tailored to address particular requirements.

Develop and document models of recognition and support for part time proceduralists – particularly in terms of costs of professional memberships and access to upskilling.

Ensure specific training arrangements for female practitioners – that not only reflect their particular work patterns and family roles but incorporate the special education/ training approaches that RDAA and ACRRM groups are currently advocating.

Providing greater prominence/recognition for procedural medicine

Opportunities exist to give greater prominence through research - via the consolidation and publication of data on the role and importance of the proceduralist in rural medicine, on both a national and a state level – to raise the profile of proceduralists, encourage a change in the degree to which these doctors are valued and inform government and key partners of the importance and implications of retaining this skill set.

Recognition of the GP proceduralist as a specialist/generalist rather than a general practitioner will promote an appropriate value-base for the rural procedural doctor.

Addressing the tension between practice and the capacity to train and earn

Provide practical answers for doctors to address their current limitations on travel and their limited capacity to be absent from practice in order to upskill, including the financial limitations of leaving an high earning situation in order to train or to contribute to service roles that have lower financial rewards. Note ACRRM's trial of regionally based, whole team training for teachers and proceduralists.

Work with partners in ARRWAG to ensure particular types of locum support are more available to reflect the requirements of practices with special needs – i.e. with a major female patient load.

Provision of suitable recognition and reward for teaching

Provide incentive recognition, including payment options, for the role of teachers and mentors and promote the need for regionally based support networks for this group.

Teaching of procedural skills to others should attract enhanced PDP/ CME points and the current CME system of some colleges could be streamlined, to ensure that points earned for a special interest can be counted for appropriate incentive payment purposes.

Further promoting regionally delivered training

Encourage specific links with regional specialist teams / hospital systems to purchase access to ongoing training and upskilling and skills maintenance – which may require re-alignment of current operational and funding arrangement.

Establish further opportunities in the regions – in smaller hospitals with a continuing procedural role, mentored by regional specialists or at least, senior doctors with appropriate training. Posts where there is not an excess of registrars and senior trainees could be used to ensure sufficient hands on and teaching time. There would be a workforce incentive for hospitals to create these posts as there is no doubt that rural doctors who have senior RMOs or Registrars to assist patient management can benefit significantly from a lightened workload and can contribute to teaching. The hospital also benefits by having more skilled personnel available.

Make short stay hospital training available for mature doctors – benefiting the hospital also, recognition could be provided through certification of the individual doctor as having completed the training.

Examine the feasibility of locally accessible training available either at regional hospitals or via distance bridging technology.

Forge links with workforce recruitment initiatives to provide a corpus of expertise in a region for teaching purposes – skills tracking and matching strategies to ensure strong links between individual teachers and the formation of local teams with complimentary skill sets.

Foster clearer identification of the potential role of regionally based educational and training organisations – many of which have data, expertise and strategic roles directly linked with ACRRM's agenda for change.

Make greater use of online modalities – including through the trial and national implementation of ACRRM's RRMEO network.

Recognising important professional and industrial barriers

Develop a reasonable and sustainable approach to indemnity arrangements including action towards meeting costs.

Promote support by regional colleagues for locally available proceduralists through their referral patterns, recognising the need for sound judgement about local limitations to services.

Examine the further engagement of surgical and other procedural equipment suppliers in local support of procedural training endeavours.

Shortage of up-to-date equipment in the rural area as a reason for lack of maintenance of skills should be investigated - if the theatre is not kept up to standard, then the easy option is to transfer. The influence of this issue in retention of proceduralists requires further audit.

Examine strategies that promote the retention of a procedural team – recognising that absence of ancillary staff can be a key determinant of the ability to continue procedures. The involvement of the whole team in regional training is also beneficial.

5. ISSUES FOR FEMALE DOCTORS

Recognising and addressing issues that require a distinct solution for female doctors

Re-skilling options for female doctors should be investigated to provide options for training without having to leave home for long periods of time.

Means should be found to address the cost of medical indemnity required to undertake an upskilling period of practice as a procedural GP. For female doctors, the training costs are often incurred in advance of income return and the costs of training, travel, indemnity and certification are barriers to re-engagement in procedural work.

Ways should be found to broaden the terms of support for doctors covered by Treasury Managed Funds (NSW) or other VMO arrangements in order to develop incentive grants for short upskilling terms.

Regional training options should be considered that generate local training access – eg through NSW or other procedural GP grants – to develop local, short term, supernumerary positions for regional training.

Bridging courses for doctors, who have been outside the procedural workforce should be developed, including skills updates and experience in the use of new equipment. Safe and appropriate environments for female practitioners to regain skills and confidence should be provided.

Options could be explored for the design and provision of a special course for female doctors, by female doctors.

6. CONCLUSION

ACRRM is moving forward on a number of fronts to implement a number of the issues outlined in this report and to ensure others are brought to the attention of the appropriate agency. A joint RDAA ACRRM paper is being prepared for submission to the Australian Health Ministers' Advisory Committee outlining issues and solutions on industrial, professional and training matters. A number of consultation and working groups are progressing particular strategies and further research work has been undertaken on the provincial and urban-based proceduralists with an interest in supporting the rural sector.

Rural organisations are invited to send exemplars of their strategic plans and/or their programs that currently address any of the issues above, on a national or a regional scale, in order that ACRRM may assist in the promotion and dissemination of models of best practice in support of procedural practice.