Rural training pathways for specialists

2020

Introduction

1. Approximately 30 per cent of Australians live in rural and remote locations. Limited access to medical practitioners contributes to the lower health status and life expectancy of people who live in these areas; this issue is more pronounced the more remote the community is.[1]

2. While many medical students have positive training experiences in rural areas, progression through prevocational and vocational training often requires a return to metropolitan centres. At this point many trainees develop the personal and professional networks integral to their future life and career path. Such trainees are less inclined to return to practice in rural areas.

3. Despite now training more medical practitioners per head of population than most countries in the Organisation for Economic Co-operation and Development, Australia is still reliant on international medical graduates to provide services in rural and regional areas.

4. Aside from the Specialist Training Program (STP) which provides funding to support specialist training posts in non-traditional settings and general practice training initiatives, where both rural training and rural generalist pathways are/have been established, little headway has been made in respect of creating rural non-GP specialist (hereafter referred to as specialist) training pathways and sustainable employment options post training.

5. There are many challenges to training in rural and regional centres, including but not limited to access to a sufficient clinical case load, appropriate supervision and assessment, professional isolation, financial support to attend training in metropolitan centres and opportunities for employment post training.

6. The purpose of the position statement is to provide a strategic overview of the required components to implement a successful rural training pathway for specialists. This will train doctors with skills specific to the unique requirements of remote and rural areas and increase retention of specialists outside of metropolitan centres.

AMA Position

7. Australians deserve equal care regardless of where they live. A whole of government approach is required to review health service models, training pathways, and employment arrangements to better align medical workforce and training with community requirements.

8. Coordinated and accurate workforce data will be crucial to the success of any pathway, as training positions, infrastructure, and supports must be targeted to ensure that communities receive the workforce they require. Addressing specialty as well as geographic distribution will require providing trainees with better workforce data to assist career decision making, as well as providing opportunities for positive training exposure and immersion early enough to allow for trainees to establish a connection with a rural area.

9. The AMA supports the establishment of formal, sustainable pathways to support specialist training in regional areas to meet the needs of rural and remote communities. The introduction of rural training pathways for specialists is part of a broader reorientation of doctor training to facilitate more training in rural and remote locations and allow for a better understanding of local context and service requirements, with support for trainees to return to metropolitan centres for advanced training when necessary.

[1] Australian Institute of Health and Welfare (2018) "5.2 Rural and remote populations" *Australia's health 2018*. Australia's health series no. 16. AUS 221. Canberra: AIHW

10. Financial incentives should be provided for all doctors who practise outside of the major metropolitan centres.

11. Rural specialty training pathways should allow for flexibility within training, with each College determining the requirements of their programs.

Essential elements of a successful pathway

12. The medical profession has a role to play in promoting careers in rural and regional medicine through medical school and during prevocational training, and in identifying and encouraging doctors with an interest in an undersupplied speciality and/or working rurally to do so. Doctors who have a positive experience while on rural placement are more likely to practice rurally during their career,[2] while positive training experience in rural areas increases the likelihood of returning to practice rurally.[3]

13. Medical colleges have a responsibility to train doctors with the skills and commitment to provide care where it is needed most, particularly in underserved rural and regional communities. Ideally this would be through the establishment of specific rural training programs. Colleges should consider creating or transferring accredited posts in regional or rural areas to support specialty training.[4] Many Colleges have formulated their own strategies for developing and implementing rural training pathways. This is commendable and contributes to the foundation which already exists for developing speciality specific pathways.

14. The AMA supports a greater emphasis on establishing rurally based training programs that provide extended cross-specialty training for trainees seeking to practice in rural and regional areas. This includes examining the current barriers for accreditation of prevocational and vocational training posts in regional areas and developing mechanisms for accreditation of innovative posts that maintain high standards of quality.

15. Approaches that allow for more flexibility in access to and movement between specialty training pathways are required, including consideration of competency based training rather than time-based approaches, with the aim of placing trainees in roles that provide them with sufficient clinical caseloads and type over the course of the program. Case volume, type, minimum numbers and expectations should be clearly outlined prior to commencement to provide clarity in the pathway for trainees. This will create more efficient training pathways that meet community need.

16. Consideration also needs to be given as to how alternative models of supervision and assessment could provide greater flexibility in establishing training pathways to meet the needs of communities outside of metropolitan centres while continuing to meet training program requirements and accreditation standards. The development of functional links between regional training networks and existing training infrastructure is integral to this. It is essential that adequate supervision is available throughout training. This supervision should include ensuring that trainees are maintaining safe working hours.

17. Training programs will need to adopt a variety of approaches to identify and select trainees with a desire to work in rural and regional areas. This could include rewarding applicants with a rural and regional background and/or work history to facilitate an increase in trainees with a desire to work in rural and regional areas.

18. The AMA encourages the establishment of rural training networks to support specialist training in rural and regional areas, utilising existing accredited training posts and building on existing

[2] Denese Playford, Hanh Ngo, Surabhi Gupta and Ian B Puddey (2017) "Opting for rural practice: the influence of medical student origin, intention and immersion experience". *Med J Aust* 207(4): 154-158.
[3] Wendy Brodribb, Maria Zadoroznyj and Bill Martin (2015) "How do rural placements affect urban-based Australian junior doctors' perceptions of working in a rural area?" *Australian Health Review* 40(6) 655-660.
[4] Australian Medical Association (2018) *Medical Workforce and Training Summit Report*.

infrastructure such as rural clinical schools and universities, with the involvement of specialty colleges. This would shift the focus to training in rural and regional location, rotating trainees through metropolitan centres for advanced training where possible, and provide opportunities for trainees to develop mentoring and networking contacts. While there is support for this model, in practice regional training networks have been difficult to establish in specialty training and more work is required to identify barriers and enablers to leverage this model.

19. Post-training metropolitan-based hub and spoke models can provide support and attract specialists interested in working in rural and regional areas by providing links and opportunities for regular short-term rotations in metropolitan centres, backfilling roles, developing professional and referral networks and ensuring opportunities for ongoing career and skill development. This would also reduce barriers to ongoing professional development and skills retention and promote inclusion of rural specialists in societies and access to clinical audits and quality assurance programs.

20. Promotion and demonstration of the hub and spoke models during training would provide opportunities to promote careers in rural and regional medicine and dispel stereotypes surrounding rural and regional medical careers.

21. Employment conditions for trainees must be designed to provide clearer paths to specialist qualification and employment post-Fellowship through continuity of employment for trainees, support from their home hospital to undertake additional training, and negotiating with hospital administration for employment post training. This would help to address the problem of doctors being trained for jobs that do not exist or hospitals not prepared to invest in the infrastructure to support specialist positions. This will require the involvement of medical workforce planners.

22. Trainees on a rural specialist training pathway must be adequately funded for the entirety of the training program. This includes relocation payments for the trainee and their partner/family. Additional support in the form of helping partners to find suitable employment or childcare arrangements is also necessary. Local Hospital Districts or Rural Workforce Agencies could coordinate with training providers or Colleges to develop programs to achieve this.

23. Funding and support are also crucial in supporting trainees when they must return to the metropolitan training facility.

24. Remuneration for specialist trainees on a rural training pathway must be enough so that they do not need to consider pursuing additional work, for example as a private assistant, to cover the cost of living. This detracts from case load experience and undermines the overall rural training experience, which increases the likelihood of doctors returning to the city. [5] The AMA has called for a rural isolation payment available to all rural doctors with the level of support provided increasing with rurality.[6]

See also:
AMA Position Statement: Regional Training Networks 2014
AMA Position Statement: Medical Workforce and Training 2019
AMA Position Statement: Fostering Generalism in the Medical Workforce 2019
AMA Position Statement: Rural Workforce Incentives 2017
AMA/RDAA Rural Rescue Package
AMA Medical Workforce and Training Summit Report 2018

[5] Brodribb et al (2015) "How do rural placements affect urban-based Australian junior doctors' perceptions of working in a rural area?" *Australian Health Review* 40(6) 655-660.
[6] AMA/RDAA (2016): building a sustainable future for rural practice: the Rural Rescue Package