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Dear Ms Ramsperger,

Thank you for inviting the AMA Council of Doctors in Training to make a submission to the Department's consultation questions on how to How Accreditation Practices Impact Building a Medical Specialist Workforce. Our response is attached and addresses Questions 1 – 4 as these were within our remit.

We look forward to an ongoing dialogue with the Department on this issue. The AMA Council of Doctors in Training has its next face to face meeting in Melbourne on 22-23 February 2020. The first day of that meeting will host our annual trainee forum with representatives from every trainee college committee attending. This would be a great opportunity to discuss this project, and Sally Cross, Senior Policy Adviser, Workplace Policy, will be in touch to discuss this further.

Please do not hesitate to contact Sally on scross@ama.com.au if you wish to discuss any aspect of our response further.

Yours sincerely,

Dr Tessa Kennedy

Chair, AMA Council of Doctors in Training

1. Are representatives of the AMA Council of Doctors in Training directly involved in specialist medical college accreditation of training posts / settings / networks? How?

The Australian Medical Association (AMA) and AMA Council of Doctors in Training (CDT) are routinely asked by the Australian Medical Council (AMC) to provide feedback on the education, training and continuing professional development programs provided by each specialist college when a college is undergoing assessment by the AMC as part of the College's re-accreditation.

CDT also provides input into the review of the AMC standards for assessment and accreditation of specialist medical programs and professional development programs.

Often trainee college representatives contact CDT when trainees are struggling to resolve an issue from within the College. CDT will correspond with the college, expressing concerns over the impact of an issues raised by trainee chairs.

CDT guides best practice across several areas impacting upon college training; such as leave entitlements, examination standards and fairness in selection, and through public position statements written by CDT which then sets an expected standard against which a college's performance is judged.

2. What do you think are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan specialist training pathways? What is the biggest challenge impacting your organisation?

There are many challenges to accrediting training places in rural and regional centres, including but not limited to access to sufficient clinical case load, access to professional development, and professional isolation.[1] Others include financial support to attend training in metropolitan centres and opportunities for employment post training.

Research suggest other issues related to attracting specialists to rural areas include continual on-call shifts, difficulty finding locum cover, lack of privacy and children's schooling.[2] Further the viability of rural specialist practice is said to depend on nearby hospital facilities, staff, population size and infrastructure.[1]

Reports also suggest that resources needed to process College accreditation visits, complete the paperwork/business case for new positions and to find funding is just too big a burden for rural hospitals with small junior doctor/human resource units.

Increased rural training opportunities and regional workforce planning is needed to develop and recruit relevant specialties.[1] 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. This includes providing trainees with accurate workforce data to assist career decision making, as well as providing opportunities for positive training exposure and immersion early enough to allow trainees to establish a connection with a rural area.

<u>Other issues raised by trainees with CDT include:</u>

- Existing regional training hubs do not always have an appropriate workforce or the capacity for supervision or do not have adequate staffing to allow time off for teaching/learning. There is a disconnect between regional hubs, GP training providers and hospitals which prevents regional hubs from realising their full potential. To combat this, state governments

[1] O'Sullivan B, McGrail M, Russell D. Rural specialists: The nature of their work and professional satisfaction by geographical location of work. *Aust. J. Rural Health* 2017, 25: 338-346.
[2] Bappayya S, Chen F, Alderucciot M, Schwalb H. Caseload distribution of general surgeons in regional Australia: is there a rile for a rural surgery sub-specialization? *ANZ J Surg* 2019, 89: 672-676.

need to link their funding of hospitals to engagement with regional training hubs (which are federally funded).

- Training opportunities that do exist often have a procedural focus with fewer opportunities to train in non-procedural specialties notwithstanding community need. Often the most needed clinicians e.g. aged care, neurology, paediatrics; are solo practitioners who don't have the capacity to supervise because they are so overwhelmed by their clinical workload.

- The Federal government's program timeline does not match the academic year and college accreditation timeline. It fails to recognise the long lead time needed to identify a position, accredit it with a college and find a suitable candidate AND make the funding deadline. Some colleges have large amounts of unspent STP funds because of exactly this problem.

- Shortages in adequate staff to cover trainees attending courses and/or conferences, exacerbated by the longer travel times, is a bigger issue than remuneration. This lack of cover prevents trainees from attending core training opportunities which they otherwise might have been able to attend.

- Training for most specialties also involves research or academic engagement, and many trainees are interested in academic positions which are frequently less available in rural/regional areas. The capacity to do rural research is hindered by lack of research infrastructure compared to metropolitan hospitals. Expansion of rural training pathways should consider capacity building to support increased access to research opportunities in rural locations.[3] This includes the expansion of rural based academic units and attracting and training research engaged, rural based consultants.

3. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?

Elements working well

Some specialist colleges have specific regional training programs. For example, RANZCOG works at different stages of traineeship and fellowship to support and grow the number of specialists in rural, regional and remote areas:

[3] McGrail M, O'Sullivan B, Bendotti H, Kondalsamy-Chennakesavan S. Importance of publishing research varies by doctor' career stage, specialty and location of work. *Postgrad Med J* 2019, 95: 198-204.

- All applications received for the FRANZCOG training program are assessed for rurality, with points awarded to candidates who have been residents of rural, regional and remote areas for a minimum of three years during secondary school education and have also undertaken minimum two-year stint as a General Practitioner in areas that are MM2-7.

- STP has enabled RANZCOG to expand the financial support to more eligible settings, especially in rural and remote areas.

- RANZCOG offer Provincial Integrated Training Program (PITP) positions to candidates who are already based in rural areas, have worked in such areas, or who are interested in pursuing a career in rural and regional areas.

- GPPTSP is a workforce support program aimed at improving access to obstetric services in regional, rural and remote areas.

The RACS Rural training program also has the following elements:

- Rural coach program

- Additional application points for rural trainees

- Gen Surg and Ortho require their trainees to provide rural service time/rotation of minimum 12months.

- Rural fellowship program

- Rural Surgery subsection which trainees (pre-set, set and even medical students) can be members of.

- Rural surgery STP funded program

- Rural research program

The expansion of the dual (split rural/metropolitan) training pathways by the RACP is recognised as an important initiative to promote specialists with both sub-specialist and general skills. Likewise, community based STP places are considered important for improving awareness of and interest in rural psychiatric practice. [1]

<u>Key components to maintain quality and safety</u>

All Australians deserve access to quality health care regardless of their geographic location – the training of medical professionals to deliver that care is intrinsically linked to access.

Quality & Safety: ability to participate in ongoing audit and quality and safety activities during the program and any subsequent admission to a sub-speciality association must be available. The development of rural-metropolitan partnerships may include honorary cross appointments between rural and metropolitan institutions to foster ongoing learning and exchange of ideas as well as the ability to perform difficult cases together in metropolitan centres.

Competency based training rather than time-based training: programs should aim to place trainees in roles that are high volume with a competency-based logbook framework rather than service provision. Specialities should outline case volume and type and minimum numbers clearly for the fellow to achieve.

Appropriate training: Bappayya et al suggests that a broad range of surgical skills across various specialties is fundamental for general surgeons to provide surgical care to their local community at a rural and regional level. Further the RACS statement on generalists, generalism and extended scope of practice recognises that surgeons working across a broad or extended scope of practice need initial broad training in multiple specialty areas to reflect clinical needs, or when the need for broad scope is recognised subsequently, further training and support in their non-core specialty areas.[4]

Develop mentoring and network contacts: rural clinicians in a sub-speciality may face clinical isolation at their future work destination where they may be the only doctor performing certain procedures. Establishing cooperative, easily accessible and mutually supportive relationships with specialised colleagues and institutions will help to deliver a safe and high-quality service to patients. For example, a fellowship placement in a metropolitan centre can develop an ongoing partnership with a clinician/s so that they participate in quality and safety activities, and other CPD activities with a similar cohort of clinicians. This could also translate into ongoing mentoring, referral and continuous medical development relationships.[4]

Assessment: logbook, CPD, interview etc as per the standard of each current speciality program.

Supervision: Ideally a rural supervisor should be an active member of the chosen sub- speciality society but there may be many instances where this does not exist so criteria should be created e.g. splitting supervision between an experienced local senior specialist and a virtually connected sub-specialist. Technology could be used to support supervision via video logbooks or some of the new augmented reality applications for instance. E.g. www.proximie.com

[4] Royal Australasian College of Surgeons. Position paper. Generalists, Generalism and Extended Scope of Practice.

Supportive legal and credentialing frameworks: medicolegal risk from extended scope of practice can be reduced if there is a strong collaborative relationship between the narrow scope specialist and broad or extended practice specialist, particularly where there are good lines of communication, agreed clinical guidelines and share clinical responsibility.[4]

4. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training and in specialties that communities need?

Feedback suggests that prior to specialist training, intern allocation systems need review. This is based on reports that in some jurisdictions, rural hospitals are preferenced last for domestic graduates and tend to be filled by international medical students who need an internship to return to their home country.

The over prioritisation of metro "academic centres" in intern allocation systems potentially undermines the effort rural clinical schools make to expose students to non-metro practice. An example where this does not occur is in South Australia and New South Wales; which have a lottery system that means even the top of the class can be allocated to a smaller urban or even non-metro hospital, preventing metropolitan centres from cherry picking the best and brightest, or at least the perception that this is the case.

Specialty colleges and jurisdictions have a role to play to:

- Review training position accreditation standards to ensure they remain relevant and support the establishment of training positions in areas of need. This includes increased state government funding to assist rural hospitals to improve infrastructure such as rural trainee accommodation.
- Support generalism, providing extended cross-specialty training for trainees seeking to practice in rural and regional areas. Opportunities to obtain diploma qualifications to expand scope of practice in rural areas should be explored.
- Promote careers in rural and regional medicine.
- Identify opportunities through medical school and during the prevocational years to encourage doctors with an interest in their specialty and working rurally.
- Adopt a variety of approaches to identify and select trainees with a desire to work in rural and regional areas. Examples include prioritising the selection of trainees with a

demonstrated rural practice intent into their desired program and offering extra points to applicants with a rural and regional background and/or work history in the selection process to facilitate an increase in trainee entering training who have a desire to work in rural and regional areas. Many training boards in colleges have rural representatives and community representatives, and these may be avenues that can further identify potential trainees with rural intent.

- Incentivise training by providing clear pathways to employment post-Fellowship through mentoring and negotiating with hospital administration for trainees considering a rural and regional career.

- Establish rural training centres by creating and/or utilising existing accredited posts. This would shift the focus from metropolitan areas to training in rural and regional locations and rotating trainees through metropolitan centres as relevant. The South West Victorian Regional Surgical Training Hub (Geelong/Ballarat/Warrnambool/Hamilton) has been a successful example of how this model is able to operate in practice. See below on AMA Position Statement on Regional Training Networks – 2014.

- Require rural/regional state hospital funding to be dependent on collaboration with regional training hubs and universities/clinical schools. Reports suggest the relationship between rural clinical schools and hospitals is often just transactional and there is a tremendous disconnect between hospitals and rural clinical schools.

- Develop alternate models of supervision and education to support training positions in rural areas. This includes teleconference, telehealth and networked supervision models to support access to supervision, provide educational links and access to training opportunities for trainees working in rural areas.

- 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.

- Longer (two to three year) training and employment contracts, inclusive of planned city based and rural rotations, to support rural training pathways, should also be investigated as one way to assist with rural workforce planning and provide for a longitudinal approach to supervision and training.

- The concept of a 'reverse STP' should be explored a possible solution to provide access to sub-specialty city-based rotations for rural trainees as required, inclusive of funding to support relocation costs, etc. The possibility of city-based positions being quarantined or 'preferenced' for rural rotations into metro centres could also be explored.

- Post-training metropolitan based hub and spoke models can provide support and attract specialists interested in working in rural and regional areas through 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.

- Promotion and demonstration of these models during training to provide opportunities to promote careers in rural and regional medicine and dispel stereotypes surrounding rural and regional medical careers.

Regional training networks

The AMA position statement on Regional Training Networks – 2014 provides a blueprint to improve medical workforce maldistribution by enhancing specialist and generalist training opportunities, and supporting prevocational and vocational trainees to live and work, in regional, rural and remote areas.

The model encourages the establishment of networks to support specialist training pathways in rural and regional areas, the creation of new or transfer of existing accredited training posts to rural areas and building on existing 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.

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.

Flexible entry and exit points must also be a key feature of RTNs, in order to minimise barriers for trainees to transition between training in these networks and other settings and avoid stigma surrounding inflexible rural training pathways.