

# College commitment to medical workforce provision

## POSITION STATEMENT



### College programs are ultimately dedicated to workforce outcomes

All College undertakings across education, training, research, and professional advocacy are ultimately dedicated to achieving the outcome of a sufficient, motivated and appropriately skilled workforce to deliver safe, quality care which meets the needs of rural and remote communities.

Underpinning all College endeavours is the contention that medical practice should reflect the best possible service model to meet community needs. For the ACRRM, communities in rural and remote locations and particularly those of high needs sub-groups such as rural and remote Aboriginal and Torres Strait Islander people are of priority interest.

### Workforce outcomes must be a key focus for Rural and Remote Medicine

Logically, workforce considerations should be implicit to all efforts toward quality service provision and they are of heightened importance in the rural and remote context.

There is a clear national imperative to do more to bring access to healthcare for rural and remote Australians to an equitable standard. Currently people in rural and remote communities compared to their urban counterparts: have lower health status,<sup>1</sup> use medical services less and receive far less per capita government health funding<sup>2</sup> and this occurs despite the fact that rurally-based general practitioners are working much longer hours than urban equivalents.<sup>3</sup>

Aboriginal and Torres Strait Islander people have a health status which is alarmingly low relative to the general population and a disproportionate number of these people live in rural and remote Australia. These communities warrant a particularly high level of health service attention.

A defining characteristic of rurality / remoteness from a medical service perspective is that if a doctor is unavailable within the locality, practical barriers to accessing medical care become substantive and in emergencies potentially life-threatening. This situation is exacerbated by a second defining feature, namely that there are virtually no medical specialists in rural and remote Australia, nor is there the wide breadth of allied health specialists, facilities and resources available in cities.

Relative to the urban context therefore rural and remote communities' access to quality care is far more sensitive and vulnerable to small changes in the supply of doctors.

On the other hand, in the rural community context an individual generalist doctor is able to make a substantive positive impact on their communities' access to services, when they are willing and able to assume wider responsibility and provide a broader and more advanced scope services to meet their communities needs.

### Workforce outcomes are integral to quality service provision

There is a complex relationship between the twin goals of producing quality medical practitioners and of providing a number sufficient to meet needs.

The College does not uphold the view that setting low qualification standards is a commendable nor effective mechanism for increasing rural workforce numbers. On the contrary as well as lowering the standard of rural care and potentially endangering people in rural communities; from a workforce perspective this is likely to lead to high rural doctor attrition and to lowering the reputation and esteem of the rural doctor profession as whole.

Just as it is strategically counterproductive to pursue quality goals without consideration of workforce imperatives, it is equally flawed to pursue workforce goals without considering the qualitative aspects of the medical professionals that are being produced.

The College supports all positive efforts to increase the number of doctors in rural areas but believes that these efforts in isolation will never deliver equitable health access to rural communities. This will only be possible when these efforts are coupled with a framework to produce (at least some) rural doctors with the special skill set, motivation and confidence to deliver services locally which can provide equivalence to city-based service within the limitations of the resources and geography of the rural community.

To achieve this requires doctors with commitment and competence to work in community-responsive models of delivery. For example, through local general practitioners: providing hospital-based emergency care and basic procedural services; coordinating care models involving teleconsulting and visits from urban specialist consultants; assuming responsibility for community health issues and advocacy; and, working cooperatively with nurse practitioners, aboriginal health workers and other local health service providers. The Rural Generalist model has been developed to describe such a practitioner.

Quality thus will be achieved through grooming the doctors most capable and willing to provide the services needed in rural and remote communities; ensuring their professional standards, training and continuing professional development experience are in alignment with providing these services; and ensuring that these models of care are supported in the wider health services framework.

## The right approach to attaining a sustainable, high-quality rural and remote medical workforce

The appropriate approach requires the following elements:

### 1. Training the right people

Appropriate selection to vocational training (as in medical schools) should identify the people likely to become competent, confident long-term rural doctors. There is little evidence to support the contention that academic credentials (usually based on urban based training) are a valid gauge of registrars' propensity to thrive as rural doctors. They give no measure of candidates' likelihood to pursue rural practice, nor preparedness/ capacity to provide high-responsibility, extended care where necessary. An appropriate model should include the following:

- Eligible candidates meeting an acceptable minimum academic standard.
- Eligible candidates being able to demonstrate an interest in the health of rural and Aboriginal and Torres Strait Islander health through their personal history.
- Personal qualities associative with success as rural doctors should be assessed and factored into the selection process. For example, it has long been the position of the College now supported by considerable evidence that the personality traits of adventurousness and self-reliance are significantly predictive of a rural medical career and importantly, predictive of producing doctors who have the disposition to thrive and provide high level skills in the areas of the greatest workforce need.<sup>4,5,6,7</sup>

- Preference being given to candidates with a rural background (as this is highly predictive of rural practice careers).<sup>8</sup>
- Selection eligibility should be from as early as possible after medical school graduation but open to interested medical graduates at all experience levels.

### 2. Teaching the right skills

It is important to ensure that general practice training provides doctors with the professional mobility to practice anywhere. From the perspective of attaining rural workforce outcomes it is of equal importance that training and professional development provides the competencies and confidence to be able to provide the breadth and depth of services associated with meeting the needs of rural and remote communities.

There needs to be a core of doctors in rural and remote communities who do not just provide minimum level general practice services but have as core competencies, a certified broad and advanced scope of practice which can fill the service gaps within their community. These doctors not only need the requisite skills, but the professional motivation, clinical courage and resourcefulness to enable them to adjust their scope of practice in response to the needs and the circumstances of their community.

### 3. Providing the right teaching experience

The right learning experience has several key elements:

- The appropriate training experience should be vertically integrated along the medical school, junior doctor, vocational training, fellowship and professional development continuum and this pipeline should be open to newcomers at all professional stages.
- Training along the pipeline should be undertaken as much as possible in rural, remote and at least regional locations. Training undertaken in rural locations needs to be complemented with appropriate education delivery models.
- All educators in the training pipeline should understand, value, and promote the distinctions and challenges of rural practice. It is particularly important that such educators are in contact with trainees at all stages of learning especially during periods in urban training settings.
- Training is well supported through a collegial peer-network as well as a professional community who share in their value for, and commitment to rural practice.



#### 4. Ensuring learning leads to the right job

Training for the best practice (Rural Generalist) model of care needs to lead to opportunities for employment and work in this model of care. Health services need to recognise the skill set and provide employment, remuneration, credentialing and health resource provision to facilitate the practice.

#### 5. Continuously redefining rural medical generalist best practice

The distinct circumstances of rural and remote practice will be best served by models which are developed around these distinctions. Furthermore, education, training and standards programs need to reflect these best practice models.

There is a growing body of evidence to support the effectiveness of rurally-adapted medical delivery models.

Ideally, these models should be evidence-based drawing on the experience of doctors in the field in rural and remote communities across Australia as well as internationally. The College strongly supports further development of these models.

There is an ongoing imperative to continuously explore, evaluate and redefine the best practice models for optimal provision of care by generalist doctors in rural and remote communities.

#### Find out more

If you have any queries relating to this Position Statement, please contact us by:

**Email:** [policy@acrrm.org.au](mailto:policy@acrrm.org.au)

**Phone:** 1800 223 226

**Website:** [mycollege.acrrm.org.au / contact-us](http://mycollege.acrrm.org.au/contact-us)

#### Endnotes

- 1 AIHW. Australia's Health 2014 Australia's health series no. 14. Cat. no. AUS 178. Canberra: 2014.
- 2 AIHW. *Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure*. Health and welfare expenditure series no. 50. Cat. no. HWE 50. Canberra: 2011.
- 3 AIHW. Medical Workforce 2012. National Health Workforce Series No. 8. Cat. No. HWL 54. Canberra: 2014. (S.5.1)
- 4 Eley D, Walters L, Laurence C, Elliot T, Cloninger R. *Congruence of personality trends by strength of intention and eventual choice*. Annual Convention of the American Psychological Association, Washington DC USA: 2014.
- 5 Eley D, Young L, Przybeck T. *Exploring the Temperament and Character Traits of Rural and Urban Doctors*. Journal of Rural Health. 25(1):43-39. Winter 2009.
- 6 Eley D, Young L, Przybeck T. *Exploring temperament and character traits in medical students; a new approach to increase the rural workforce*. Medical Teacher, 31(3), e79-e84: 2009.
- 7 Eley D, Cloninger C, Walters L, Laurence C, Synnott R, Wilkinson D. *The relationship between resilience and personality traits in doctors: implications for enhancing well being*. PeerJ, 1:e216: 2013.
- 8 AHMAC *Career Decision Making by Postgraduate Doctors: Key Findings*. 2005. (Pg.3)



**ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live, and pay respect to their Elders past present and future.**

