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Australia New Zealand Society of Palliative Medicine

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Re. RACP Regional Rural and Remote Physician Strategy

The Australian and New Zealand Society of Palliative Medicine (ANZSPM) welcomes this opportunity to provide comment on the above Position Statement.

ANZSPM welcomes RACP's commitment to develop a Regional, Rural and Remote Physician Strategy as a roadmap for the RACP to challenge the inequitable status quo and to reverse what is perceived as an outdated and culturally traditional metrocentric model of physician training and employment. ANZSPM shares RACP's concern to establish a blueprint to a more inclusive and well-rounded system of training and mechanisms for growing and supporting current and future physicians in all communities.

General Comments

The College will need to consider how best to collaboratively work with other stakeholders in physician training (recommendation 17 lends some optimism to this happening). This includes active consideration of how the RACP will use the credentials and qualifications of 'non-physicians' and accept that these people have a role to play in physician training in regional, rural and remote areas. As the draft Strategy acknowledges, regional, rural and remote practice is inherently multi-disciplinary and rural generalists play a major role in bridging the specialist care gap. If we are to bridge the RRR gaps in physician training in the next 20 years, with training that specifically addresses the needs and circumstances of medical professionals living outside of the cities and their patients, then we need to involve the people who are provided that care now. There simply aren't sufficient physicians in rural locations to expand rural training with any speed.

We note the tone of frustration / surprise in the report around the push-back against mandatory rural experience. Although well-meaning, such proposals can have significant unintended negative consequences, and many small RRR services will continue to be reluctant to take on trainees who are not voluntarily joining their team, at the expense of those who may be genuinely interested. ANZSPM members warn that it will be some time before mandatory rural experience could be required of trainees – the strategy needs to gain momentum and rural health professional pathways need to be much more firmly established before mandatory terms in rural areas would be

considered acceptable and equitable for all trainees. At this point in time, mandatory rural placement will create more barriers to training than benefits (although there would be some gains made).

As an alternative, ANZSPM members strongly encourage the development of rural training networks as a means to both take a multidisciplinary approach to training and to overcome current barriers created by the small number of services well enough staffed to take up trainee supervision. By illustration, in reasonably sized regional towns (MM4; NZ Medium Urban Area) , a palliative medicine service will not be sufficient to provide supervision for a full-time trainee, but if it were part of a 'network' and the LHD agreed to sponsor a trainee position (with accommodation) then trainees could rotate from the nearest large medical precinct to the township for 2-3 week blocks of time. A Network approach could overcome the barrier of isolation, and indeed informal networks have formed over time to meet this need and so there is a basis from which to start. We draw your attention to the proposal recently submitted by RACP on ANZSPM's initiation for government funding of the establishment of a rural and remote palliative care training network as a pilot that could inform the development of robust training networks in other specialties.

ANZSPM has also been advocating the importance of measuring the outcomes of any rural training programs for some time. When it comes to increasing the rural palliative medicine workforce, supporting rural palliative medicine training is only half the story. We also need to help rural palliative care services recruit and retain palliative medicine specialists.

Collecting data on rural palliative medicine training and following up rural palliative medicine trainees to better understand how their careers develop will help us to improve the recruitment and retention of palliative medicine specialists in rural and remote areas. We welcome RACP's focus on the collection of data on rural palliative medicine training and urge RACP to include repeated surveying of rural palliative medicine trainees to explore their career progression. This will provide important insights into how to attract and retain these important skills in regional, rural and remote locations over the longer term.

The expanded use of telehealth to support training is also important, and likely deserving of its own strategy. Telehealth as a support to training and to health care delivery (rather than a replacement for local training and placements, and local health service delivery) will become increasingly important.

Questions for consideration

1. What do you think are the key barriers and enablers to achieving equitable health outcomes for RRR communities?

ANZSPM is confident that the RACP has utilized its access to the literature from the last 20 years that outlines the complex and many-faceted answers to this question well.

2. Are there any aspects or recommendations in the draft Strategy that present an opportunity for the RACP to collaborate with your organisation or that raise concerns?

ANZSPM urges the RACP to prioritise the following actions in finalizing its Strategy:

1. Establish rural training networks to increase the number of health services that can participate in physician training and the quality and enhance the lived experience of regional, rural and remote training pathways. Continue to help us to advocate for funding for establishing of a pilot network focussing on the Palliative Medicine Specialty.

2. Establish a 'competency based' training framework rather than a rigid 'type-of-service' modular framework. This would be the one major change which would significantly increase capacity to provide substantial training in palliative care in rural locations.

3. Ensure that rural trainees also have the opportunity to be placed for a time in large tertiary centres. There are vitally important learnings about the health system generally, health inequity and service delivery that can really only be learned by time in a large tertiary centre. So, even with a push to increase rural training and 'rurally-based' trainees, there is an important role for training secondments of 'rural registrars' into large urban centres for 6 – 12 months.

3. Do you have an RRR strategy that you would be prepared to share with us?

ANZSPM has established a Rural and Remote Special Interest Group which has been a very effective vehicle with which to inform health strategy and policy and ANZSPM's own Strategic Plan. It has been able to provide clear input into ANZSPM at a very senior level with good effect. Therefore, the establishment of rural and remote interest groups, and a committee structure to provide formal advice at a high level within the organization is recommended as a particularly effective part of RACP's way forward in this area.

We trust this advice is helpful to you. Please reach out to our Chief Executive Officer, Janice Besch (ceo@anzspm.org.au) if you would like to discuss points raised and she will put you in touch with either myself or another expert member.

Yours sincerely,

Dr Christine Mott
President ANZSPM