Royal Australasian College of Surgeons

Retain for Rural

Rural Health Equity Strategy
April 2021

Executive summary

A Fellowship of RACS stands for quality in surgical care; but quality cannot be truly present unless equity is accepted as an integral component.[1]

Building on the Select for Rural and Train for Rural Strategies, the Rural Surgery Section committee now turns to the retention of surgeons in rural and remote practice. The Rural Surgery Section Committee is focused on patient-centred surgical care and a sustainable surgical workforce in remote, rural and regional Australia and New Zealand.

The Strategy is evidence based and addresses the World Health Organisation WHO Increasing access to health workers in remote and rural areas through improved retention: Global Policy Recommendations. The strategy draws on the experiences and suggestions of rural FRACS and SIMG surgeons. The Strategy provides pragmatic actions to meet the rural surgical goals of the RACS Strategic Plan, Policies and Position Papers and the Surgical Competence and Performance Guide. The Strategy meets the Australian Federal Government's National Medical Workforce Strategy goals of equity and correction of health workforce maldistribution.

The Retain for Rural Strategy proposed actions are presented in three parts: The Rural Surgeon, Specialist International Medical Graduates and Surgical Services. The strategy addresses the WHO domains of Education, Personal and Professional Support, Infrastructure and Surgical Systems.

Specialist International Medical Graduate surgeons continue to make enormous and valued contributions to caring for rural people. Surgery is a team sport and retention of surgeons cannot be considered in isolation. Surgeons work within surgical teams and within larger surgical services. Sustainability can be applied to the safety and professional satisfaction and work-life integration of individual surgeons, the support of and reliance on an internationally trained rural workforce and the viability of whole surgical units, surgical services and networks of surgical care.

THE STRATEGY PROPOSES

1. **Surgeons**
    a. Development of Global, Remote/Rural/Regional and Deployable GRiD faculty within RACS (see Train for Rural Strategy)
    b. Write Technology as a Tool for Inclusion Position Paper
    c. Collaborate with regulators to recognise and protect enhanced/broad scopes of practice for rural surgeons
    d. Advocate with jurisdictions for financially sustainable models of remuneration for rural surgeons
    e. Continue to advocate for portability of entitlements for SET trainees and FRACS surgeons in public practice
    f. Development of a rural surgical hub on the RACS website
    g. Collaborate with RACMA and jurisdictions to develop a mediator model between rural surgeons and hospital administrators
    h. Advocate for safe hours contracts for rural surgeons, with the onus on hospitals to devise protocols for task substitution, transfer or locums and service level responsibility for safe rostering.
    i. Foster a pro-rural culture within RACS

2. **Specialist international medical graduate (SIMG) surgeons:**
    a. Optimise specialist pathway application and assessment processes,
    b. Optimise exam attainment and connection with peers, with a process for notifying relevant societies of successful SIMG application and pathway to specialist practice and development an SIMG "welcome pack" for each society.

c. Prioritise SIMG applications for areas of need and collaborate with specialty societies and jurisdictions on models of care to allow for interim services and supervisory models that contribute to long term retention.

3. **Surgical services:**
    a. Advocate for infrastructure and funding for rural surgical services
    b. Foster a culture of collective responsibility for rural health equity and
    c. Foster a culture of supportive peer relationships across distances, aligned with referral and transfer pathways, with reciprocal responsibility

1 Background

ALIGNMENT WITH RACS STRATEGIC PLAN

Rural retention initiatives are consistent with the RACS Strategic Plan, Code of Conduct, Diversity and Inclusion Plan and position papers (Equity of access to surgical care, Rural surgery).[2]

The Rural Surgery Section Committee's objectives are [3]

a. to ensure the provision of quality surgical care to the populations of regional, rural and remote areas of Australia and New Zealand

c. to advise and assist RACS with workforce issues relating to the provision of surgical services including recruitment, retention, training and support for surgeons working in regional, rural and remote Australia and New Zealand

POLICY CONSIDERATIONS

These recommendations are consistent with the World Health Organization Increasing Access to Health Workers in Remote and Rural Areas through Improved Retention: Global Policy Recommendations, especially recommendations A5, B1, B3, C, D2, D3. [4]

These recommendations are consistent with the Australian Medical Association position papers:

- Rural Training Pathways for Specialists [5]
- Better Healthcare for Regional, Rural and Remote Australia [6]
- Regional Training Networks.[7]

2 Recommendations - Surgeons

The recommendations are evidence based and consistent with external reputable entities (listed above). The recommendations provide pragmatic actions to meet the rural surgical goals of the RACS Strategic Plan, policies and position papers and the *Surgical Competence and Performance Guide*.

EDUCATION

WHO Recommendation A5 - *Design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention.*

Global Remote/Rural/Regional and Deployable (GRiD) Surgery

- Establish the GRiD Faculty: Alongside the SET rural curriculum and GRiD dual fellowship curriculum, GRiD surgeons will have opportunities to join the faculty as members, mentors, teachers, supervisors, trainers.
- Establish a GRiD section at the RACS Annual Scientific Conference

- Curate GRiD Library resources with a link from library home page and TOC alerts.

Continuing Professional Development (CPD):

- Technology as a tool for inclusion. Develop a RACS policy of remote by default for all meetings and CPD events and, where an in-person component is necessary, a hybrid approach to allow remote access (e.g., a synchronous parallel online stream/webcast). The One College digital transformation project and then the COVID-19 crisis accelerated a whole of College transition to video meetings and online CPD, registrar tutorials, meetings, and selection. This has been of benefit for rural and remote surgeons, has saved time and costs of travel for individuals. The CPD working group plan to convene focus groups of Rural Surgery Section members to further develop CPD resources.
- A review of current CPD content offerings and develop new offerings in line with GRiD curriculum
- Adequate internet in rural and remote areas is essential for rural surgeon participation. We will continue to advocate for internet access as an essential service for rural and remote communities.

REGULATION

WHO Recommendation B1 - *Introduce and regulate enhanced scopes of practice in rural or remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention.*

Within RACS:

1. Develop GRiD dual fellowship PFET qualification
2. Existing RACS policies papers on Equity of Access to Surgical Care, Surgical Generalism and Remote, Rural and Regional Surgery

External:

Collaborate with medical and specialist registration bodies (AHPRA, AMC and NZMC), Governments (capability frameworks) and hospitals, jurisdictions and Royal Australasian College of Medical Administrators RACMA for hospital credentialling/scope of practice for broad or extended scope of practice.

FINANCIAL SUSTAINABILITY

WHO Recommendation C - *Use a combination of fiscally sustainable financial incentives (such as hardship allowances, grants for housing, free transportation, paid vacations etc.) sufficient enough to outweigh the opportunity costs associated with working in rural areas (as perceived by health workers) to improve rural retention.*

Rural surgeons are disproportionately exposed to financial risk and other natural disasters, and elective surgery cessation with ongoing private practice costs. Advocating for financially sustainable models of remuneration for rural surgeons will help ameliorate these conditions.

- Packages for salaried surgeons should be competitive/comparable to urban salaries plus incentives/allowances based on distance, isolation and increased costs of travel for CPD.
- Packages for VMO fee-for-service surgeons (predominantly Australian context) should be examined for new models where financial risk is more equitably shared between health service and surgeon. This is so it protects surgeons against total loss of operating income during elective surgery cessation, with ongoing private rooms costs (in some states there are no public outpatient clinics outside urban centres; all care is provided in private practice room), due to budgetary constraints, natural disasters (like the 2019-20 Australian bushfires) and pandemic (COVID-19).
- A minimal service level/floor payment or financial compensation for surgeons that acknowledges their financial risk, could be introduced for these circumstances. The same incentives provided to rural general practitioners and practices should be expanded to rural specialist practices (initiatives such as practice incentive payments, support for practice nurses, higher Medicare rebates).

- In Australia, we should collaborate with other bodies (AMA, state and territory departments of health) on award arrangements/VMO contracts. We should explore options to collaborate with the Association of Salaried Medical Specialists (ASMS) in New Zealand.

We must continue to advocate for the portability of entitlements for SET Trainees and GRiD Fellowship surgeons who cross state borders to undertake training and dual appointments or coordination/pooling of entitlements for surgeons in border towns.

Continual support and promotion of rural Fellowship programs and grants is essential. This could be delivered by:

- Compile a list of financial grants/scholarships/incentives for rural surgeons in each county and include a link in each RSS newsletter and on Rural Surgery Section Online information hub (more details below). Currently available grants include the Support for Rural Specialists CPD grants and Australian Federal Government rural health practitioner rural financial incentive scheme (paid annually based on years of service). Similar incentives available in New Zealand need to be explored.
- RACS must continue to fund the Provincial Surgeons Fellowships annually. It is awarded by the Rural Surgery Section Committee for rural surgeon CPD travel and accommodation. Under current COVID-19 circumstances (travel restrictions), we should consider changing the policy to allow for funds to be used in other ways to support CPD.

PERSONAL AND PROFESSIONAL SUPPORT

RACS Rural Surgery Section Online Information Hub

A longitudinal relationship with the Rural Surgery Section at RACS, from medical school through to retirement, is facilitated by RACS' relationships with rural medical schools (surgical and rural societies), prevocational doctors, SET training (via the Rural Career Coordinator) and GRiD faculty. A vibrant and relevant RACS Rural Surgery Section Online Information Hub on the RACS website would capture all these points of engagement. The online information hub would collate resources and links to CPD, networking, mentoring, social, employment and outreach opportunities.

Hospital administration (The elephant in the room)

Effective relationships between hospital administrators and clinicians are crucial for long term retention. The consequences of unresolved disputes can be devastating for patient access to care and for employment opportunities for surgeons and all other members of the wider surgical team. If a surgeon leaves employment at a rural facility, there are no other local options for employment and the community loses a surgeon in relocation and sometimes the whole surgical service. To manage this risk, an independent mediator could be engaged (with skills relevant to working with RACMA medical administrators, jurisdictional administrators, and surgeons) to resolve disputes effectively without loss of access to care for patients. RACS could work with RACMA, medical professional/industrial organisations and governments to develop access to this service.

Safe working environment

Work-life balance, flexible work and effective boundaries must be safeguarded. These conditions are highlighted in the RACS safe hours paper. We should consider advocating with AMA for safe hours contracts for rural staff specialists and VMOs, putting the onus on hospitals to devise protocols for task substitution or transfer or locums with service level responsibility for safe rostering. This will ensure there is cultural change to protect surgeon wellbeing and patient safety.

Career transitions in place

The older surgeon transitioning to non-procedural practice or retirement could consider roles with rural medical students, skills courses, audit, peer review, practice visits, medical administration or surgical services, mentoring, evaluation of programs, re-accreditation, assisting with reflective practice of proceduralists, or a coaching role for early career specialists. Funding these positions should be consider as the current fee-for-service model does not allow for this.

Recognition

A culture exists within the surgical profession, and passed onto trainees, that rural surgery is second best. Successful rural surgeons need a broader scope of practice and more, not less, skills to achieve equivalent patient outcomes with fewer resources and context specific challenges. We need to cultivate a pro-rural culture. Peer relationships, rural training opportunities, and movement of surgeons between urban and rural worksites helps to increase understanding and mutual respect and recognition of the unique skills and contexts of both rural and urban surgeons. We need to call out anti-rural cultures and behaviours at RACS.

Publicly recognising the work of rural surgeons can continue via the RACS RSS Rural Surgeon Awards and through RACS media and publications (articles promoting rural surgery in Surgical News, RACS Post Op podcast, RSS Chair involvement in RACS webinars). University medical school rural surgical clubs and National Rural Doctor Associations produce media to promote rural surgical careers and RACS rural surgeons have featured in these videos and podcasts.

SPECIALIST INTERNATIONAL MEDICAL GRADUATE (SIMG) SURGEONS

WHO Recommendation B3 - *Ensure compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives so as to increase recruitment and subsequent retention of health professionals in those areas.*

Specialist International Medical Graduate Surgeons are an essential, welcome and valued part of rural surgical care, who arrive with limited local knowledge and peer networks. We need to set them up for success in patient care and professional and personal life.

The strategy proposes:

1. The SIMG committee continue to work to optimise specialist pathway application and assessment processes

2. The SIMG Committee consider prioritising SIMG applications for those applicants who have already accepted offers of employment in rural areas of need and collaborate with specialty societies and jurisdictions on models of care to allow for interim services and supervisory models that contribute to long term retention. The Retain for Rural strategy aims to foster a culture of patient-focused rural surgical care, where community need for surgical care is our first priority, so that if a region of Australia or New Zealand has sponsored an SIMG, who does not satisfy the SIMG assessment, the College could work with stakeholders to develop an alternative to provide surgical services to the area of need. The recent successful partnership between the Australian Society of Plastic and Reconstructive Surgery and Royal Darwin Hospital, in delivering an interim model of care while allowing an appointed SIMG to achieve their specialist pathway requirements in another setting before taking up their post long term in Darwin sets a great precedent of collaboration for Rural Health Equity.

3. The SIMG Committee develop an efficient process for notifying the relevant surgical society or association of an SIMG surgeon's successful application. This could facilitate an SIMG colleagues' connection with local professional networks and provide the best environment for them to succeed in the Fellowship Examination, if this is required. We suggest the provision of a "Welcome Pack" from each society that could contain:
    a. Application for associate membership of the society, where this is allowed in each society's constitution
    b. Information on how to access
        i. Speciality specific clinical information, for example clinical guidelines, treatment and referral protocols
        ii. Continuing professional development (or maintenance of professional skills) opportunities including scientific meetings and state section meetings
        iii. Examination preparation activities including registrar education/tutorials and registrar conferences, examination preparation resources, courses and practice examinations

c. Offer of connection with mentors and peers to enable development of a professional network and supportive peer relationships in addition to their primary work location. This could include contact details of state speciality committee members and other willing FRACS and SIMG peers, plus the state RACSTA representative, if the SIMG is required to sit the Fellowship examination.
d. Links to RACS policy and position papers and online CPD activities relevant to rural surgery, for example, Safe Hours Policy, Aboriginal and Torres Strait Islander Health Course.

3 Surgical services

INFRASTRUCTURE

WHO Recommendation D2 - *Provide a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make these posts professionally attractive, and thereby increase the recruitment and retention of health workers in remote and rural areas.*

Infrastructure and equipment in rural settings need to be bolstered. This is supportive of AMA position papers on rural health infrastructure.

SURGICAL TEAMS

WHO recommendation D3 - *Identify and implement appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas, and, where feasible, use telehealth to provide additional support to health workers in remote and rural areas.*

We must recognise that surgeons can only achieve patient outcomes as part of a surgical team, including the patient. We should continue to develop RACS relationships with other professional bodies involved in surgery and continue interdisciplinary training opportunities like the Safer Surgical Teamwork course and Definitive Surgical Trauma course. Expanding or redesigning other courses to include nurses, anaesthetists, and surgeons should be considered.

SURGICAL NETWORKS

Supportive professional relationships are essential to career success, surgeon wellbeing and patient care. Collaborative peer relationships across distance are necessary for effective rural surgical services and surgeon retention. Relationships between remote, rural, regional and urban surgical services require systems and cultures to support them. The goal is for effective local multidisciplinary teams with links with accountable larger centres, with bidirectional support and obligation.

CULTURE AND PEER RELATIONSHIPS

Surgical peer networks, local and distant, can be developed informally during training and more formally through connection of mentors via the Rural Career Coordinator Program (see 'Train for Rural' strategy). Networks can be maintained and renewed through connection to speciality society, the Rural Surgery Section and RACS events, including the new GRiD faculty. These relationships can be supported by a pro-rural culture at RACS, with promotion of positive depictions of rural surgery and calling out anti-rural behaviour. Rural focused urban surgeons (RuFUS) are essential to promoting a pro-rural culture.

SYSTEMS

Clinical peer relationships aligned with referral and transfer pathways need to be developed intentionally. Robust relationships between facilities with reciprocal responsibility contribute to the quality and safety of care for patients and the professional development of surgeons. Actions that could demonstrate robust systems include:

- Systems of dual appointments and credentialing at rural and urban hospitals to allow bidirectional movement of surgeons

- Rural surgeons can participate in professional development, clinical governance and audit and multidisciplinary meetings at regional and urban centres and “swap” with an urban surgeon to allow skill renewal, CPD or leave cover
- RuFUS can participate in
    - Telehealth, teleradiology/allied health including secondary telehealth (surgeon to surgeon)
    - Regular outreach (including registrars) or locums to the same rural location for continuity of care and mentoring/coaching local surgical teams
    - Inreach and working with other sites of care in referral pathways to optimise care close to home and facilitate timely transfer when needed.
- Accountability of tertiary and quaternary hospitals. These institutions should be responsible and accountable for supporting remote/rural/regional surgeons in a designated area
- Clearly defined referral and transfer protocols and pathways within regions, enabling rural people to get care in the right place at the right time.

Appendices

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