



Royal Australasian

College of Surgeons

Collaborate 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, Train for Rural and Retain for Rural Strategies, the Rural Surgery Section committee now turns to collaboration outside the Royal Australasian College of Surgeons. The goal is to improve health outcomes for rural people. 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 Collaborate for Rural Strategy proposed actions are presented in four parts: a framework of National Surgical Systems, Remote Central and Northern Australia Surgical Services, New Zealand Rural Surgical Services and Collaboration with Rural Stakeholders, Regulators and Medical Administrators.

The strategy addresses the WHO domains of Education, Personal and Professional Support, Infrastructure and Surgical Systems and the recommendations:

B2 - Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practising in rural and remote areas.

B3 - Introduce and regulate enhanced scopes of practice in rural or remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention.

THE STRATEGY PROPOSES

1. RACS adopts the proposed framework for National Surgical Systems
2. In Australia:
 - a. RACS convenes a forum to develop a strategy for Remote Central and Northern Surgical services (RCANS). Selection, training, scholarships and return of service obligations could be surfaced during this process (refer to the 'Train for Rural' strategy, section 4.3)
 - b. RACS convenes a meeting with the Royal Australian College of General Practitioners Rural, Australian College of Rural and Remote Medicine and nursing stakeholders to develop systems for interdisciplinary training in surgical skills including general practitioners with extended scope of practice in surgery.
3. In New Zealand:
 - a. Rural Surgery Section committee forms a New Zealand subcommittee (comprising four New Zealand members, RACS NZ councillors and representatives from NZ National Board).
 - b. RACS convenes a New Zealand Rural Surgical Services Forum in September 2021.
4. RACS commences collaboration with:
 - a. Other surgical team stakeholders via Council of Presidents of Medical Colleges to encourage development of rural health equity programs in all specialist medical colleges and via the National Rural Health Alliance.
 - b. Regulators to enable fit for purpose scopes of practice for rural surgeons, Royal Australasian College of Medical Administrators, Australian Medical Council, Australian Health Practitioner Regulatory Agency and Medical Council of New Zealand.

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

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.

PROPOSED NATIONAL SURGICAL SYSTEMS

WHO Recommendation B2 - *Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practising in rural and remote areas.*

WHO Recommendation B3 - *Introduce and regulate enhanced scopes of practice in rural or remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention.*

To address rural health inequity, we need a patient-centred strategy for surgical care within Australia and New Zealand, with safe, quality care as close to home as possible, utilising local resources, interdisciplinary teams of providers and strong links between tiers of surgical care. Context is key; for rural and remote health, one size does not fit all. We need to normalise multiple effective models of surgical care incorporating safe hours rostering, interdisciplinary teams and task substitution or transfer when needed. People in rural areas need to have access to safe surgery as close to home as possible. The goal is a national system of team based surgical care, starting with patient and place rather than practitioner. This means care is provided by the practitioner closest to the patient with the appropriate skills. Care would be provided by interdisciplinary teams of surgical providers working within tiers of surgical complexity with robust relationships across tiers and place. Surgical practitioners will include nurses, general practitioners, and surgeons.

RACS and the speciality societies cannot achieve this alone. Many stakeholders are involved in the rural health space. All share a common goal of equity in health outcomes for rural people. All stakeholders

are acting in good faith. Effective local and regional models of service delivery and collaboration exist. Attempts at collaboration at a national level have occurred. The Australian Government created the office of National Rural Health Commissioner. There are multiple stakeholder intersections, for example between Federal and State Government Departments of Health, public hospital/District Health Boards and small business (e.g., rural general practices), between the states and territories and between health care disciplines. These intersections can be a source of conflict but also an opportunity for collaboration and innovation. Professional silos and the historically individualist nature of medical training can limit collaboration.

It is not possible or necessary to start with a blank page. We can make progress by considering two new paradigms to tackle the problem.

1. Collective patient centred decision making (Figure 1)
2. The National Rural Surgical Team: based on trust, teams, technology and resources (Figure 2)

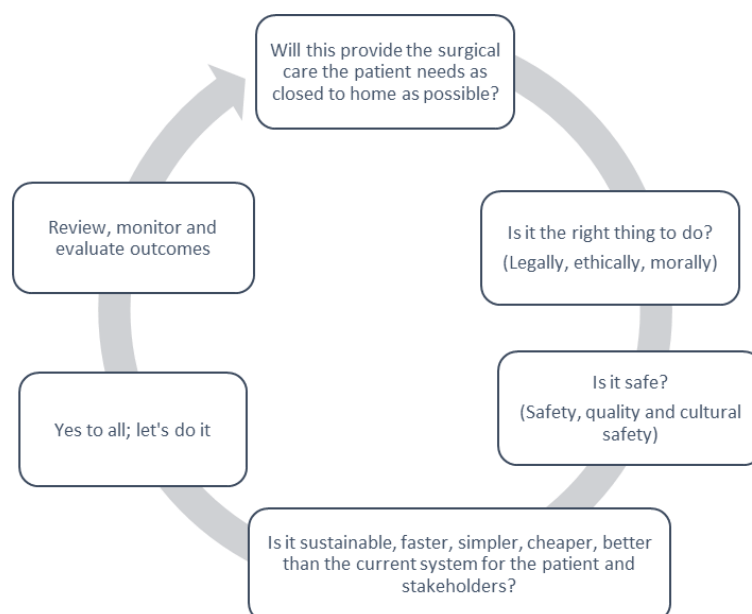
These paradigms emphasise a collective focus on the needs of the patient, a whole of system approach, communication, and collaboration, consolidating existing relationships and currently successful service delivery models and innovating to fill gaps. They provide a framework for us to seek answers to these questions:

- a) What do patients need?
- b) Who could be trained to provide this care and what resources do they need?
- c) How could we deliver this training, accredit practitioners, maintain their skills and provide supportive professional networks including CPD and peer reviewed audit?
- d) What resources do we already have that can be built upon?
- e) What models are already working well?
- f) Who else is involved in this space? Who can we collaborate with?

Adding a geographical Framework of tiers of surgical care:

- Remote
- Rural
- Regional
- Urban

Figure 1. Collective patient-centred decision making for RACS Rural Health Equity Strategy



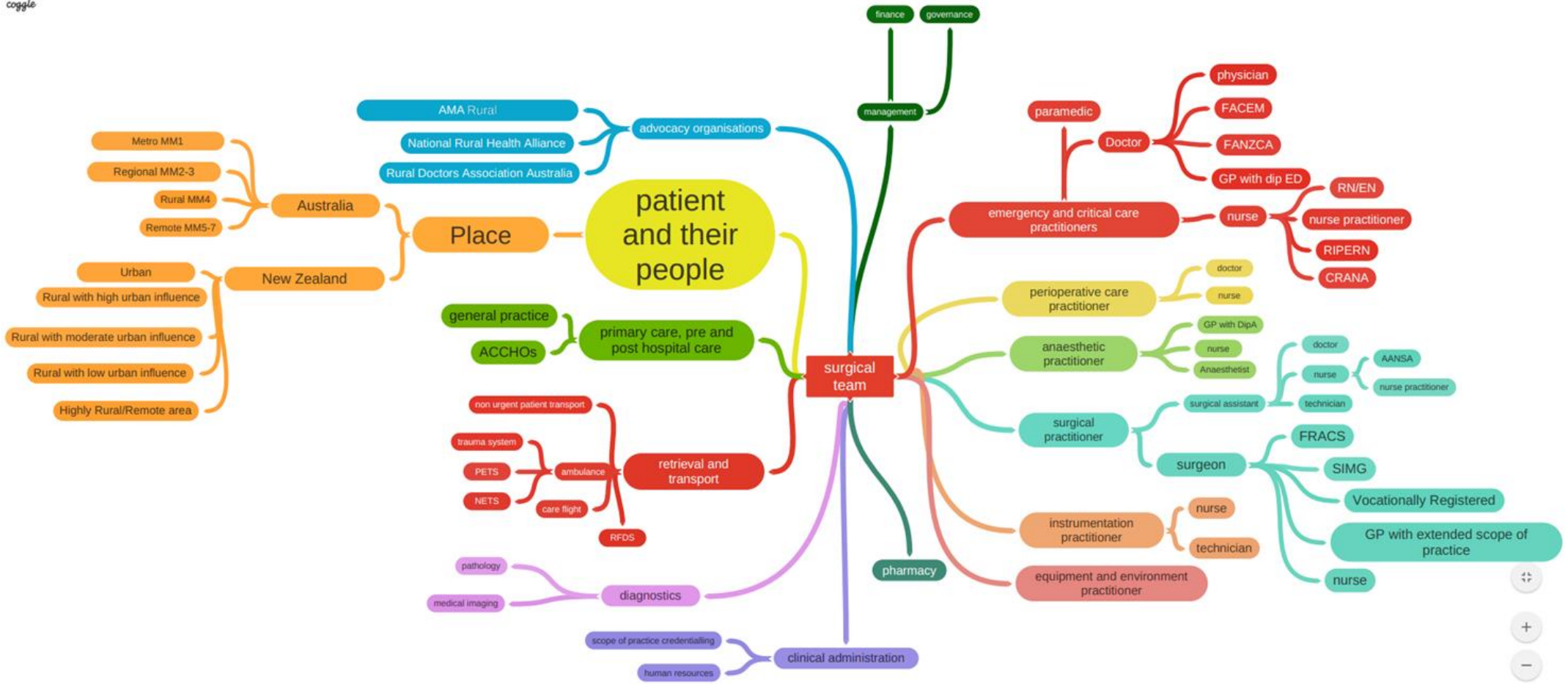


Figure 2. National Rural Surgical Team

A NATIONAL RURAL SURGICAL TEAM: TRUST AND TEAMS, TECHNOLOGY AND RESOURCES

Trust and teams

Diversity in the health workforce improves patient outcomes. Teams do better than individuals and diverse teams do better than homogenous teams. Apart from the protected elements of diversity in our society, we highlight particularly the diverse thinking, skills, knowledge, experience, and culture of the various stakeholder groups (including the patient and their community). At a national or whole of system level, we can leverage this diversity to learn from each other and engage in productive conflict to drive innovation in team based rural surgical care. For conflict to be productive, we require a common goal, trust, robustly respectful communication, and cultural safety.

At a patient health care team level, we can provide an environment for innovation, with a focus on outcomes and flexibility in processes. This may mean drawing on existing teams, reassigning roles or having pluripotent roles and providing training and CPD where needed. The aim is for team-based care rather than focusing on individual practitioners or practitioner type; that means, not just focusing on surgeons or general practitioners with extended skills, consider that nurses and other health workers will be capable, with training, of providing basic surgical care.

Healthcare teams are ideally placed for purpose driven innovation: they care, they are experts in understanding patient needs, making decisions in the best interests of their patients, working in diverse teams and with often constrained resources. Rural healthcare workers form professional communities of learning that are, by necessity, multi- and interdisciplinary. Effective teams become self-generating and self-retaining. Investing in existing effective teams is key. Over time, providing training in teams, rather than professional silos, will reinforce the effectiveness of team-based care. Examples include the RACS Safer Australian Surgical Teams, EMST and simulation (such as the rural obstetric emergency course). Interdisciplinary training, skills maintenance, supportive professional networks for peer support, interdisciplinary communities of learning, quality and safety activities can reinforce the effectiveness of rural surgical teams.

Alongside team-based care, we need to consider how we credential individuals, teams, sites and networks for surgical services, with regulations, funding and ensuring that credentialing is aligned with team-based care and patient outcomes rather than with individual practitioners. Once a team is in place, focus as much on retention of teams as on recruitment.

Technology and resources

Technology can unite across distances and decrease costs. We need to meet the patient where they are; that means using low-cost technological solutions operable from the patient's preferred device and with the patient's current access to phone/internet, while advocating for equitable access to communications (internet access as an essential service for all people in Australia and New Zealand). This may include geographically linked rebates for phone telehealth where video services are not supported on current internet capability, and using free video calling apps.

Rural surgical teams need a minimum level of infrastructure and recurrent funding to function. We support funding systems related to patient need and patient outcomes. Rural teams also accept the need to work within constrained resources. Reduce, reuse, recycle: reduce duplication and cooperate to share resources, use what we have, repurpose (including people!), upskill/multiskill, empower and educate patients, data as a resource, share existing data, divide the work, play to our strengths.

Recruitment of a surgeon to a location without a surgical team or resources is planned failure. We need to identify where services are required then plan to recruit teams and provide them with the resources and structures they need. We cannot recruit a surgeon to a location with no team, facilities or guaranteed income.

FRAMEWORK FOR NATIONAL SURGICAL SYSTEMS

What do patients need?

People in rural areas have all kinds of health problems and needs all kinds of health practitioners.

We can define the types of elective and emergency surgical procedures required for remote, regional, rural and urban sites of care. Existing resources include RACS essential surgical skills, RACGP and ACRRM extended skills in surgery curricula and nurse practitioner curricula.

Firstly, we need to determine the minimum surgical service level the location needs. This is based on

1. Engagement and consultation with local community and health care workers in each identified location to determine what is needed, what services already exists, what would be needed in terms of facilities, human resources or upskilling of current staff to provide the minimum determined level of surgical services.
2. Data around population and common problems and minimum population levels for sustainable service.

Secondly, we need to determine the human and non-human resources required locally and in communications and transfers/retrievals. Funding models including different models for different tiers where needed, team funding rather than funding tied to individual doctors, outcome-based, flexible on process, funding remote care based on patient need and access to infrastructure (e.g., telephone consultations, email/asynchronous telehealth, secondary telehealth: doctor to doctor to discuss patient care without patient having to travel). Connections including communications and retrieval/transport resources, transfer protocols in both directions, responsibility of each tier to support the other.

This process must not be restrictive: focus on outcomes, flexible in process. The intention is not to restrict or prohibit practitioners from performing procedures that are within their own scope of professional practice and within the facility's scope of practice. The intention is to provide as much care, safely and as close to home as possible, with adequate resources allocated based on community need with the goal of health equity. (Note the Australian States and Territories are undertaking a capability framework process.)

Who could be trained to provide this care and what resources do they need?

The surgical team is much more than the surgeon. Surgical care starts with primary care (doctors, nurses, ambulance, Aboriginal health workers) with diagnosis, triage, stabilisation then transfer (ambulance, RFDS, CareFlight) then several tiers of hospitals with doctors and nurses (see Figure 2). Equivalent New Zealand surgical teams need to be explored. Who could be trained to provide this care and what resources do they need? Or, who makes up the potential health care team for remote, rural and regional people? Table 1 expands on groups who can provide this care. RACS and RSS already has an existing relationship with them, some of which could be further developed.

Table 1. A list of groups who can be trained to provide patient-centred care.

DISCIPLINE	GROUP	EXISTING RSS/RACS RELATIONSHIP
Community health	First aid, pharmacy in a box (RFDS)	Community reps on RACS Council and committees.
First responders	Ambulance, RFDS, CareFlight, Community Emergency Response Team, Ambulance Community Officers, Country Fire Authority, Police, SES	Chair is connected to RFDS Director of Public Health and Research Dr Fergus Gardiner. Chair has met with CareFlight Medical Director.
Aboriginal and Māori health workers	<i>Are there other kinds of community health workers?</i>	RACS Indigenous Health Committee and its Māori and Māori Health Advisory Groups

Nurses	Registered nurses in hospitals including perioperative nurses, ED nurses, Practice nurses, Nurse practitioners, Remote area nurses, Rural and isolated practice endorsed registered nurses, organisations Australian Nursing and Midwifery Federation, Australian Association of Nurse Surgical Assistants (AASNA), CRANA.	RACS has contacts within AASNA
Medical Doctors	General practitioners with FRACGP or FACRRM and have extended skills ED physicians (FACEM), Anaesthetists (FANZCA), Medical administrators (FRACMA), Radiologists (FRANZCR), Pathologists (FRCPA) Surgeons specialising in all nine specialties. RSS, Indigenous Health, Global Health, Surgical Directors, STANZ Board of SET and Specialty Training Boards especially ANZ Boards in General Surgery, AOA FTC, NZOA, Education Board and Professional Development and Standards Board	RACS influence with its internal groups, and externally via CPMC
Technical staff	Biomedical, theatre technicians, supply and maintenance	
Allied health	Audiologists, physiotherapists, podiatrists, dietitians, speech therapists, and occupational therapists including hand therapists	
Clinical administrators	Medical administrators and RACMA Directors of Nursing CEOs in smaller facilities	
Pharmacists	Hospital Pharmacies Community/Private Pharmacies	

How could we deliver this training, accredit practitioners, maintain their skills and provide supportive professional network including CPD and peer reviewed audit? What resources do we already have that can be built upon? What models are already working well?

Building on the Select, Train and Retain for Rural strategies, RACS needs to broaden its focus to others in the surgical team and consider models of interdisciplinary training in surgical skills that will improve rural surgical care. RACS has engaged at a national level for other crises in public health including seat belts in road trauma, alcohol related harm and intimate partner violence. Rural Health Equity is an extension of RACS advocacy for improving the health outcomes of our communities.

RACS does not need to reinvent the wheel or devise a one size fits all, centralised, command and control solution. We do need to create a culture and framework to allow interdisciplinary teams to continue to work within or develop training and service delivery models matched to patient need and context. RACS needs to

- Focus on patient and place
- Focus on outcomes, flexible on process
- Focus on service needed, flexible on healthcare worker providing the service
- Work with other stakeholders: What do they need from RACS? How can we help? What frameworks already exist and how can we contribute?

- Learn from what is working in other specialties and within surgery: case studies
- Work with other specialties: ED, O&G, paediatrics, anaesthetics, physicians (palliative care, dialysis, diabetes, stroke)
- Work within surgery: ear health programs, trauma, burns, management of acute neurotrauma guide
- Develop a culture of equity, collectivism, and peer cooperation (not competition) within RACS

What resources do we already have that can be built upon? What can RACS offer?

- Leadership including position papers, Rural Health Equity Strategy
- Skills courses: Essential Surgical Skills (Recommended skills to be gained by the end of Post Graduate Year 2 prior to entry Surgical Education and Training (SET), Recommended Skills for General Practice Proceduralists, January 2015), JDOCS, EMST, SAST
- CPD and Audit, MALT, online CPD portal
- Peer networks

What models are already working well?

There are multiple precedents for speciality colleges training general practitioners in extended skills and for providing interdisciplinary education including Diplomates in FACEM, palliative care, O&G, anaesthetics from other specialty colleges, the EMST and SAST courses and team-based simulation skills maintenance in anaesthesia and obstetric emergencies. National systems of interdisciplinary care plans and pathways exist for disaster and epidemic, burns, trauma, cancer care, stroke network, cardiac, paediatric (neonatal hearing screening and referral, cleft palate prenatal screening and referral). Case studies of these interdisciplinary modes of care are in the appendices. They share common themes of:

- an identified need,
- development of multiple models of service delivery suited to patient and place,
- flexibility of discipline of healthcare worker delivering service,
- systems of interdisciplinary training with specialty colleges' provision of training to other disciplines, including through diplomates,
- coordination with reciprocity between stakeholders,
- systems of clinical governance,
- interaction with public health initiatives.

Who else is involved in this space? Who can we collaborate with? What services and resources are involved?

Community	Consumers Health Forum of Australia Rural Health Alliance
Community health services	General practices Community health centres Bush nursing centres Aboriginal Community Controlled Health Services Pharmacies First aid: St John Ambulance
Hospitals and day procedure centres	Emergency department Theatre including CSSD, biomedical, recovery Wards Radiology and pathology pharmacy
Patient transport	Emergency: retrieval RAS, MAS, RFDS Transport infrastructure: roads/rail/boat/plane Secondary patient transport services including ambulance, RFDS, non-urgent patient transport services
Communications	Telephone Internet

Money	<ul style="list-style-type: none"> Patient capacity to pay Publicly funded services Privately funded services Not for profits
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What Australian organisations are involved?

Australian Federal government	<ul style="list-style-type: none"> Minister for Health and Minister for Regional Health, Regional Communications and Local Government Department of Health (Chief Medical Officer, Rural Health Commissioner, MBS, PBS, Rural Health Multidisciplinary Training Program)
Australian State and Territory governments	<ul style="list-style-type: none"> Ministers for Health Departments of Health: Chief medical officer, public hospitals Ministers for Emergency services (Ambulance metropolitan and rural) Clinical networks (e.g., WA Country Health, QLD Rural and Remote)
Not for profit providers	<ul style="list-style-type: none"> Royal Flying Doctor Service (primary care, retrieval, transport) CareFlight (retrieval and transport)
Registration bodies	<ul style="list-style-type: none"> Australian Medical Council AHPRA Medical and nursing colleges
Universities and associated collaborations	<ul style="list-style-type: none"> Rural medical schools Rural training networks Spinifex network Federation of Rural Australian Medical Educators Deans of Medical Schools
Private Hospitals	
Health insurers	
Commercial entities	<ul style="list-style-type: none"> Telecommunication companies
Advocacy groups	<ul style="list-style-type: none"> Australian Indigenous Doctors Association National Rural Health Alliance AMA Rural Doctors Association of Australian and their state sections United General Practice Australia

The image features a minimalist, abstract design. On the left, a large, light gray semi-circle is partially visible. To its right, a vertical strip contains three overlapping, rounded rectangular shapes: a dark blue one at the top, a medium blue one in the middle, and another dark blue one at the bottom. On the far right, a light gray semi-circle is also partially visible, mirroring the one on the left. The word "Appendix" is centered within the light gray area on the left.

Appendix

Case studies of interdisciplinary systems of care

CASE STUDY 1: WHEREVER THERE ARE PEOPLE THERE WILL BE A NEED FOR EMERGENCY CARE.

The simplest concept of an equitable and sustainable system of care, is for emergency response. Paramedics, emergency physicians and nurses know that wherever there are people, there will be a need for emergency care. They know they cannot have emergency physicians, nurses and paramedics in all places at all times. There is a system of care, with flexibility in care provider suitable to patient and place and training to support each level. It starts with widely available training in first aid for community members. Then, first response and transport, starting with Community Emergency Response Teams (CERT), then increasingly complex stabilisation and transport systems including ambulance paramedics, Mobile Intensive Care Ambulance (MICA), adult retrieval service, RFDS, CareFlight etc.

The doctors and nurses providing emergency care include remote area nurses, Aboriginal health workers, rural and isolated practice endorsed registered nurses (RIPERN), ED nurses, FACEM, general practitioners with Emergency Medicine Diplomas. This emergency system articulates with specialised systems of care designed to improve outcomes from trauma, stroke, burns, complicated maternity care. Further, the Australian College of Emergency Medicine provides certificate, diploma and advanced diploma programs in emergency medicine, pre-hospital and retrieval medicine.⁸

CASE STUDY 2: WHEREVER THERE ARE PEOPLE THERE WILL BE A NEED FOR OBSTETRIC CARE.

There are multiple stakeholders involved in obstetric care: people (women, babies and their families), communities, Aboriginal health workers, nurses (midwives), doctors (GPs, obstetricians, anaesthetists, paediatricians, physicians), health services (primary care including Aboriginal Community Controlled Health Service, general practice, hospitals ranging from acute care bush hospitals through to quaternary with NICU), first response and transport services (including CERT, ambulance, RFDS/ CareFlight/ Newborn and paediatric Emergency Transport Service (NETS)).

Models of service delivery start with a midwife (home or hospital), with others available if needed and with flexibility of discipline. This is followed with care provided by:

- first response and primary transport services (CERT, ambulance)
- medical and nursing care
 - obstetric care can be provided by obstetrician or general practitioner with Diploma and Advanced Diploma of Obstetrics and, sometimes, general surgeon with training in caesarean section
 - nursing can be provided by ED (RIPERN etc), maternity ward, perioperative
 - anaesthetic care can be provided by anaesthetist or GP with anaesthesia training
 - paediatrician: paediatrician, GP with diploma in paediatrics, neonatologist

A system of protocols, communication and transport between services exists between

- interhospital transport services: RFDS, Care Flight, Ambulance, NETS
- tertiary hospital for higher risk pregnancies and quaternary hospital with NICU

A system of training is place. RANZCOG offers certificates in women's health and diploma and advanced diploma in obstetrics and gynaecology.⁹ A system of oversight and continuous improvement includes RANZCOG case note review booklet and perinatal mortality audit.

REFERENCES

- ¹ Royal Australasian College of Surgeons. Equity of access to surgical care [Internet]. 2017. Available from: https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/position-papers/2017-01-10_pos_rel-com-002_equity_of_access_to_surgical_care.pdf?rev=e2eb02fb242e4ce38a64c37ab2ed558d&hash=CE4C16358C5F809B8D3D75433BA76B59
- ² Royal Australasian College of Surgeons. Our values & constitution [Internet]. Available from: <https://www.surgeons.org/about-racs/about-the-college-of-surgeons/our-values-constitution>
- Royal Australasian College of Surgeons. Code of Conduct [Internet]. 2016. Available from: <https://www.surgeons.org/become-a-surgeon/about-specialist-surgeons/code-of-conduct>
- Royal Australasian College of Surgeons. Nine RACS competencies [Internet]. 2019. Available from: <https://www.surgeons.org/trainees/the-set-program/nine-racs-competencies>
- Royal Australasian College of Surgeons. Strategic Plan 2019-2021 [Internet]. 2019. Available from: <https://www.surgeons.org/resources/reports-guidelines-publications/strategic-plans>
- Royal Australasian College of Surgeons. RACS Diversity and Inclusion Plan [Internet]. 2016. Available from: <https://www.surgeons.org/resources/reports-guidelines-publications/action-plans>
- RACS position papers
- Royal Australasian College of Surgeons. Equity of access to surgical care [Internet]. 2017. Available from: <https://www.surgeons.org/about-racs/position-papers>
- Royal Australasian College of Surgeons. Rural and Regional Surgical Services [Internet]. 2014. Available from: <https://www.surgeons.org/about-racs/position-papers>
- Royal Australasian College of Surgeons. Outreach Surgery in Regional, Rural and Remote Areas of Australia and New Zealand [Internet]. 2015. Available from: <https://www.surgeons.org/about-racs/position-papers>
- Royal Australasian College of Surgeons. Generalists, Generalism and Extended Scope of Practice [Internet]. 2015. Available from: <https://www.surgeons.org/about-racs/position-papers>
- ³ Royal Australasian College of Surgeons. Sections Terms of Reference [Internet]. 2018. Available from: <https://www.surgeons.org/resources/interest-groups-sections/rural-surgery/about-the-rural-surgery-section>
- ⁴ World Health Organization. Increasing access to health workers in remote and rural areas through improved retention Global policy recommendations [Internet]. 2010. Available from: <https://www.who.int/hrh/retention/guidelines/en/>
- ⁵ Australian Medical Association. Rural training pathways for specialists 2020 [Internet]. 2020. Available from: <https://ama.com.au/position-statement/rural-training-pathways-specialists-2020>
- ⁶ Australian Medical Association. A plan for better health care for regional, rural, and remote Australia [Internet]. 2016. Available from: <https://ama.com.au/position-statement/plan-better-health-care-regional-rural-and-remote-australia>
- ⁷ Australian Medical Association. Regional Training Networks - 2014 [Internet]. 2014. Available from: <https://ama.com.au/position-statement/regional-training-networks-2014>
- ⁸ Australasian College of Emergency Medicine. Certificate and Diploma Programs [Internet]. [cited 2020 Nov 21]. Available from: <https://acem.org.au/Content-Sources/Certificate-and-Diploma-Programs>
- ⁹ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Certificate in Women's Health & DRANZCOG [Internet]. [cited 2020 Nov 21]. Available from: <https://ranzcog.edu.au/training/certificate-diploma>