21st July 2021

Ms Alexis Mohay
Director, Postgraduate Training Section
Australian Government Department of Health

Via email: Alexis.Mohay@health.gov.au
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Dear Ms Mohay,

Re: How Accreditation Practices Impact Building a Non-GP Rural Specialist Medical Workforce

Thank you for inviting Medical Deans Australia and New Zealand (Medical Deans) to provide input on the Draft Report of *How Accreditation Practices Impact Building a Non-GP Rural Specialist Medical Workforce* (the Report).

Medical Deans welcomes the focus on increasing the availability and support for regionally based specialist training, and welcomes the recommendations in the Report including recognition of the importance of local resourcing, coordination and connections necessary to establish, build, maintain and sustain rural training places. Our submission includes feedback on the report's findings overall and specific comments related to the draft recommendations.

The Government has invested substantially in establishing medical education infrastructure in regional and rural areas through the Rural Health Multidisciplinary Training (RHMT) Program enabling Rural Clinical Schools and, more recently, Regional Training Hubs (RTHs) to provide and coordinate high quality rural training experiences. The recent independent evaluation of the RHMT Program[1] commissioned by the Department of Health noted its success in building "a strong foundation for rural health workforce training and research in rural, remote and regional areas" and "the inherent value it provides to communities and health services".

This review of specialist training provides an opportunity to build on this investment and leverage the connections and infrastructure already in place, to not only build capacity in rurally based specialist training but also to connect this training across the pipeline and with future career opportunities in rural and regional areas. The need for this has long been recognised, with the 2013 Mason Review of Government Health Workforce Programs[2] noting that "an additional emphasis towards supporting vertically integrated rural positions and building partnerships between organisations at different levels of the training spectrum to assist with achieving distribution outcomes needs to become embedded within these [specialist training] programs".

[1] https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-health-rhmt-evaluation
[2] https://www1.health.gov.au/internet/main/publishing.nsf/Content/D26858F4B68834EACA257BF0001A8DDC/$File/Review%20of%20Health%20Workforce%20programs.pdf

Whilst the Report makes recommendations on encouraging and facilitating connections across colleges and specialties, there is no reference to building alignment and integrating across the training continuum and we urge the Department to ensure this is rectified.

To support the expansion of accredited specialist training in rural areas and enable this integration, stronger regional governance arrangements are needed. Those with the local knowledge, relationships and connections are in the best position to most effectively facilitate and actively manage rural training based on their needs, and need to be empowered with the appropriate authority and responsibility to make the necessary decisions, to run the necessary programs, and provide the necessary support so doctors stay on a rural path at every stage of training and into their career.

While the report acknowledges the differences between rural and metro specialty training models, we found the language used to describe rural experiences to sometimes be deficit-framed. For example, the phrase on page 4 "rural health services … may not be able to provide the same training experience as a metropolitan setting" implies that the experience in the metropolitan setting is the benchmark, which we suggest isn't always the case. Indeed, the purpose of accreditation is to ensure that training provided in any setting is of the high quality required. Feedback from medical students indicates rural training is highly valued with many rural placement programs being oversubscribed. We also understand that a regional training program in Victoria achieved a 100 per cent pass rate for surgical trainees, higher than many metropolitan training programs. It is important that we move away from inadvertently continuing the historical rhetoric that rural training is somehow deficient to recognising that, when properly established and supported, and while rural training can and should be different, it is of the same high quality as metro training and is valued among junior doctors and trainees.

In addition, we suggest that more context is provided to the phrase describing the nature of rural training as "generalist specialist rather than pure specialist or subspecialist". Whilst this is often true, it overlooks the importance of generalist specialists, such as general surgeons and general physicians, and the opportunity to tap into rural training to support increased interest in and development of these specialties that are recognised as being in undersupply in Australia. We note that one of the priority areas in the draft National Medical Workforce Strategy (NMWS) is dedicated to building generalist capacity in the medical workforce.

Whilst we understand that this review is focused on non-GP specialist accreditation, it is worth noting that the approaches taken and models adopted could greatly impact and potentially benefit GP specialist accreditation and training, especially that of rural GPs and Rural Generalists. For example, there are significant benefits to training places for Obstetrician-Gynaecologists also being available to those GP-specialists requiring training in obstetrics. We encourage the Department to consider including reference to this within the Report, and further exploring models that would support this.

Draft recommendations

- Recommendation 3 – We welcome the recognition that rural expertise needs to inform accreditation of rural training, however we suggest the wording is strengthened to ensure rural expertise is given the appropriate level of recognition and that the purpose of its inclusion is clear, for example by including the following wording: "…accreditation teams to include rural

Fellows or Fellows with rural expertise *to ensure appropriate understanding within the teams informs the assessment*".

- Recommendation 4 – Note: the above also applies to Recommendation 4, to ensure rural expertise appropriately contributes to informed "individualised and contextualised assessments".

- Recommendation 5 – We suggest that specific mention be made of the value of leveraging the existing medical training infrastructure to help the colleges engage with rural supervisors and support specialty training. Establishing mechanisms to do this takes valuable time and resource and we need to encourage avoidance of unnecessary and costly duplication that might otherwise occur.

- Recommendation 12 – We support this recommendation and suggest it be expanded to the sharing of information with pre-vocational training providers to again support the move to a more aligned and connected training continuum.

- Recommendation 13 – We support this recommendation however note that care needs to be taken to ensure that improving consistency does not work against the move to increased flexibility.

- Recommendation 15 – We welcome the recognition that local support and resourcing is essential and should be shared across specialist training stages. As the report notes, RTHs have demonstrated their achievements contributing to the co-design of new and novel specialty training pathways and accreditation posts. This is another opportunity to build on the existing infrastructure where RTHs could support the preparation for accreditation processes given their existing connections with rurally-inclined graduates, junior doctors, health services, training providers and the Colleges. Some RTHs already provide a similar function to that described in this Recommendation.

- Recommendation 22 – We support the recognition that collaboration is required to deliver rural training however note that this is currently only referencing collaboration within the specialist training context. We strongly urge the Department to include within this recommendation, and elsewhere in the Report, the need for collaboration across the training pipeline and the benefits this would bring.

- Recommendation 23 – We agree that supervisory capacity is critical to developing sustainable rural training models. So too are other aspects such as clinician leadership, and researcher and educator roles to support a sustained rural medical training workforce. We suggest this recommendation is revised to a broader frame rather than focusing solely on supervisor skills.

- Recommendation 24 – We welcome the recognition that network-based training models are valuable in facilitating specialty training across rural health services. To facilitate this, we need long-term vision, planning and commitment to increasing the allocated positions and actively planning for, providing and managing training opportunities. As noted earlier, we suggest this Recommendation recognise that this needs more than systems and advocates for a regional

governance model that provides appropriate authority to make these decisions based on local knowledge and foresight particularly given the length of specialty training and lag time.

- Recommendation 26 – We are curious as to the rationale for this recommendation and how it aligns with the draft NMWS. We are aware that medical graduates and doctors in training move across state boundaries for many reasons, and believe that specialty training pathways should recognise the need to take these in- and out-flows of trainees into account.

- Recommendation 27 – As noted previously, regional and rural training providers need to be empowered to plan, support, and manage the training capacity and needs in their communities. Medical Deans has long advocated the 'flipped' model of training to support this, and within this, the need to recognise, support and build local rural leadership. As such, we suggest the wording of this recommendation be revised to echo the importance of rural leadership, and the vital role of metropolitan and larger regional health services paly in supporting this. As it is currently worded, the focus remains on the leadership being centred in the cities.

- Recommendation 28 – We welcome the recognition that training networks require adequate resourcing and coordination to sustain them. Whilst a dedicated co-ordinator role is essential, care needs to be taken that its creation does not inadvertently duplicate an existing organisation or function in the region. As highlighted earlier, RTHs have demonstrated their capacity to coordinate opportunities across a range of disciplines and health services. We should build on these achievements and government's investment and require the coordination function to sit within the remit of existing organisations, such as the RTHs, rather than create new parallel models. This would be both efficient and effective, and avoids adding duplication and confusion to an already crowded training landscape.

- Recommendation 30 – As noted previously, we strongly support collaboration and emphasise that it should occur across the entire medical training continuum and not solely within the vocational training space. We suggest this recommendation is amended to reflect this.

- Recommendation 31 – As noted previously, there is an opportunity to leverage the existing connections established by RTHs to facilitate engagement across the training continuum. This continuity of support for trainees is more likely to support them staying in the regions and the Report's case studies demonstrate in some regions, RTHs are already making tangible contributions in resolving issues and securing accreditation posts.

As noted throughout our submission, now is the time to build on the Government's significant investment in regional training infrastructure. Strengthening regional governance will enable those with local relationships, knowledge, and commitment to make strategic, long-term decisions about medical training opportunities that best support their trainees and their communities – from medical school through to fellowship.

Whilst the Report notes that consultations were completed prior to the COVID-19 pandemic, and makes reference to "challenges that may have impacted accreditation or training during this time", we'd like to note that – fully acknowledging the challenges, disruption, uncertainty, and incredible hard work that has faced all those involved in medical education and training – we also have seen significant change and innovation during this time; including by the accreditation councils. The

disruption caused by this global shock has created an opportunity for step-change to the traditional approaches to medical and other health professional education and training. This is a rare opportunity that must not be wasted to drive a much-needed shift in how we think and the ways we work, to deliver benefits over and above those possible through incremental change.

Medical Deans would like to thank you again for the opportunity to contribute to this important work. Should you wish to discuss any of the comments provided in this submission further, please contact Medical Deans' CEO, Helen Craig, at hcraig@medicaldeans.org.au.

Yours sincerely,

Richard Murray
President
Medical Deans Australia and New Zealand