Dr John Bonney
President
Australasian College for Emergency Medicine
workforce@acem.org.au

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

15 September 2021

Dear Dr Bonney

Thank you for providing the Rural Doctors Association of Australia (RDAA) with the opportunity to provide feedback on Australsian College of Emergency Medicine (ACEM) Workforce Planning Recommendations. RDAA is the peak national body representing the interests of rural doctors, including rural GPs, rural generalists and rural consultant specialists, across Australia and the rural and remote communities where they work and live.

In response to the recommendations I would like to provide some initial feedback and will then respond to the specific consultation questions, which should be considered in context of the RDAA general feedback commentary.

RDAA commends ACEM for exploring strategies to enhance the distribution of the ACEM workforce, increasing the training opportunities and improving the supports to the non-ACEM medical workforce.

In bundling regional, rural and remote locations together the workforce planning proposal for ACEM will provide a disservice to the 'real' rural and remote communities of Australia. RDAA has a strong principle underpinning our own Rural Medical Workforce Plan and that is to define rural and remote as locations in Modified Monash Model (MMM) 3-7. Based on the documentation ACEM has provided for this consultation process, state captials such as Hobart and Darwin as well as large regional centres like Tooowoomba, Townsville and Cairns are included in the regional, rural and remote data set as well as the all the proposed workforce planning initiatives and will be included in the workforce distribution measures. These locations have significant advantages over 'real' rural and remote locations such as Alice Springs, and Mt Isa. Building numbers of Fellows and Trainees in MMM 2 locations while failing to increase numbers in MMM 3-7 would be considered a failure of the proposed strategy not a success by RDAA.

For locations in MMM 3-7 it is essential that the total medical workforce is considered in the planning, not just considering the ACEM workforce in a silo. Many rural hospitals do not have the activity in its emergency service to support a consultant specialist ACEM workforce in a full time capacity. For many rural health services, sustainability of the local medical service is based on the the integration of medical staffing across the primary and secondary sectors, hence the strong support by RDAA of the Rural Generalist model.

RDAA members value the support and professional development provided by ACEM through the EMET, and would like to ensure this continues into the future. For some states such as Queensland, the support provided through the Clinical Coordination Centre staffed by FACEMs is also highly valued as a remote back up for emergency care and retrieval preparations.

Recommendation 1 – Accredited Training Networks
RDAA supports the concept of established Networks not only for training but for patient quality and safety improvements.

Recommendation 2 – Incorporation of Rural Training into Training Networks
It is essential that as part of the Training Network, that the rural training includes sites in MMM 3-7. RDAA would propose a scale where a Network should include a Tertiary Centre, MMM2 (or level 5/6 depending on scale of Clinical Services Capability Framework in each state), MMM 3-7 sites which are a combination of FACEM led emergency departments and rural emergency services staffed by Rural Generalists and GP VMOs.

Movement of trainees to alternate locations needs to be implemented with financial and social support. Accommodation support needs to be provided in particular, as many ACEM trainees will have a partner and/or family and short-term relocation of the entire family unit may not be possible. These supports should be made equitably available to rural based trainees relocating on temporary basis to a larger centre or city, as well as city based trainees relocating to rural.

Recommendation 3 – Mandatory Rural Training within Each Network
RDAA supports the concept of a mandatory rural training period within each network, however this needs to be considered to ensure rural is viewed as a key experience by trainees, and remains a valued rotation. Often mandating the training can create a sense of resentment, so the benefits of a rural placement (MMM 3-7) need to be clearly articulated and the experience linked to a real advantage in terms of Fellowship qualification. RDAA would propose that IRTP positions are linked to the more remote training sites, and not MMM 2 locations.

The proposed minimum dedicated period of training in a rural, regional and/or remote site within a network, based on our Rural Consultant Specialists feedback, should be 12 month rotation, not six months. This is consistent with the RDAA Workforce Plan and proposed reform for the Specialist Training Program (STP), tabled with the Government and Commonwealth Department of Health. This should also be prioritising placements in MMM 3-7, only utilising MMM 2 locations as part of "rural" if all training placements are fully subscribed in MMM 3-7. MMM 2 locations in Western Australia are more likely to provide a greater "rural" type experience than those in large regional centres in Queensland. Hobart and Darwin certainly should not be considered as rural placements for the purposes of a rural experience.

Training placements must be considered to ensure a balance between Rural Generalist trainees as well as ACEM registrars. RDAA does not support a full transition of a rural hospital, eg Level 3 emergency service, to be a full FACEM service. There is a balance of workforce that must be supported and maintained.

It must also be recognised that the experience for ACEM registrars in rural hospitals will be different from what they are exposed to in large tertiary centres, not better, not worse but it will be different. The context of rural medicine will often mean there is not the availability of 24/7 CT, there is no access to onsite consultant specialist support from cardiology or neuro, as just a couple of examples. The context of rural medicine must be considered as a highly valuable experience and participation in a rural rotation will contribute to training a well rounded Emergency specialist.

RDAA believes that regardless of the end point of a Consultant Specialist's career, all doctors will at some stage be a provider to a rural patient and therefore understanding the context and capacity of rural health services will enhance the quality of care they are able to provide to patients and the support they provide remotely to rural health care professionals. A quality rural clinical placement will make any doctor a better doctor for the experience and insights.

Recommendation 4 – Remote Supervision
RDAA supports this concept and would also table the need to expand remote assessment provisions. The COVID pandemic has exposed many weaknesses in a number of medical college's assessment processes, and remote assessment will be critical in future models.

Recommendation 5 – Non FACEM senior decision makers
With the combination of remote supervision and recognition of non-FACEM senior clinicians participating in accredited training, it facilitates increased training opportunities in rural and remote

locations, without reducing the quality of the educational experience or training environment. It is essential the on-site or on-call supervision support is available on a all shifts of the trainee/registrar, in addition to remote supervison.

Finally, RDAA members report that initiatives, in relation to the sharing of emergency trainees between rural and large regional or tertiary facilities, have been considered previously within various state health systems. The reality has been that the smaller rural site will serve as overflow early in the year, and as the workforce profile changes at the larger centre, the rural rotation is pulled back. RDAA recognises the Network concept is different model, however it is essential that the initiatives ACEM has outlined are genuine commitments and going forward the new Networks must be able to demonstrate an improved distribution of the trainees.

RDAA would be keen to continue to engage with ACEM on the development of the rural workforce strategy. Attached is a copy of the RDAA Rural Medical Workforce Plan for your information, we had requested to present this on multiple occasions to the secretariat of the Council of Presidents Medical Colleges, but unfortunately that request could not be accommodated in December 2020 and February 2021.

If you have any further questions or wish to discuss the feedback outlined in this submission please do not hesitate to contact RDAA through the Chief Executive Officer, Peta Rutherford via email ceo@rdaa.com.au or mobile 0427 638 374.

Yours faithfully

Dr John Hall
President