Royal Australasian College of Surgeons

Australian Government
Office of the National Rural Health Commissioner

National Rural Surgeons' Training & Retention Workshop February 2024
Issues and Outcomes Paper

A call to action

The Royal Australasian College of Surgeons (the College) Strategic Plan 2022-24 describes a mission to improve access, equity, quality, and delivery of surgical care to meet the needs of our diverse communities across Australia and Aotearoa New Zealand. The issues and barriers facing training and retention of rural[1] surgeons within the College and its specialty partners have often been discussed. A drive for new action across the College, government, regulators, service providers, community advocates, and health system designers seeks to address the issues and remove barriers where action will have the greatest impact.

In February 2024, the National Rural Surgeons' Training & Retention Workshop brought together Australia's leaders in surgical education, training, and regulation. It was funded by the Department of Health and Aged Care through the College's Flexible Approaches to Training in Expanded Settings (FATES) projects. Workshop participants consistently issued urgent calls for an increase in the number of surgical training posts in rural areas as a critical lever to improve the delivery of safe and high-quality surgical services and training where they are needed most in the short, medium, and long-term. This requires immediate focus from the College, specialty partners, governments, regulators, and service providers for impactful change while concurrently building on other rural medical workforce initiatives.

Workshop participants agree that rural communities deserve a local surgical and medical workforce that delivers safe and high-quality surgical services and training where they are needed most. This can be achieved without compromise on the quality or safety of training or education. Stakeholders must recognise the inherent, unique additional benefits found within rural training posts and thus flexibility is needed in how the training and education standards are met in different ways in a diverse range of contexts. Learnings from other specialist medical colleges in how they have embarked on or addressed these very challenges to support, improve or remediate training sites in ways that are often different to that found in the settings where the standards originated, will guide a successful transition to place-based rural surgical training.

The College and its specialty partners have an important role, as part of their social licence, to meet community healthcare needs and should lead this activity to ensure systems and structures are in place to support junior doctors to train and work rurally. If the College is unable to show the necessary leadership to respond to this need, isolated calls for other institutions to take control of training and specialist recognition may gather momentum, as has happened elsewhere. Expedited action is in the interest of all stakeholders, particularly because there are increasingly impatient calls from Australian communities for place-based rural training and workforce.

Workshop participants listened, talked, and shared ideas. The College should now take action in partnership with and with the support of specialty partners to improve access, equity, quality, and delivery of surgical care to meet the needs of diverse communities across Australia.

[1] Rural will be used to encompass rural, remote, and regional throughout this document.

Background and context

Australia's medical workforce is geographically maldistributed. Approximately 7 million people or 28% of Australians live in rural and remote areas[2] but only 15.8% of Surgical Fellows (FRACS) work rurally[3] and for five of the nine surgical specialties, less than 5% of surgeons have their main practice in non-metropolitan locations[4] and less than 10% of surgeons are active in non-metropolitan locations[5]. The reasons for this are complex and multifactorial. This affects access to essential surgical services and impacts rural patients' health outcomes. Despite increased Australian Government commitment to support specialty training in rural areas over the past decade, the majority of specialty training is still delivered in metropolitan areas and major barriers persist for medical specialists to practise and undertake training in rural Australia. Rural regions require generalists in each specialty, however limited rural surgical training opportunities increase alignment to metropolitan models of practice and the trend towards sub-specialisation.[6, 7]

For many years, governments have been drawn to the attractive short-term valuable supplementary rural surgical workforce provided by Specialist International Medical Graduates (SIMGs). Yet, many SIMGs do not stay in rural locations after completion of moratorium periods and as specified in the World Health Organisation's Global Code of Practice on the International Recruitment of Health Personnel, there are ethical considerations in recruiting large numbers of trained surgeons from source countries with health personnel shortages.[8] Rural communities need their appropriate population share of Australian-trained medical specialists.

Workshop summary – overview, key themes, and actions

The National Rural Surgeons' Training & Retention Workshop on 9 February 2024 in Melbourne was co-hosted by the College and the Office of the National Rural Health Commissioner (ONRHC) and facilitated by Professor Brendan Murphy AC. It brought together 57 stakeholders representing government, regulatory bodies, professional interest groups and specialist medical colleges.

Attendees heard about the development and early outcomes of the highly successful Rural Psychiatry Training Program in Western Australia and the Australian Orthopaedic Association's Regional Orthopaedic Surgery Strategic Plan. The work done by the College's Rural Health Equity Committee on the Rural Health Equity Strategy was presented and the Australian Medical Council described how accreditation standards and training frameworks are supporting increased rural training and supervision and encouraging collaboration between stakeholders. Findings were presented from the research undertaken by the College's FATES project team and their Consortium partners of the Australian and New Zealand College of Anaesthetists (ANZCA), the Royal Australasian College of Medical Administrators (RACMA), the Royal Australasian College of Physicians (RACP), and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO):

FATES 1 research identifies barriers and solutions to accreditation of training posts in rural hospitals.

FATES 2 research studies rural training networks and models for supervision, mentoring, orientation, and culturally safe and effective training pathway for Indigenous medical specialist trainees.

The scene setting concluded with the RACMA and their perspectives on recruitment and retention of health professionals and administrators in rural settings, and the important role culture and local communities play in that.

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[2] Australian Institute of Health and Welfare. Rural and remote health [online]. AIHW, 30 Apr 2024. https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health (viewed May 2024).

[3] Royal Australasian College of Surgeons. 2022 surgical workforce census summary report. Melbourne: RACS, 2023. https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/reports-guidelines-publications/workforce-activities-census-reports/PUB-2022-Surgical-Workforce-Census-Report---final.pdf?rev=4df8fb5add5949109776b0b0c5bd0d4e&hash=92EBAD7C555D97E8834EF3A36A4F05B5 (viewed Apr 2024).

[4] Ibid.

[5] Royal Australasian College of Surgeons. RACS activity report 2022. Melbourne: RACS, 2023. https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/reports-guidelines-publications/workforce-activities-census-reports/2022_RACS_ActivitiesReport_Web_final.pdf?rev=9536e2ab9e9149a1a24e2d2d0d5a6dea&hash=9B9D0982964DABDA4FFC0A52432EC37B (viewed Apr 2024).

[6] Clancy, B. Royal Australasian College of Surgeons Rural Health Equity Strategic Action Plan: excellence through equity. *ANZ J Surgery* 2022; 92: 1990-1994.

[7] Department of Health. National medical workforce strategy 2021-2031. Canberra: Department of Health, 2022. https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf (viewed Apr 2024).

[8] World Health Organization. Sixty-third World Health Assembly: WHO global code of practice on the international recruitment of health personnel 2010. Geneva: WHO, 2010. https://iris.who.int/bitstream/handle/10665/3090/A63_R16-en.pdf?sequence=1 (viewed Apr 2024).

Beginning with an acknowledgement that the barriers to rural surgical training and retention are well known, attendees identified and prioritised those key issues; clear themes, priorities and actions emerged. These are summarised below.

Theme 1 – Flexibility in accreditation and supervision, and support for accreditation

Problems	Accreditation is the main barrier to sustainable and effective rural training posts. It is complex, time consuming, administratively burdensome, inflexible, and metropolitan-centric. If accreditation is withdrawn, an entire service and training rotation can be withdrawn which disrupts many lives and affects patient care. Rural hospitals and rural surgeons are not resourced to do the complex work to apply for accreditation, and rural hospitals struggle to meet metropolitan expectations which are inferred as gold standard. Current accreditation criteria use the number of surgeons at a site as a de facto measure of quality of supervision. Using other measures, for example full-time equivalent (FTE) direct surgeon supervision, may be more appropriate. Rural hospitals may have fewer surgeons, but higher FTE direct surgeon supervision. Measuring quality in several ways will allow for more rural sites to be accredited for training. Rural supervisors are not provided with adequate resources (financial, administrative) or dedicated time to supervise trainees. Rural surgeons need more resources to provide surgical supervision and training.
Learnings	The Rural Psychiatry Training Western Australia Program has demonstrated the benefits and cost-effectiveness of converting registrar positions from non-accredited to accredited, and by creating Royal Australian and Zealand College of Psychiatrists' first accredited rural zone in 2022. Barriers such as an initial reluctance to have some level of remote supervision were overcome and the program has proved to be attractive to trainees, including from other regions, while being cost-effective to the extent that Western Australia Country Health Service is planning program expansion.
Considerations	A crucial issue in conversion of non-accredited posts is the restriction on overtime and after-hours work for registrars. Health services rely on non-accredited medical officers to do much of the on-call and after-hours work, in part because of College restrictions on hours for trainees. Conversion of a position into a training one reduces the time the person in that position can be on-call or work after-hours. For health services, this can compromise service delivery and make health services reluctant to seek accreditation. There have even been cases where hospitals have relinquished the accreditation of a position in response to increased surgical wait times. Safe hours rostering should be a reasonable expectation of all junior medical staff; staffing levels and rosters should be adjusted so that both accredited and non-accredited registrars equally participate in appropriate and safe after-hours rosters.
Opportunities	Training opportunities and experience are often better in smaller sites. For sites with one registrar, there are more opportunities for assisting or being first surgeon. Rural surgical services are frequently provided by SIMGs. The requirements for a supervisor to be a Fellow means many rural sites cannot be accredited. A solution would be to appoint SIMGs as co-supervisors with a virtually present supervisor partner; structured relationships with metropolitan hospitals could enable this. The FATES project demonstrates that flexibility in supervision models can allow them to be fitted to the region *and* service setting. A holistic assessment of accreditation site applications that determines when an application meets outcome criteria, rather than process criteria, would enable this flexibility. Training site accreditation could be performed for multiple specialties and subspecialties from the same data set if processes were aligned. Many aspects of accreditation are not specialty specific. The College is encouraged to establish a central support unit to facilitate such alignment.

Theme 1 – Flexibility in accreditation and supervision, and support for accreditation			Impact (benefits)	Timeframe (-term)
Agreed actions	1.1.	The College to circulate the revised Hospital Training Post (HTP) Accreditation Standards.	Medium-high	Short
	1.2.	The College and Specialty Training Boards to investigate new flexible and digitally enabled models of supervision and accreditation, including onsite surgical supervision, and SIMGs as trainers but not supervisors. This can be assisted/supplemented by remote surgical supervisors, as part of the FATES project.	High	Short / medium
	1.3.	Information on changes to supervision standards to be shared between the College and Training Managers.	Medium-high	N/A – ongoing
	1.4.	The College to continue to develop an accreditation support unit with a specific remit to assist rural sites applying for accreditation and expand inclusion to other medical specialties as appropriate.	High	Medium
	1.5.	Explore options to seek cross-specialty supervision in rural settings and engage the Australian Medical Council, then report findings to the College and Rural Health Equity Steering Committee. An example could be a principal FRACS orthopaedics supervisor for an orthopaedics post could be supported by a secondary FRACS general surgery supervisor.	High	Short / medium

Theme 2 – Opportunities for training and training selection

Problems	Workshop participants reflected that College culture is metropolitan-centric in that it does not: • sufficiently weight community need and the likelihood of selected trainees meeting that community need and • have rurally rich curricula across all surgical specialties to influence and foster rural careers. Rural clinical schools proactively weight rural origin, underserved and under-represented persons in selection processes but without purposeful replication in specialist college selection processes, rural clinical school efforts to create a workforce that communities need is diminished. Workshop participants perceived a lack of support for First Nations students and registrars. The risks associated with this are First Nations workforce attrition and inability to achieve greater representation of First Nations Fellows and trainees as outlined in the College's *Diversity and Inclusion Plan*, which could affect intentions to achieve holistic social and health impacts.
Learnings	Through the College's *Rural Health Equity Strategic Action Plan,* Council have endorsed the 'Select for Rural' initiative with selection points for rural origin, rural medical school, and rural work experience. Five Speciality Training Boards have adopted this initiative. The Royal Australian and New Zealand College of Psychiatry has developed 'scaffolding' to support growth in their rural training and Fellowship, and this includes having identified metropolitan-based rural champions to foster positive attitudes towards rural careers.

Considerations	Failing to embed rural affirmative criteria will diminish the influence that government-funded rural programs have had and the strategic direction of the *National Medical Workforce Strategy*. It is in the College's interest to ensure all that can be done within the College's influence is done to support rural and generalist careers. The College's objectives cannot be achieved without service providers maintaining accredited posts wherever possible to enable rural communities to access care closer to home. The College's 'Train for Rural' initiative seeks trainees across all specialties to have rural exposure. This initiative will be strengthened once the College's Specialist Training Program-funded Rural-Facing Surgical Curriculum work is developed and implemented.
Opportunities	Learnings from medical schools focused on weighting selections towards rural origin students, underserved and under-represented populations can be applied to selection processes within the College. Workshop participants strongly supported changes to the College's selection processes by prioritising rural origin trainees and community need. There are additional opportunities in identifying and selecting rural, surgically inclined trainees early in their career and placing surgical trainees into rural communities early in their career to allow them to form strong community connections. Rural affirmative criteria in selection from the 'just missed out' cohort can also be applied but would require careful monitoring of pre- and post-intervention outcomes to ensure that such selection bias is not 'gamed'. Rural affirmative changes can have profound effects for doctors with a strong and genuine intention to practice rurally by providing clearer pathways for them to do so. Modifications to selection processes are best implemented with strong rural representation on selection committees to value and provide a positive rural inclination in selections. Increased cultural support for First Nations candidates would facilitate their completion of training and increase their opportunities to work on Country.

	Theme 2 – Opportunities for training selection		**Impact** (benefits)	**Timeframe** (-term)
Agreed actions	2.1.	The College and Specialty Training Boards/Committees to review selection committee membership to ensure appropriate rural representation and to review current selection and training criteria that may impact those considering rural training [aligned to Action 3 in *Select for Rural* from the College's *Rural Health Equity Strategic Action Plan*].	High	Short
	2.2.	The College/Boards to seek and facilitate entry to training in PGY3/4 for rural trainees with rural origin, plus one-year rural medical school experience, and one-year rural work experience prior to entry into training.	High	Short / medium
	2.3	The College and Specialty Training Boards/Committees to promote culturally safe surgical experiences for trainees identifying as Aboriginal and Torres Strait Islander and / or Māori.	High	Medium
	2.3.	The College and Speciality Training Board to provide non-First Nations trainees with training to enable them to train within diverse communities and deliver culturally competent care for Aboriginal and Torres Strait Islander and / or Māori patients, their families and community [aligned to Action 3.3 in *Participation of All Diversity Groups* from the College's *Diversity and Inclusion Plan*].	High	Medium

Agreed actions	2.4.	The College and the Specialty Training Boards/Committees to promote the rural surgical experience – breadth and types of surgical experience – and to advise on the support trainees might require in the rural context that differs from the standard metropolitan rotation.	High	Short / medium
	2.5.	The College and Specialty Training Boards/Committees to implement the Rural-Facing Surgical Curriculum, which focuses on understanding the rural context, rural contextual decision-making, and Rural Focused Urban Surgical Skills (RUFUS). The Rural-Facing Surgical Curriculum skills traverse all specialties.	High	Short and ongoing

International Models of Care

Canadian studies of the demographic characteristics of general surgeons practising in rural Canada have stratified the procedures they performed by community population size and have recommended that graduating residents who intend to practise in rural settings receive a broader training experience than their urban colleagues, arguing that optimal training for rural surgical practice should include experience in obstetrics and gynaecology, orthopaedics, urology and otolaryngology.[9] This is the thinking behind the rural generalist role that is being rolled out in general practice but applies equally well for the rural surgeon. There are several successful innovative models of training that the College and the Specialty Training Boards could evaluate as to fit for purpose so that Aotearoa New Zealand and Australian people can access safe high-quality surgical care in the community where they live.

Theme 3 – Leadership role in workforce planning

Problems

Inadequate data collection, sharing and integration is a recognised barrier undermining health workforce planning. Enhanced data use requires collaboration between health services, the College and government. There is work underway within government to address defined datasets and additional opportunities exist for federal, state and territory and health departments and the College to share data to assist training and workforce planning.

It is not well understood what 'meeting community needs' in rural Australia means. Regional, rural, and remote communities are adaptive and complex environments. When working together, agencies must utilise data driven strategies to identify and meet the needs on a community-by-community basis. For example, in addition to demographics and population health data, government agencies and all other stakeholders must collaborate to identify the surgical needs of specific rural and remote communities. This requires deeply understanding the population health in a community to provide the appropriate surgical care. This task requires collective action between stakeholders, especially the jurisdictions and those on the ground who know their community best, sharing perspectives and considering of data.

[9] Schroeder T, Sheppard C, Wilson D, et al. General surgery in Canada: current scope of practice and future needs. *Can J Surg* 2020; 63: E396-E408.

Opportunities	The Health Workforce Taskforce (a working group progressing priorities under the direction of the Health Chief Executives Forum) has been convened to address data collection and sharing. This taskforce is implementing recommendations from the *Independent review of Australia's regulatory settings relating to overseas health practitioners* which comprise workforce data reforms. Outcomes from this should also facilitate improved workforce data for the College. Planning a rural surgical workforce requires strategic thinking and clarification of leadership and stakeholder roles. Specialty medical colleges have a leadership role in workforce planning and could work more directly with federal, state and territory governments to identify workforce supply gaps between community need and the public and private sectors. Leadership is key for creating the supportive culture in which change can occur and improve rural training experiences for all. Accrediting rural training posts so that trainees can fill these gaps by providing high-quality service while participating in safe, high-quality training, could be facilitated by the College and Specialty Training Boards/Committees in some cases, where indicated by global supply projections, by increasing the total number of surgical trainees. For other specialties, relocation, over time, of some metropolitan posts may be appropriate to increase rural training without causing national over supply. Such decisions would need to be tied to increased flexibility of supervision standards facilitated through use of new technologies and models of supervision and with excellent training experience and attractive support packages for trainees.

Theme 3 – Leadership role in workforce planning			**Impact** (benefits)	**Timeframe** (-term)
Agreed actions	3.1.	The College and Specialty Training Boards/Committees to continue to collect workforce data and make it accessible to college staff and external stakeholders, and to continue to collaborate with the Health Workforce Data Intelligence Unit (Department of Health and Aged Care) in building a pathway for effective and ethical workforce data sharing and to complement FATES 1: Rural Accreditation Project.	High	Short and ongoing
	3.2.	The College and Specialty Training Boards/Committees to standardise their workforce data collection with and across jurisdictions and identify community needs based on workforce data and nature of surgical presentations.	High	Short / medium
	3.3.	The College and Specialty Training Boards/Committees to support necessary leadership skills development to enable sustainable rural surgical training experiences when working within the rural healthcare sector.	High	Short / medium
	3.4.	The College to consider partnership with an interested State or Territory Health Department to do an in-depth pilot study of the surgical workforce needs of an identified regional area where there is strong local leadership for change [linked to Action 5.2].	High	Short / medium

Theme 4 – Governance and resources to operationalise rural surgical training

Problems	Uncoordinated regional approaches create inefficiencies when resources could be pooled into networks or hubs for rural surgical training. This can be detrimental to harmonising training and training pipelines even within local health networks and can underutilise available workforce who are equipped to oversight such operations.
Learnings	The Rural Psychiatry Training Western Australia Program has shown that success required changes to governance, selection and onboarding, education programs, clinical rotations, and support. This was supported by the Royal Australian and New Zealand College of Psychiatry receiving accreditation for a new training program zone for this rural pathway through the Australian Medical Council.
Considerations	A regional network can offer trainees repeated and supported exposure over four to five years of planned rotations within the network and can be supported with digital teaching technology to support localised gaps in expertise. Networks need governance structures to ensure standards of education and support are maintained, and the governance must include rural representation. This is a role that hospital and medical administrators can and should undertake. Further, development of rural training sites needs to be complemented and supported by public hospital appointments for new Fellows. This would enable trainees and their families to maintain their social and professional connection to a region or establish such connections.
Opportunities	Rural surgeons work to a generalist scope of practice across and within subspecialties. This is an attractive point of difference for some trainees. Elevating the status of generalism by developing generalist curricula for rural surgical practice can leverage this draw factor. Innovative promotion of rural training and careers within the College and to aspiring surgeons can further raise the profile and appeal of working within regional and rural communities.

Theme 4 – Governance and resources to operationalise rural surgical training			**Impact** (benefits)	**Timeframe** (-term)
Agreed actions	4.1.	The College and the Specialty Training Boards/Committees to promote positive stories of rural surgeons, focusing on the positive points of difference with the breadth and types of surgical experiences that can occur in non-metropolitan settings.	High	Short and ongoing
	4.2.	RACMA to develop expertise and policies for their Fellows to support rural surgical training and supervision.	Medium-high	Short / medium
	4.3.	The Department of Health and Aged Care to review existing regional training hubs to ensure commitment to advanced surgical training.	Medium-high	Short / medium
	4.4.	The College and the Specialty Training Boards/Committees to work with jurisdictions to develop alternative models of supervision and support in areas not served by existing training hubs [linked to Action 5.1].	High	Short / medium
	4.5.	The College and the Specialty Training Boards/Committees to develop a framework for the requirements of regional training networks and establish appropriate governance [linked to Action 5.1].	High	Medium
	4.6.	The College and Specialty Training Boards/Committees to form or link with regional training networks that are based on community needs as informed by health workforce data. Accreditation of posts should be shared, and on-site training provided, across each network.	High	Medium
	4.7.	The College and Specialty Training Boards/Committees to link rural and urban centres and require sub-specialty surgeons with their trainees to regularly visit rural sites on rotations.	Medium-high	Medium

Theme 5 – Collaboration and partnership

Problems	The nature of medical workforce training has many stakeholders interpreting, influencing and/or implementing segments of the training pipeline, at times with a subjective focus on their own segment of the pipeline. Disruptions to one segment in the pipeline can disrupt flow through other segments with outcomes ranging from training posts becoming unaccredited, trainee attrition, or friction between stakeholders. Collaboration and shared responsibilities are necessary to reduce these risks in specialty training.
Opportunities	There are opportunities for all or most medical colleges to foster and develop structured relationships between themselves and between metropolitan and rural hospitals to assist rural hospitals to provide supervision and resources, and post-fellowship employment opportunities. This would permit new models of supervision and access to specific elements of training, which cannot be provided in the regional setting, and a roster of visiting surgeons to provide services and support regional surgeons and trainees. A larger pool of surgeons can assist addressing difficult issues of workplace culture and support medical leadership and when supported by training provided by other colleges can create training ecosystem that supports all medical trainees, their supervisors and training posts better. That medical training ecosystem in turn services the community better across a range of health services they require and encourages retention and sustainability. Jurisdictions have a role to maintain support in hospitals, travel subsidies, new technologies, and telehealth for outpatient and to build and resource the platform for the medical training ecosystem.

Theme 5 – Collaboration and partnership			**Impact** (benefits)	**Timeframe** (-term)
Agreed actions	5.1.	The College and Specialty Training Boards/Committees to negotiate memorandum of understandings and service level agreements with jurisdictions and other medical colleges / universities to design the governance of the network hub and spoke models of training [linked to Actions 4.4 and 4.5].	High	Short and ongoing
	5.2.	The College and Specialty Training Boards/Committees and one jurisdiction to scope a pilot in one region [linked to Action 3.4].	High	Short / medium

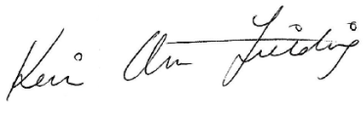
Summary

All identified solutions feature in the College's Rural Health Equity Strategic Action Plan (2020), which Dr Bridget Clancy presented on, together with the College's Rural-Facing Surgical Curriculum. Effective implementation of the solutions and actions identified in the workshop will result in positive long-term impact for rural and remote Australians and increase their access to specialist surgical services closer to home. Inaction will further diminish access and future specialist surgical care will be limited to major urban centres. This will cost Australia more and provide less care where it is needed most.

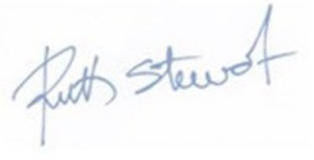
The Rural Psychiatry Training Western Australia Program has shown that success required changes to governance, selection and onboarding, education programs, clinical rotations, and support.

Success of implementation of the actions in the five key themes requires leadership within and by the College and collaboration with federal, state and territory governments, medical schools, and health services to enable a coordinated approach to surgical workforce planning. Change is not about diminishing standards but doing things differently. The role of generalists in rural areas must be a focus, and education is key but requires appropriate rural training, selection of the people that will stay in rural communities and increasing the rural competence of those who make the decisions.

Prof. Brendan Murphy AC
Facilitator



Assoc. Prof. Kerin Fielding
Royal Australasian College of Surgeons President



Adj. Prof. Ruth Stewart
National Rural Health Commissioner