ANZCA
FPM

ANZCA regional and rural workforce strategy

JANUARY 2021

The college acknowledges the Traditional Custodians of Country throughout Australia and recognises their unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to society. We pay our respects to ancestors and Elders, past, present and emerging.

The college acknowledges and respects ngā iwi Māori as the Tangata Whenua of Aotearoa and is committed to upholding the principles of the Treaty of Waitangi, fostering the college's relationship with Māori, supporting Māori fellows and trainees, and striving to improve the health of Māori.

Contents

Summary of priority areas, objectives and actions	4
Introduction	6
Priority Areas	11
Priority area 1: Workforce planning	12
Priority area 2: Engagement and collaboration	14
Priority area 3: New roles and innovation	16
Priority area 4: Positive rural careers	18
Priority area 5: Support and development	20
Priority area 6: Health and wellbeing	24
References	26

Summary of priority areas, objectives and actions

Priority area	Objectives	Actions
1. Workforce planning	Access relevant population and health workforce data to inform workforce planning.	**1.1** Establish core workforce KPIs and a process for their collection and dissemination. In Australia these will be accessed through college data, the Department of Health's National Health Workforce Data Set and the National Medical Workforce Strategy currently under development. In Aotearoa New Zealand these will be accessed through college data, the Health Workforce Directorate within the Ministry of Health/ Manatū Hauora and other sources.
		1.2 Embed processes to accurately collect, analyse and share anaesthesia and pain medicine workforce data in Australia and Aotearoa New Zealand.
		1.3 Develop regular reporting and evaluation of workforce initiatives and activities, such as through wider circulation of college reporting to the Department of Health on workforce and the Specialist Training Program.
2. Engagement and collaboration	Engage appropriately and strategically with government to secure support via funding and placements and advocate for equitable access to healthcare.	**2.1** Continue to work closely with government to secure long-term funding for rural training posts and advocate for further Specialist Training Program-Integrated Rural Training Pipeline posts for ANZCA.
		2.2 Build strong relationships with key internal and external stakeholders to improve workforce distribution, including regional committees, regional training hubs and regional and rural health services.
		2.3 Work with District Health Boards and heads of departments in Aotearoa New Zealand to identify non-metropolitan training opportunities.
3. New roles and innovation	Develop and implement a rural general practice anaesthesia training and continuing professional development program.	**3.1** Through the Joint Consultative Committee on Anaesthesia, continue to provide training and support to GP anaesthetists.
		3.2 In collaboration with other specialist medical colleges, develop and implement a Diploma of Rural Generalist Anaesthesia.
		3.3 Develop a communications strategy to raise awareness of rural GP anaesthesia training and CPD programs.

Priority area	Objectives	Actions
4. Positive rural careers	Promote the benefits and rewards of working in regional and rural areas to anaesthetists and specialist pain medicine physicians.	**4.1** Encourage selection committees and employers to consider rural background and previous rural placements in the selection of trainees for regional and rural training positions.
		4.2 Ensure that trainees, fellows and specialist international medical graduates in regional and rural areas have access to appropriate personal, social and professional support networks.
		4.3 Develop a communications strategy to promote positive regional and rural careers in anaesthesia and pain medicine.
5. Support and development	Develop holistic support and development, leadership and research opportunities for anaesthetists, specialist pain medicine physicians and specialist international medical graduates in regional and rural areas.	**5.1** Ensure that fellows, trainees and specialist international medical graduates in regional and rural areas have access to the same high quality training and professional development opportunities as their metropolitan colleagues.
		5.2 Establish mechanisms to ensure professional mentorship and support networks are available to regional and rural trainees, fellows and specialist international medical graduates.
		5.3 Explore partnerships and funding options to increase the number of regional and rural sites conducting trials in perioperative care and pain management.
	Support the college's commitment to gender equity and implementation of the gender equity action plan in regional and rural areas.	**5.4** Facilitating flexible and family/carer-friendly work practices through promoting and enhancing access to part-time training, flexible working hours and family/carer-friendly rostering for regional and rural trainees, fellows and specialist inernational medical graduates.
6. Health and wellbeing	Support the wellbeing of anaesthetists, specialist pain medicine physicians and specialist international medical graduates in regional and rural areas.	**6.1** Engage with relevant members and other stakeholders to better understand and meet the support needs of those in regional and rural areas.
		6.2 Develop evidence based online support resources for supervisors of training, education officers and welfare advocates to address and provide critical incident debriefing in regional and rural areas.
		6.3 Establish dedicated online support resources for trainees in regional and rural health services who are unable to access face to face critical incident debriefing.
		6.4 Ensure fellows, trainees and specialist international medical graduates in regional and rural areas have access to all available college and other available health and wellbeing resources.

Introduction

Background

The Australian and New Zealand College of Anaesthetists (ANZCA), including the Faculty of Pain Medicine (FPM), is the accredited education and training body responsible for training, assessing and setting standards for all specialist anaesthetists and pain medicine physicians in Australia and Aotearoa New Zealand.

The college's mission is to serve the community by fostering safe and high quality patient care in anaesthesia, perioperative medicine and pain medicine. Underpinning this mission is the premise that all people have a right to access high quality healthcare, regardless of where they live. The college is committed to addressing the geographic distribution of anaesthetists and specialist pain medicine physicians in order to improve health outcomes and access to health services for Australian and New Zealand communities outside of metropolitan areas.

Globally, many countries grapple with geographical imbalances in the distribution of their health workforce. As a geographically large country with a relatively small population, Australia is no exception in facing issues surrounding equitable access to health services.[1,2] Figure 1 illustrates the geographic distribution of selected medical practitioners in Australia (2019 data). It is evident that, with the exception of emergency medicine physicians, the number of doctors per capita rapidly drops with increasing remoteness. In 2019 85 per cent of anaesthetists and 88 per cent of specialist pain medicine physicians were located in major cities[3] (compared with around 72 per cent of the population living in major cities).[4]

> The purpose of this regional and rural workforce strategy is to document our commitment to improving health outcomes for Australian and New Zealand communities in non-urban areas and to the health and wellbeing of fellows, trainees and specialist international medical graduates living and working in regional and rural areas.

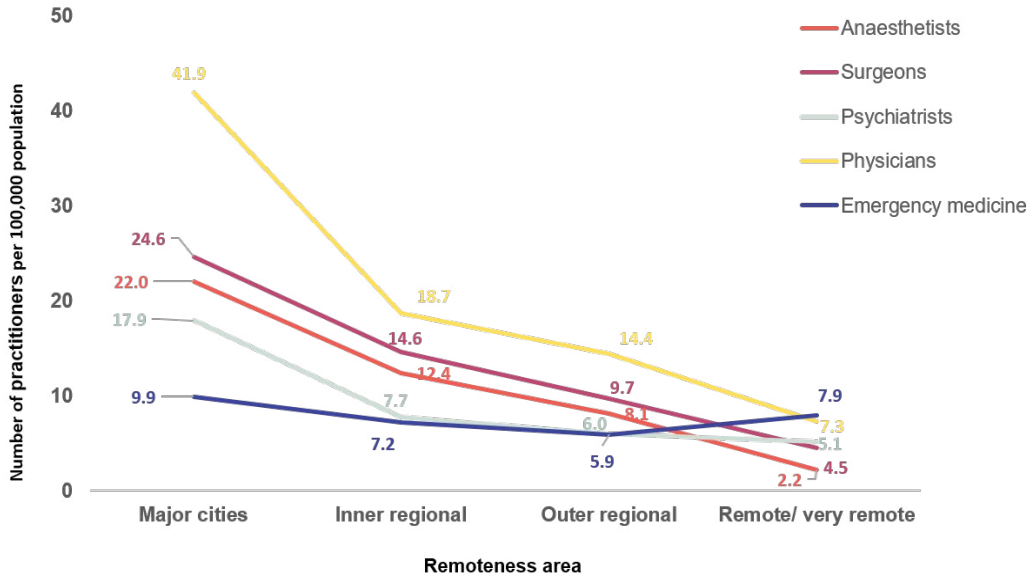

Figure 1: Selected medical practitioners (head count) per 100,000 population by Australian geographic remoteness area, 2019.[7,8]

In Aotearoa New Zealand, 90 per cent of anaesthetists and 91 per cent of specialist pain medicine physicians work in urban or secondary urban areas based on 2015 and 2016 workforce survey data provided to ANZCA by the Medical Council of New Zealand/Te Kaunihera Rata o Aotearoa. Census data from 2013 showed 78.3 per cent of the New Zealand population lived in urban or secondary urban areas.[5]

The governments of Australia and Aotearoa New Zealand make significant investments in initiatives to better distribute the health workforce.[6] In Australia, health workforce program expenditure was forecast to reach more than $1.7 billion in 2016-17 with over $700 million of this directed to the medical workforce. To date, the majority of programs in Australia designed to address maldistribution have focused on GPs, with attention turning to other specialists in more recent years. For ANZCA the most significant of the Australian government health workforce program is the Specialist Training Program. The operational framework of this program was revised in 2017 following a comprehensive review undertaken by the Department of Health. The Specialist Training Program provides funding to ANZCA for 37 anaesthesia and 5 pain medicine training posts, with the focus of the program now firmly on building training capacity outside of metropolitan areas.

While it would be unrealistic, and an inefficient allocation of resources, for the distribution of the specialist medical workforce to mirror that of the general population, there are opportunities to improve access to specialist services through initiatives such as expanding training opportunities in regional areas and outreach models of care.

Addressing workforce maldistribution and supporting fellows and trainees working in non-metropolitan areas through the development of a regional and rural workforce strategy is one of the five goals in ANZCA's 2018-2022 strategic plan. Objectives of the strategy include:

1. Accessing current and predicted population health workforce data to inform workforce planning.
2. Engaging appropriately and strategically with government to secure support via funding and placements and advocate for equitable access to healthcare.
3. Developing and implementing a rural general practice anaesthesia training and continuing professional development program.
4. Promoting the benefits and rewards of working in regional and rural areas to anaesthetists and specialist pain medicine physicians.
5. Developing holistic support and development, leadership and research opportunities for anaesthetists, specialist pain medicine physicians and specialist international medical graduates in regional and rural areas.
6. Supporting the college's commitment to gender equity and implementation of the gender equity action plan in regional and rural areas.
7. Supporting the wellbeing of anaesthetists, specialist pain medicine physicians and specialist international medical graduates in regional and rural areas.

As one of the largest specialist medical colleges in Australia and Aotearoa New Zealand, the college plays an important role in the health and wellbeing of Australians and New Zealanders. The purpose of this regional and rural workforce strategy is to document our commitment to improving health outcomes for Australian and New Zealand communities in non-urban areas and to the health and wellbeing of fellows, trainees and specialist international medical graduates living and working in regional and rural areas. The strategy sets out the overarching priorities and accompanying activities the college will undertake to achieve this.

Indigenous health

While most Indigenous people in Australia and Aotearoa New Zealand live in urban areas, a significantly greater proportion live in non-urban areas compared with non-Indigenous peoples. As such, any regional and rural workforce strategy must also consider Indigenous health issues.

The health and wellbeing of Indigenous peoples in Australia and New Zealand is an urgent health priority due to significant disparities between the health and wellbeing of Indigenous and non-Indigenous people in both countries across a wide range of measures.[9]

In Australia, Aboriginal and Torres Strait Islander people have a significantly shorter life-expectancy than non-Indigenous Australians, with 54.9 years the median age at death for an Aboriginal and Torres Strait Islander male compared with 78.6 years for a non-Indigenous male.[10] Statistics on surgery, hospitalisation and elective surgery waiting times also suggest differences in access to care for Aboriginal and Torres Strait Islander people. Compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander people have an admission rate for emergency surgery almost twice as high, lower rates of elective admissions, experience longer median waiting times for elective surgery (37 days versus 43 days respectively) and are hospitalised at more than twice the rate.[11]

In Aotearoa New Zealand, Māori experience significant inequity in health outcomes compared to non-Māori. Māori have a shorter life-expectancy at birth than non-Māori (73 years for Māori males and 77.1 years for Māori females, compared to 80.3 years for non- Māori males, and 83.9 years for non- Māori females) and experience poorer outcomes across a broad range of health status indicators. Directly relevant to anaesthesia, Māori also have significantly poorer outcomes following surgery. The Perioperative Mortality Review Committee found Māori have a 16 per cent greater risk of dying after surgery than New Zealand Europeans, and this difference remains after adjusting for socio-demographic and clinical factors.[12]

Young patient Justine and her mother Alisha at the Gove District Hospital in Nhulunbuy, East Arnhem Land.

A key component of addressing inequities in Indigenous health is to improve Indigenous representation in the health workforce. Medical workforces that are more representative of Indigenous communities are more likely to understand and be responsive to the needs of these communities, and to deliver culturally appropriate care. Opportunities for Aboriginal and Torres Strait islander and Māori people to pursue careers in health are increasing, however Indigenous health practitioners are still significantly under-represented. Workforce development involves increasing recruitment, retention and support of Indigenous health practitioners. It also involves ensuring that non-Indigenous health practitioners are equipped to practice in a culturally safe and responsive manner, to improve the ability of mainstream care to meet the needs of Indigenous people.

In 2018 the college launched an Indigenous health strategy which identifies four pillars to frame our work towards health equity for Aboriginal and Torres Strait Islander people in Australia and Māori in Aotearoa New Zealand — governance, partnerships, workforce and advocacy. In developing our Indigenous health strategy, we reviewed government priorities, Indigenous health strategies from other organisations, the health inequity literature, experiences of care for Indigenous patients and experiences of training and working in the health sector for Indigenous health practitioners. The college also engaged with other organisations and sought input from Indigenous health organisations, junior doctors and trainees. Our Indigenous health strategy represents a clear and public statement by the college on its areas of focus in Indigenous health and should be considered in conjunction with this regional and rural workforce strategy.

Underlying principles

The development of this regional and rural workforce strategy has been guided by a number of principles which will also underpin its implementation. These are:

1. Health equity is a safety and quality issue and patient safety and high quality care is paramount.
2. All patients have a right to access safe and high quality care, regardless of where they live.
3. Safe and high quality care is best achieved through collaboration and constructive engagement with relevant sectors and stakeholders.
4. Diversity within the workplace and the community is supported and valued.
5. Fellows, trainees and specialist international medical graduates have the right to train and work in inclusive, respectful and supportive environments.

Royal Darwin Hospital specialist anaesthetist Dr Edith Waugh reassures young patient Justine and her mother Alisha as they prepare for Justine's dental procedure at the Gove District Hospital in Nhulunbuy, East Arnhem Land.

Priority Areas

ANZCA's regional and rural workforce strategy outlines six key priority areas to guide our activities and initiatives to:

- Improve health outcomes for Australian and Aotearoa New Zealand communities in regional and rural areas.
- Develop a valued, skilled and healthy anaesthesia and pain medicine workforce in regional and rural Australia and New Zealand, practising within a supportive environment and culture, focused on delivering safe and high quality patient care.

The remainder of this document details the objectives and proposed actions for each of these priority areas.

PRIORITY AREA 1 **Workforce planning**	**Objective** Access relevant population and health workforce data to inform workforce planning.
PRIORITY AREA 2 **Engagement and collaboration**	**Objective** Engage appropriately and strategically with government to secure support via funding and placements and advocate for equitable access to healthcare.
PRIORITY AREA 3 **New roles and innovation**	**Objective** Develop and implement a rural general practice anaesthesia training and continuing professional development program.
PRIORITY AREA 4 **Positive rural careers**	**Objective** Promote the benefits and rewards of working in regional and rural areas to anaesthetists and specialist pain medicine physicians.
PRIORITY AREA 5 **Support and development**	**Objective** Developing holistic support and development, leadership and research opportunities for anaesthetists, specialist pain medicine physicians and specialist international medical graduates in regional and rural areas. **Objective** Supporting the college's commitment to gender equity and implementation of the gender equity action plan in regional and rural areas.
PRIORITY AREA 6 **Health and wellbeing**	**Objective** Support the wellbeing of anaesthetists, specialist pain medicine physicians and specialist international medical graduates in regional and rural areas.

Priority area 1: Workforce planning

1.1 Overview

Workforce planning involves an ongoing process to identify and address gaps between supply and demand in anaesthesia and pain medicine services, in essence "having the right people with the right skills in the right place at the right time."[13] Understanding the current workforce as well as potential future needs is fundamental to workforce policy and planning. The scale and pace of health sector reforms, new technologies and evolving patient needs present challenges for planning workforce responses. Other factors to consider in planning for the anaesthesia and specialist pain medicine physician workforce include increased medical student numbers, changes in workforce participation, population growth and increased demand for services.

Determining the number of trainees required to meet the needs of communities is complex and challenging and involves many different stakeholders including health jurisdictions, employers, medical colleges and governments. Since 2004 the college has accredited hospital departments rather than individual training posts, with the number of training posts available being the responsibility of employers (in Australia this is jurisdictional departments of health through their teaching hospitals, and in Aotearoa New Zealand district health boards through their teaching hospitals).

Reliable data and intelligence are necessary precursors to workforce planning. Long lead times in training specialist physicians adds another layer of complexity to workforce forecasting. In anaesthesia, trainees are currently unable to undertake their entire training outside of metropolitan areas due to the need to fulfil volume of practice and specialised study unit requirements. Regular evaluation and reporting of workforce policies and initiatives is required to measure their effectiveness and foster a culture of continuous improvement.

1.2 Objectives and actions

Priority area	Objectives	Actions
1. Workforce planning	Access relevant population and health workforce data to inform workforce planning.	**1.1** Establish core workforce KPIs and a process for their collection and dissemination. In Australia these will be accessed through college data, the Department of Health's National Health Workforce Data Set and the National Medical Workforce Strategy currently under development. In Aotearoa New Zealand these these will be accessed through college data, the Health Workforce Directorate within the Ministry of Health/Manatū Hauora and other sources
		1.2 Embed processes to accurately collect, analyse and share anaesthesia and pain medicine workforce data in Australia and New Zealand.
		1.3 Develop regular reporting and evaluation of workforce initiatives and activities, such as through wider circulation of college reporting to the Department of Health on workforce and the Specialist Training Program.

Royal Darwin Hospital anaesthetist Dr Edith Waugh (left) is a visiting specialist at the Gove District Hospital in Nhulunbuy, East Arnhem Land.

Priority area 2: Engagement and collaboration

2.1 Overview

The governments of Australia and Aotearoa New Zealand make significant investments in initiatives to better distribute the health workforce. In Australia, health workforce program expenditure was forecast to reach more than $1.7 billion in 2016-17 with over $700 million of this directed to the medical workforce.[14] To date, the majority of programs in Australia designed to address distribution have focused on GPs, and these have had a modest success.

For ANZCA, the most significant Australian government health workforce program is the Specialist Training Program, which incorporates the Integrated Rural Training Pipeline and the Training More Specialist Doctors in Tasmania program. The operational framework of the Specialist Training Program was revised in 2017 following a review undertaken by the Department of Health. The Specialist Training Program provides funding to the college for:

- 42 full-time equivalent anaesthesia and pain medicine Specialist Training Program training posts.
- 8 full-time equivalent Specialist Training Program-Integrated Rural Training Pipeline training posts.
- 7.75 full-time equivalent Specialist Training Program-Training More Specialist Doctors in Tasmania training posts comprising trainees, supervisors and coordinators.

Through the Specialist Training Program, the college has a valuable mechanism to build training capacity in regional areas. The new operational guidelines which came into effect in 2018 require that a minimum of 48 per cent of all ANZCA's Specialist Training Program training posts are outside of major cities. In addition, the guidelines require that the implementation of the program contributes to enhancing the availability of the specialist workforce in rural and remote locations and enhance Indigenous health outcomes.

Aotearoa New Zealand also faces geographical maldistribution issues with poorer access to services in rural and regional areas and difficulty recruiting doctors in these areas. Maldistribution across different vocational groups is also evident, with a shortage of general practitioners in Aotearoa New Zealand.

2.2 Objectives and actions

Priority area	Objectives	Actions
2. Engagement and collaboration	Engage appropriately and strategically with government to secure support via funding and placements and advocate for equitable access to healthcare.	**2.1** Continue to work closely with government to secure long-term funding for rural training posts and advocate for further Specialist Training Program-Integrated Rural Training Pipeline posts for ANZCA.
		2.2 Build strong relationships with key internal and external stakeholders to improve workforce distribution, including regional committees, regional training hubs and regional and rural health services.
		2.3 Work with District Health Boards and heads of departments in Aotearoa New Zealand to identify non-metropolitan training opportunities.

Priority area 3: New roles and innovation

3.1 Overview

In some rural and remote regions of Australia circumstances preclude the referral of certain types of surgery and there are no specialist anaesthesia services. The college recognises the vital role general practitioners with advanced training in anaesthesia can play in these communities and is committed to continuing to provide supervision, training and continuing professional development (CPD) opportunities to support them to provide safe and high quality care.

ANZCA is a member of the tripartite Joint Consultative Committee on Anaesthesia (JCCA), in partnership with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. Together with our JCCA partners, the college is focused on ensuring that the care provided by GP anaesthetists is safe, meets contemporary high standards of clinical practice and is practical and responsive to the needs of rural practitioners and the communities they serve. This work includes ensuring that the training curriculum for GP anaesthetists clearly articulates the competencies that all trainees are expected to achieve and that trainees are able to accurately assess the resources available to them in any given geographic environment.

The college is also committed to ensuring that GP anaesthetists continue to receive appropriate support, supervision and the opportunity to maintain their anaesthesia skills and knowledge by undertaking an ongoing case-load and participation in CPD in the field of anaesthesia in accordance with a JCCA-endorsed CPD program.

While there has been continuous improvement of the existing GP anaesthesia program, there is recognition that several issues need to be addressed, including:

- Consistency of anaesthesia training.
- Access to established educational resources to supplement the clinical-based training program.
- Standardised examination process.
- Linking ongoing CPD to the currency of the qualification.

Consequently, ANZCA, in collaboration with other specialist medical colleges, is developing a Diploma of Rural Generalist Anaesthesia that will be implemented in Australia.

3.2 Objectives and actions

Priority area	Objectives	Actions
3. New roles and innovation	Develop and implement a rural general practice anaesthesia training and continuing professional development program.	**3.1** Through the Joint Consultative Committee on Anaesthesia, continue to provide training and support to GP anaesthetists.
		3.2 In collaboration with other specialist medical colleges, develop and implement a Diploma of Rural Generalist Anaesthesia.
		3.3 Develop a communications strategy to raise awareness of rural GP anaesthesia training and CPD programs.

Lazarus, five, and his mother Joanne at the Gove District Hospital after his dental procedure

Priority area 4: Positive rural careers

4.1 Overview

While increasing the amount of training occurring in regional and rural locations is important, a broader regional workforce strategy needs to support this to ensure longer-term and sustainable outcomes. For example, it has long been recognised that medical students with a rural background are more likely to practise in rural areas.[15] This association between a rural background and becoming a rural doctor has been referred to as the 'rural background effect', and an analysis of a large cohort of commencing medical students demonstrated this effect to be a strong and positive predictor of attraction to rural practice.[16]

It is also important that quality rural training experiences are available for trainees from non-rural backgrounds. Studies have demonstrated that urban-based students who undertake an extended regional and rural placement are more than three times as likely as those with a rural background to express a first preference for a rural internship.[17] Rural training rotations are a key mechanism through which urban medical students gain exposure to rural practice and lifestyles. Research shows that for some medical students and junior doctors, a rural placement modifies longer term work aspirations about where to work, with positive experiences increasing the openness to rural practice. Conversely however, poorly supported rural exposures may shift the aspirations of students and junior doctors away from rural practice.[18]

Regional and rural practice may also have a stigma attached, with some trainees perceiving that the quality and professional experiences of rural work can be inferior to that of metropolitan training in large teaching hospitals.[19] A holistic approach that supports doctors and promotes the positives of rural practice (while recognising that it is not for everyone), is necessary to develop a sustainable, healthy and professionally satisfied regional and rural workforce.

4.2 Objectives and actions

Priority area	Objectives	Actions
4. Positive rural careers	Promote the benefits and rewards of working in regional and rural areas to anaesthetists and specialist pain medicine physicians.	**4.1** Encourage selection committees and employers to consider rural background and previous rural placements in the selection of trainees for regional and rural training positions.
		4.2 Ensure that trainees, fellows and specialist international medical graduates in regional and rural areas have access to appropriate personal, social and professional support networks.
		4.3 Develop a communications strategy to promote positive regional and rural careers in anaesthesia and pain medicine.

Dr Nathaniel Hiscock and Dr David Chan at GV Health in Shepparton, Victoria.

Priority area 5: Support and development

5.1 Overview

Sustainable regional and rural health workforce outcomes must be supported by a holistic workforce strategy covering both personal and professional aspects of attracting and retaining specialists to non-urban areas. Support for these broader issues is provided by an Australian Medical Association 2016 survey of nearly 600 rural doctors about their views on how to improve rural health care.[20] Among the sample of specialists surveyed, the top five priorities were:

- Providing extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters.
- Ensuring that rural hospitals have modern facilities and equipment.
- Encouraging medical colleges to include rotations for trainees to rural areas.
- Access to high-speed broadband for medical practices.
- Further funding to ensure locum relief.

Other considerations to support the regional and rural workforce include:

Gender equity

Around 1 in 3 anaesthesia and 1 in 4 pain medicine fellows are females, with the proportion of female trainees in both specialities approaching 50 per cent. ANZCA strongly supports gender equity because of its ethical, social and economic benefits to both its members and the broader community. In 2017 the college established a Gender Equity Working Group to achieve equal opportunities for all genders.[21]

The working group has developed a comprehensive action plan which aligns with activities to build a sustainable regional and rural health workforce, such as:

- Facilitating flexible and family/ carer-friendly work practices.
  - Endorsing all genders to engage in key societal roles such as caregiving and breadwinning and encourage equal participation in work, career advancement, family life and recreation.
  - Promoting part-time training, flexible working hours, use of carers' leave and family/ carer-friendly rostering for all fellows, trainees and specialist international medical graduates.
- Providing family and carer friendly facilities in the workplace and other settings for fellow, trainee and specialist international medical graduate activities such as conferences and committee meetings.
- Developing initiatives to support confidence and capability when career is disrupted by leave or part-time work.

Further information about the Gender Equity Working group and the Gender Equity action plan are available on the college website.

Lifelong learning and leadership development

The practice of anaesthesia and pain medicine is continually advancing in terms of patient outcomes, safety and quality. Successful lifelong learners:

- Continuously strive to grow and improve.
- Remain curious, asking questions and challenging assumptions.
- Are prepared to take risks and learn from mistakes.
- Are mindful of how they learn.
- Evaluate their own performance.
- Reflect on their learning.[22]

Doctors who are training and working in regional and rural areas may not have access to the same breadth of opportunities for learning and continuing professional development as their colleagues in major cities. This is particularly true in the case of access to face-to-face workshop, seminars and conferences. Ensuring there is adequate cover of rosters to enable staff to participate in off-site development activities can also be a challenge.

Considerations to support lifelong learning and leadership development of the regional and rural workforce include:

- Providing support, supervision, mentorship, leadership development and continuing professional development opportunities to regional and rural fellows, trainees and specialist international medical graduates.
- Ensuring adequate locum support for regional and rural doctors.
- Recognising the contribution made by specialist international medical graduates to the regional and rural workforce and their particular support needs.

Academic and clinical research

Research is a key pillar underpinning ANZCA's mission and driving a culture of research and quality improvement is a key goal of the college's 2018-2022 strategic plan. For many trainees, fellows and specialist international medical graduates, participating in research activities is a rewarding and vital part of their role. As with learning and continuing professional development, the opportunities to participate in research, particularly clinical trials, can be diminished outside of large metropolitan teaching hospitals. Barriers to clinical research in rural areas include a lack of appropriate infrastructure and facilities and access to appropriate workforce such as trial coordinators.

The Australian federal budget in 2020 allocated $125 million to improve access to innovative clinical trials in regional, rural and remote areas though improving trial facilities, equipment, services and systems, reducing the burden, costs and risks for patients and their families related to clinical trial participation and increasing research capacity.

The ANZCA Clinical Trials Network and members of the tripartite Rural Specialist Interest Group are exploring options to drive research and quality improvement in regional and rural areas. To support all researchers the college has developed online resources, including a research hub and the Research Support Toolkit. These resources will assist with the development and preparation of grant applications and can provide an opportunity for researchers to request funding for research coordinators.

Work-life balance

A number of factors are impacting on workforce participation rates including changing attitudes towards careers and work-life balance. Compared with their parents or grandparents, many young professionals hold different attitudes towards work-life balance – they are more likely to travel, take 'sabbaticals' or career breaks and have periods of part-time work to devote more time to family or other pursuits.[23]

A study undertaken by the Royal Australasian College of Surgeons Trainees Association in 2010 found 34 per cent of trainees expressed an interest in part-time training.[24] The same survey reported that 0.3 per cent of surgical trainees were actually completing their training part-time with a subsequent report noting that while college policy allows part-time training, in practice such training must be organised by individuals and trainees are frustrated by barriers at the college, Specialty Board, hospital administration and medical organisational levels.[25] In 2020, around 3.1 per cent of anaesthesia trainees were undertaking part-time training.

Further evidence of the growing importance of work-life balance among doctors is provided by the most recent Medical Council of New Zealand/ Te Kaunihera Rata o Aotearoa workforce report which shows a decline in the average weekly hours worked by doctors in the ten years from 2005 to 2015. This decline is accounted for almost entirely by male doctors working fewer hours rather than any increase in the number of females entering the workforce over the period.[26]

In Australia, the MABEL survey (Medicine in Australia: Balancing Employment and Life) provides robust evidence of the decline in doctors' working hours. Since 2008 approximately 10,000 doctors have been surveyed annually, providing an extensive longitudinal cohort. MABEL data shows a significant downward trend in doctors' average weekly hours, with a fall of just under 12 per cent.

Doctors training and working in regional and rural areas can sometimes struggle to achieve a satisfactory work-life balance as there may be fewer specialists available to cover rosters or fewer locums to cover periods of leave and so on. In addition to increasing the number of specialists in regional and rural areas, other opportunities to improve work-life balance include examining alternative healthcare models (such as outreach and video or telehealth) that improve regional and rural community access to services while enabling anaesthetists and specialist pain medicine physicians to have meaningful and rewarding careers.
Achieving a work-life balance is of course an important part of specialists' health and wellbeing, which is discussed next under priority area 6.

5.2 Objectives and actions

Priority area	Objectives	Actions
5. Support and development	Develop holistic support and development, leadership and research opportunities for anaesthetists, specialist pain medicine physicians and specialist international medical graduates in regional and rural areas.	**5.1** Ensure that fellows, trainees and specialist international medical graduates in regional and rural areas have access to the same high quality training and professional development opportunities as their metropolitan colleagues.
		5.2 Establish mechanisms to ensure professional mentorship and support networks are available to regional and rural trainees, fellows and specialist international medical graduates.
		5.3 Explore partnerships and funding options to increase the number of regional and rural sites conducting trials in perioperative care and pain management.
	Support the college's commitment to gender equity and implementation of the gender equity action plan in regional and rural areas.	**5.4** Facilitating flexible and family/carer-friendly work practices through promoting and enhancing access to part-time training, flexible working hours and family/carer-friendly rostering for regional and rural trainees, fellows and specialist inernational medical graduates.

Priority area 6: Health and wellbeing

6.1 Overview

In 2013 beyondblue released the results of a ground-breaking survey of thousands of Australian doctors and medical students. The survey revealed doctors were more likely to experience psychological distress and suicidal thoughts than the general community.[27] The research also highlighted that anaesthetists were the second highest specialist group experiencing very high psychological distress and drinking at high risk or harmful levels.

These findings are corroborated by the 2017 ANZCA survey of anaesthesia and pain medicine fellows which revealed:

- 11 per cent reported high or very high levels of psychological distress as measured by the Kessler Scale (13 per cent amongst FPM fellows).
- 26 per cent reported that their work did not leave them enough time for their family/ personal life (39 per cent, FPM fellows).
- 63 percent reported occasions where they worked through illness when they should have taken time off (62 per cent, FPM fellows).
- 33 per cent respondents have personally experienced workplace bullying and 57 per cent have witnessed it (29 per cent, FPM fellows).
- 20 per cent have personally experienced workplace discrimination (11 per cent, FPM fellows) and 5 per cent have personally experienced workplace sexual harassment (4 per cent, FPM fellows).

As with striving for diversity and inclusiveness in the workplace, promoting workforce health and wellbeing is an ethical, social and economic issue. There are also patient safety and quality concerns where care is being provided by doctors who are unwell. There is a robust body of local and international evidence to support the value of workplace health and wellbeing for the physical, mental and social wellbeing of employees.[28] There are also benefits to health services and businesses in terms of reducing absenteeism, presenteeism (working when unwell), workplace injury and improving productivity.[29]

Dr Emily Fergie with her son Raphael divides her time between Perth and Albany in WA's south-east

ANZCA is making significant investments to develop a co-ordinated and collaborative approach to members' health and wellbeing. The college's draft Doctors' Health and Wellbeing Framework composes three integrated action areas:

- **Promotion** — promoting health and wellbeing by developing the positive aspects of being in the profession as well as the importance of self-care in the role of doctor.
- **Protection** — protecting health and wellbeing of doctors through advocacy with employers to reduce profession-related risk factors for health and wellbeing and increasing protective strategies.
- **Support** — providing effective and accessible services and programs to supports doctors' health and wellbeing and encouraging those who need treatment, de-stigmatising mental illness and promoting inclusion.

These are complex issues that will require multi-faceted approaches and many parts of the health system to work together to provide effective and sustainable solutions. While health and wellbeing issues are by no means peculiar to the regional and rural workforce, it is well recognised that, for a variety of reasons, people living in regional, rural and remote areas suffer poorer physical and mental health outcomes than those in urban areas. It is important to ensure that strategies and resources for doctors' health and wellbeing are available to all fellows, trainees and specialist international medical graduates, regardless of where they live.

6.2 Objectives and actions

Priority area	Objectives	Actions
6. Health and wellbeing	Support the wellbeing of anaesthetists, specialist pain medicine physicians and specialist international medical graduates in regional and rural areas.	**6.1** Engage with relevant members and other stakeholders to better understand and meet the support needs of those in regional and rural areas.
		6.2 Develop evidence based online support resources for supervisors of training, education officers and welfare advocates to address and provide critical incident debriefing in regional and rural areas.
		6.3 Establish dedicated online support resources for trainees in regional and rural health services who are unable to access face to face critical incident debriefing.
		6.4 Ensure fellows, trainees and specialist international medical graduates in regional and rural areas have access to all available college and other available health and wellbeing resources.

References

1 Schofield D, Fletcher S, Fuller J et al 2009. Where do students in the health professions want to work? Human Resource for Health. 7: 74.

2 Humphreys J, Hegney D, Lipscombe J et al 2002. Whither rural health? Reviewing a decade of progress in rural health. Australian Journal of Rural Health. 10(1): 2-14.

3 Department of Health 2020. National Health Workforce Dataset. Available at http://hwd.health.gov.au/webapi/jsf/login.xhtml. Accessed 23 July, 2020.

4 Australian Bureau of Statistics 2020. Regional population growth, Australia, 2018-19. Cat. no. 3218.0. Canberra: ABS.

5 Department of Health 2020. Op cit.

6 Australian Bureau of Statistics 2020. Op cit.

7 Statistics New Zealand 2020. Urban area unit population projections, by age and sex, 2013(base)-2043 update. Available at http://nzdotstat.stats.govt.nz/wbos/Index.aspx?DataSetCode=TABLECODE7563&_ga=2.257520463.519702500.1595474515-1510980034.1595474515&_gac=1.27332558.1595474520.CjwKCAjwx9_4BRAHEiwApAt0zgTHXi4M4CWZffKZRFwK_SS7jKM5Ie8VYtWE_qIjLuPySvZ5OGIMZhoChhgQAvD_BwE. Accessed 23 July, 2020.

8 Mason J 2013. Review of Australian Government Health Workforce Programs. Australian Government Department of Health: Canberra.

9 Liddy M 2016. Closing the gap: Australia is failing to meet its goals on tackling Indigenous disadvantage. ABC News 12 October. Available at http://www.abc.net.au/news/2016-02-10/australia-failing-to-close-the-gap-on-indigenous-disadvantage/7153234. Accessed 28 July, 2017.

10 Steering Committee for the Review of Government Service Provision 2017. Report on government services 2017, vol. E, Health. Canberra: Productivity Commission.

11 Australian Institute of Health and Welfare 2016. Elective surgery waiting times 2015-16. Available at https://www.aihw.gov.au/getmedia/3a025e54-da4a-47bf-afdd-e8adad1ae1f9/20408.pdf.aspx?inline=true. Accessed 4 September, 2017.

12 Perioperative Mortality Review Committee 2017. Perioperative Mortality in New Zealand: Sixth report of the Perioperative Mortality Review Committee. Wellington: Health Quality & Safety Commission. Available at https://www.hqsc.govt.nz/assets/POMRC/Publications/POMRC_6th_Report_2017.pdf. Accessed 18 September, 2017.

13 United States Department of the Interior 2001. Workforce planning instruction manual. Washington DC: Department of the Interior. Available at www.doi.gov/hrm/WFPImanual.html. Accessed 3 April, 2018.

14 Mason J 2013. Op cit.

15 Laven G, Wilkinson D 2003. Rural doctors and rural backgrounds: how strong is the evidence? A systematic review. The Australian Journal of Rural Health; 11: 277-284.

16 Jones M, Humphreys J, McGrail M 2012. Why does a rural background make medical students more likely to intend to work in rural areas and how consistent is the effect? A study of the rural background effect. The Australian Journal of Rural Health; 20: 29-34.

17 Clark T, Freedman S, Croft A, et al 2013. Medical graduates becoming rural doctors: rural background versus extended rural placement. Medical Journal of Australia. 199: 779-782.

18 Zadoroznyj M, Brodribb W, Martin B 2014. Understanding the decision to relocate rural amongst Australian trained urban medical students and junior doctors. Brisbane: Institute for Social Science Research.

19 Mundy G, Chapman J, Wall A 2015. Training for the future: how are rural placements perceived and how do we give our students what they are looking for? Paper presented at the Rural Medicine Australia Conference (October), Adelaide, South Australia.

20 Australian Medical Association 2016. 2016 AMA rural health issues report: rural doctors have their say. Available at: https://ama.com.au/system/tdf/documents/Rural%20Health%20Issues%20Survey%20Report%20Final.pdf?file=1&type=node&id=44431. Accessed 16 April, 2018.

21 Watterson L 2018. Endorsing gender equity. ANZCA Bulletin. March.

22 Deakin Crick R, Broadfoot P, Claxton G 2004. Developing an effective lifelong learning inventory: the ELLI project. Assessment in Education: Principles, Policy and Practice. 11(3):247–72.

23 Mundy G, Wall A, Chapman J. (2015, May). #MillennialsGoRural: preparing for the new generation of health professionals. Paper presented at the 13th National Rural Health Conference, Darwin, Northern Territory.

24 McClelland B 2010. Report Card on Surgical Education. Surgical News; 11:6: 8. Available at http://www.surgeons.org/media/18532/SurgicalNewsv11_06.pdf. Accessed 5 April, 2018.

25 Tomlinson J 2012. Flexible surgical training in Australia: it's time for a change. Available at http://www.surgeons.org/media/18744675/ppr_2012-01-04_flexible_surgical_training.pdf. Accessed 5 April, 2018.

26 Medical Council of New Zealand 2018. The New Zealand medical workforce in 2015. Available at: https://www.mcnz.org.nz/assets/News-and-Publications/Workforce-Surveys/Workforce-Survey-2015.pdf. Accessed 12 April, 2018.

27 Beyondblue 2013. Urgent action needed to improve the mental health and save the lives of Australian doctors and medical students. Available at: https://www.beyondblue.org.au/docs/default-source/media-release-pdf/urgent-action-needed-to-improve-the-mental-health-and-save-the-lives-of-australian-doctors-and-medical-students-october-2013.pdf?sfvrsn=6eae79ea_0. Accessed 6 April, 2018.

28 Comcare 2011. Benefits to business: the evidence for investing in worker health and wellbeing. Available at: https://www.comcare.gov.au/__data/assets/pdf_file/0006/99303/Benefits_to_business_the_evidence_for_investing_in_worker_health_and_wellbeing_PDF,_89.4_KB.pdf. Accessed 17 April, 2018.

29 Worksafe Victoria 2010. Workhealth healthy workplace kit. Available at: http://www.worksafe.vic.gov.au/wps/wcm/connect/f7093280439cdf6db37eb3145ee8dc5e/?a=17203. Accessed 17 April, 2018.