Innovation in rural workforce strategies by a national surgical society: the ASPS experience

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Introduction

Health services exist to address the health needs of the community. But in Australia at present there are not enough detailed data to tell us to what extent, community by community, our highly regarded health system is meeting those needs. We know that demand for health care services is growing faster than the overall economy, and that we no longer have a general shortage of doctors, but most problematically there is a significant geographic maldistribution of those doctors away from rural and regional areas.¹

For plastic surgery services, there is very little understanding of what the aggregate needs of rural communities are, or how these needs vary by community. We know by anecdote that there is significant inequity in plastic surgery services and that rural and regional locations often have unfilled positions and diminished services. We note that only 8.5 per cent of specialist plastic surgeons are permanently based outside the five largest Modified Monash level I (MMI) Australian cities.¹ We also note that this is a very low percentage in comparison to other surgical specialties.

While we briefly explore the basis for some ‘innovative’ solutions in this paper, we are constantly reminded that a prerequisite of any ‘solution’ should be an in-depth study of what Australian rural communities need or want in terms of plastic surgery services.
current geographic maldistribution of the surgical workforce with a long-term strategy aimed at selecting, training and retaining for rural and regional workforce needs.\textsuperscript{24} Our experience is that this strategy is a soundly-based, long-term strategy. But, like all long-term strategies, it requires patience and may fail. Meanwhile, in the case of rural communities in Australia, the need is urgent. ASPS has therefore adopted the position that the RACS ‘select-train-retain for rural’ strategy should be complemented in plastic surgery with a range of other innovative strategies and projects that give us some sustainable workforce outcomes over a much shorter time frame and assist to confirm, one way or another, that the assumptions made in the long-term ‘select-train-retain for rural’ strategy are accurate.

This has been what ASPS has attempted to do with the ASPS Darwin Workforce Project. In 2020, in response to a crisis in Royal Darwin Hospital (RDH) (there became almost no availability of specialist plastic surgeons at the hospital), ASPS collaborated with RDH administration to initiate this project. It involves a two-year roster of two surgeons (usually a senior and a junior surgeon) at any one time relocating with their families to Darwin for up to three months. The partnership between RDH and ASPS has been critical in getting workforce results that RDH acknowledge have not been achieved before.

The project has a way to go, but in the long-term aims to build a sustained specialist plastic surgery workforce at RDH of five to six surgeons who all live locally and all work at least part-time at RDH. The project expects to return training accreditation for the hospital and to create significantly less dependence on specialist international medical graduates (SIMGs).

What assumptions might we challenge?

There are four assumptions that the ASPS Darwin Workforce Project has identified that are worthy of challenge:

1. It has been assumed that the key role of specialty surgical societies in addressing rural medical workforce needs is in selecting and training for those needs. But the project has indicated that specialty societies play a valuable role in both networking among the specialty and in building confidence in workplace opportunities. Specialty societies can be a key partner to regional hospitals but very few of those hospitals identify specialty societies as partners.

2. Employers in rural and regional hospitals default to assuming that a single permanent individual is the solution to their service deficit. Often there is enormous emotional, human and economic investment in these individuals. However, this model often leads to overwork, excessive on-call work limiting time for respite, lack of collegial support during difficult cases and the potential for burnout. A better model is to have a community of five to six plastic surgeons, all of whom are part-time at the public hospital and who collectively constitute a full-time equivalent for that hospital of a modest 2.5 positions (this has been successfully achieved in Launceston and Hobart).

3. It is often assumed by rural hospitals that the single most important outcome is the attainment of permanent consultants. Rarely are impermanent models considered. In practice, many of these ‘permanent’ appointees do not stay long-term and their departure is seen as a failure. This cycle of hope and disappointment is poor for hospital morale. For the individual, the expectation that they will stay ‘permanently’ creates pressure rather than being seen as a comfort or source of security. Developing more sophisticated models for plastic surgery units in which there is, as standard, a hybrid model of long-term, medium-term and rotating short-term positions would lead to a more robust service no longer reliant on any one or two individuals. If there is a type of specialist who has a generic interest in rural work, rather than being wedded to a single location, it may be appropriate and possible to set up a network of rural hospitals around Australia offering medium-term positions (one to two years) with enhanced systems of mutual recognition and communication, so that such specialists could ‘experience’ different rural locations before settling down for a longer period.

4. We suggest the framing of financial and other incentives are critical in getting medical practitioners to move to regional locations but the assumptions of what constitutes an effective incentive are not well understood. Having a good salary is of course a good strategy for attracting and retaining someone to a job. However, for specialists who have made large sacrifices and completed up to 20 years of training, their motivations for working in a position are inevitably more complex. Other factors that
contribute and that should be considered are: the intrinsic satisfaction of the clinical work they are performing, the gratitude of patients, the recognition of the value of their work by their professional peers and the local community, having a greater public and professional spotlight on the value of these positions to the community and the lifestyle and quality of life for them and their family outside of work.

In addition to the above challenges to traditional assumptions, the ASPS Darwin Workforce Project has encouraged us to propose the following as successful ways of reinforcing existing rural workforce strategies:

1. Selecting from a rural environment is not a sufficiently strong basis for ensuring a future rural workforce. The five year training program in plastic and reconstructive surgery occurs at a formative time in the lives of young surgeons (when they are often forming their families) and is only available in accredited hospitals, fewer and fewer of which are located rurally. Ties to rural locations are easily lost. To overcome this, a special program could be constructed for surgical education trainees in their second year. This would allow interested trainees to maintain links and relationships in rural hospitals and to gain experience working in a rural environment.

2. Rural and regional hospitals have often been served well by SIMGs. Often SIMGs experience arduous bureaucracy and little assistance finding appropriate positions for their supervised specialist pathways. They are mostly identified as threats by their locally trained colleagues. A more creative, constructive approach is warranted by RACS, the regulators and the Department of Home Affairs which specialty societies and their training boards can play a key role in. There should be a 24 month period of supervised practice on a specialist pathway for most of SIMGs that incorporates a twinning of a rural hospital with a major teaching hospital.

3. Another key part of the quality of life of a specialist is a feeling of being part of a professional community and having collegiate relationships. Its converse, a feeling of professional isolation, is incredibly stressful and difficult to live with. In this sense the quality of the surgical and other leadership in regional and rural hospitals, and the hospital culture that they are responsible for, is one of those critical undervalued elements that is a key determinant of the success of any rural workforce strategy or program. Improving the linking of any rural position to professional, social, educational and support networks is a key element for improving the rural workforce. Rural hospitals with reputations for being well-managed high-functioning environments with a positive professional culture between administrators and medical professionals are appealing to younger medical graduates and fellows.

Conclusion

Using a single strategy to source solutions to our rural workforce deficits will always be vulnerable to failure. There is strength in a multipronged solution. A set of parallel programs acting together is likely to be more effective. The principles of flexibility and inbuilt ‘learn as you go’ mechanisms are likely to be important, as it is inevitable that each community will be different and have different needs. Having in-built review and adjustment mechanisms means that positive change is sequential and continuous rather than a cycle of hope and failure with its attendant problems of chaos and poor morale.

Note

* When we refer to rural communities and rural hospitals we mean all regional, rural and remote medical services in Australia.

References


