2014 E-dgy Issues Program

The Royal Australasian College of Medical Administrators
Rural Health Continuing Education Program
RACMA Appreciation

RACMA would like to thank all involved in the development and delivery of the E-dgy Issues Program.

These E-dgy debates would not have gone ahead without the generous and positive support of the many who contributed their time to share and stimulate robust discussion. They provided the exploration of highly relevant and pertinent issues affecting regional, rural and remote health organisations across Australia.

Each of the four webinars was moderated, presented and debated by esteemed Fellows and experts in their field, who donated their time and expertise to assisting and guiding the education and collaboration sessions contributing their knowledge.

RACMA would like to thank the steering committee for their generous support and input throughout the E-dgy Issues Program. These dedicated members included Chair Professor Gavin Frost, Dr Jean Collie, Dr Meredith Arcus and Dr Robert Grogan.

The Steering Committee worked collaboratively to help guide a successful and productive shared experience encouraging discussion and debate. This work supported access to ongoing education by leading experts, accessible to all, including rural and remote health professionals, promoting collaborative networks of mutual learning.
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Webinars and Debates

1. Revalidation
2. End of Life: Futility of Care
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4. Rural Work Life Balance: High Performance Living
The Royal Australasian College of Medical Administrators
delivered a set of four, one hour webinar presentations followed by a 30 minute e-debate and discussion for doctors and health professionals. Based on contemporary and 'edgy issues' that are current to health services, medical and clinical administration. The E-dgy Issues Program (EIP) was delivered online via a webinar format. This program aimed to enable doctors and health professionals in medical and clinical management positions in rural and remote areas, opportunities to enhance their CPD and promote best practices in medical leadership, through access to the program and developed resources.

The EIP aimed to improve networking and collegiality, provide a resource, encourage interaction and reduce the impact of professional isolation. Doctors and health professionals were able to participate in and benefit from the program.

Each webinar ran for 1 hour and comprised a presentation, debate and an opportunity for discussion with the presenter and other participants. An additional 30 minutes at the end of the 1 hour session was available for further online discussion and networking between participants to encourage interaction and reflection on the topic presented.

This booklet is a collection of the presented transcripts and debaters comment for each webinar and will also be available on the RACMA website.
Revalidation

Doctors in future will have to undertake regular evaluations of their competence and fitness to practise that go beyond current accreditation, registration and continuing professional development (CPD) standards.

The Australian Medical Board and New Zealand Medical Council have initiated discussions about the establishment of a system of revalidation amid the introduction of similar schemes overseas, most recently in the United Kingdom.

Presenters
Professor Jenny Simpson
Mr Philip Pigou and Dr Joanna Flynn

Professor Jenny Simpson

Jenny was one of the original signatories to the NHS plan in July of that year. Since then she has advised successive Governments in both the UK and overseas on clinical leadership strategy. In 2007 Jenny was requested by Ministers to lead ‘Tackling Concerns Locally’ for Department of Health, implementing the White Paper: “Trust, Assurance and Safety”.

Jenny contributed to the drafting of the Regulation for Medical Revalidation and Responsible Officers and was commissioned to write the DH Guidance for responsible officers, the competency framework for responsible officers and the training plan. Jenny currently works with the Department of Health and NHS Commissioning Board in the UK, as part of the NHS Revalidation Support Team, driving forward the radical changes to medical regulation as part of a system-wide approach to improving the quality of care and patient safety.

As well Jenny is Chairman of the European Alliance of Medical Managers (EAMM).
Medical revalidation: three countries, three approaches

The UK experience
Professor Jenny Simpson OBE
Clinical Director, Revalidation
NHS England

Background
The initial thinking about revalidation in the UK dates back to the mid 1990s, following the scandal at Bristol Children’s Heart Unit. The first thinking around clinical governance began in the late 1990’s, and appraisal became mandatory for consultants and GPs at this time. However, there were further issues with quality and safety, culminating in exposure of Dr Harold Shipman’s murder of more than 200 patients, which went unseen due to failure to link information sitting in different parts of the system. In 2003/4 Dame Janet Smith’s inquiry into Harold Shipman found that the General Medical Council (GMC) was unduly biased towards the interests of doctors and at times ‘behaved more like a gentleman’s club than a regulator’. This prompted the 2005 Sir Liam Donaldson-initiated CMO’s Review of Medical Regulation, which led to the white paper ‘Trust, Assurance and Safety’ in 2007. The white paper recommended some form of regular check on every doctor’s continuing fitness to practise.

Evolution of revalidation in the UK
‘Trust, Assurance and Safety’ led to a ministerially-led programme of work for implementation, comprising a number of work-streams developing the structures and processes for revalidation. Legislation was drawn up (on the basis of considerable research) to introduce a new statutory position – the Responsible Officer. The Medical Profession (Responsible Officer) Regulations 2010 outline the role and its function, and is focused on quality assurance and safety of care.

These regulations are unique in the UK in that they are not limited to high-level guidance. They specify not only a close collaboration between the regulator and all employing and/or contracting organisations, but also mandate specific organisational processes and the algorithm by which doctors relate to their Responsible Officers, by a ‘prescribed connection’. This legislation is about governance and overseeing quality assurance systems.

The first Responsible Officers were introduced in January 2012, the Responsible Officer Regulations were enacted in October 2012, and implementation (starting with the revalidation of Responsible Officers, higher-level Responsible Officers and other medical leaders) began on December 3, 2012 (year 0 of a 3-year implementation plan). The way doctors are linked to the Responsible Officer is clearly defined in the regulations.

The regulations were amended in February 2013, to take into account major re-structuring of the NHS – the abolishing of existing regional and local structures and the introduction of NHS England and a new regional and local structure.

Medical Profession (Responsible Officer) Regulations, 2010 and 2013: how they work
Every doctor has one Responsible Officer, and the link is defined by how they are employed or where their contract is held. Every organisation providing healthcare and employing or contracting with doctors must appoint a Responsible Officer. Only one Responsible Officer may be appointed for each organisation, other than at NHS England (employing some 43,000 doctors), which is entitled to appoint as many Responsible Officers as necessary (currently 31).

The general principle of revalidation is one of continuous appraisal, rather than periodical assessment. Within a 5-year cycle, each doctor in the UK must demonstrate their continuing fitness to practise, in the role in which they are currently employed or contracted, to the GMC. Doctors present a specified set of information, including an
annual appraisal (in an agreed format and against national standards), and feedback from patients and colleagues in addition to governance data from other internal and external sources for every role in which they are employed or contracted as a doctor. The annual appraisal is supplemented by a specified set of informal feedback processes.

Organisations are mandated to support and resource revalidation. No doctor should fail to revalidate because of a lack of support by the employing organisation.

In practice…..

In the UK we have a revalidation process enacted by legislation. We are now in year 2 of a 3 year implementation plan in which 20% of doctors have been assessed in year 1, 40% will be assessed in year 2 and 40% in year 3. Thus far, some 40,300 doctors have had a recommendation made on their fitness to practice to the GMC (22% of total). 226 doctors have had their licences removed, of which 14 have lodged an appeal (some of the 226 were about to retire, and chose not to engage in the process). By March 31, all 165,000 doctors in England (plus smaller numbers in Scotland, Wales and Northern Ireland) will have had a recommendation made. From then on the system moves to a 5 yearly process, with 20% of all doctors going through the process each year.

Prescribed connections for all doctors in England: how doctors relate to Responsible Officers

The hierarchy of prescribed connections has been established (see figure). All Responsible Officers (currently 800) in England are trained to an agreed specification, have an agreed set format for appraisal (MAG form) and agreed national training specification for appraiser training. The format is embedded in the regulations. National policies are in place for responding to concerns for every type of employment/contracting relationship.

Running the programme

The national PMO works with small teams in each of 4 regions, running support networks, monitoring systems and quality assurance. The National programme is funded from Department of Health/ NHS England budget. Other organisations must fund their own processes. Responsible Officers are themselves doctors and therefore need to be appraised, so they also relate to a Responsible Officer. A pool of regional appraisers has been developed to appraise Responsible Officers. Challenges remain in ensuring funding is protected from the demands of the wider service in times of budgetary constraints.

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Current work and next steps

Issue to consider are:

• Ensuring consistency of decision-making and thresholds for intervention across all doctors and all organisations. This can be achieved by establishing networks for Responsible Officers, appraisers and case investigators/case managers, and organising national and regional events to calibrate approaches and standards across the country.

• Aligning policies across every sector. We are still struggling with the best way to manage the process for some doctors, such as locum doctors, especially those who do not have a connection within their employing organisation, and doctors with no obvious connection.

• Quality assurance – monitoring and reporting, implementation of FQA

• Integration of quality assurance revalidation with wider quality improvement processes across the entire health service

• Having a policy and a programme in place to integrate and standardise remediation, through the national Professional Support Unit, which is currently being set up

• Ensuring that national clinical priorities (e.g. cancer treatment, heart disease treatment) are integrated into medical appraisals (doctors being monitored about how they are doing versus the national clinical priorities).

Closing Summary

In the UK there is a national programme to implement medical revalidation that is mandated by legislation and is now in year 2 of a 3-year implementation programme. The programme is on track with the plan, with licenses being withdrawn from non-engaging doctors. The long-term benefits of implementation are being assessed by both the General Medical Council and the Department of Health, who have just started a 10-year research program into the long term benefits of revalidation.
Revalidation is a global issue. In New Zealand the process is called recertification, in the UK and Australia it is known as revalidation, while in Canada it is ensuring competence. When considering the revalidation process, we can take a global look at what the risks are in terms of the profession, what the background has been in terms of risk identification and mitigation and what the future holds in terms of continuing competence of practitioners. In New Zealand, the current recertification legislation, the Health Practitioners Competence Assurance Act (HPCA), was introduced in 2004. This legislation has a key purpose of ensuring the lifelong competence of practitioners.

In 1897, the Lancet view of New Zealand as an environment for medical practice was as “…a happy home for every kind of unfeathered quack.” (Lancet 1897 (1): 490). If this was either the perception or the reality (or both) at the time, it would be of concern to the profession and the regulator. We have moved on significantly since then.

The focus of recertification in New Zealand is now about ensuring competence. There is a clear statutory requirement by the regulator to ensure the competence of doctors and that the health and safety of the public is protected: “…to protect the health and safety of members of the public by providing for mechanisms to ensure that (doctors) are competent and fit to practise …” (Section 3 of the HPCA 2003). Other provisions of the HPCA 2003 include section 118, which sets out the role of the regulator. Paragraph D talks about the regulator promoting the competence of doctors, while paragraph E indicates that the regulator is required to set programmes to ensure the ongoing competence of doctors. Clearly it is not feasible for the regulator to assess the practice of all doctors, so there is a need to take a risk-based approach, such as that identified by Harry Cayton, the CEO of the Professional Standards Authority UK.

A risk approach

Cayton argues that “Right Touch Regulation” is about thinking about and identifying what the risks are in terms of any profession, and the risks from that profession to the public.

To be successful in applying this approach, the regulator needs to be consistent across all branches of the profession, and across all risks. When identifying the seriousness of a risk, the regulator needs to look at interventions consistent with the risk level being assessed, address them in proportion to their degree of risk and then ensure that doctors are achieving the level of competence required to avoid the risk. The programme should target interventions where the risk sits, so that individual practitioners are targeted in different ways according to their level of risk and competence (i.e. not the same/identical programme for all doctors; increased intervention for those not meeting the standard).

The level of risk and the mitigation strategies need to be clearly described. Professor Malcolm Sparrow of the Practice of Public Management, Harvard US, summarises this in terms of the confidence that regulators and medical and other health professionals need to be able to establish: “If you can describe a specific risk, what you did about it, why you think it was effective … that isn’t a story anyone can have trouble understanding.”

Good regulation is not just about managing risk (i.e. achieving quality assurance); it’s also about the very important quality improvement aspect, which improves the standard and quality of the profession and the practice of medicine overall. In ‘The Good Doctor – What Patients Want’, former New Zealand Health and Disability Commissioner Professor Ron Paterson argues “… that it is possible to improve patient care by lifting the veils of secrecy and better informing patients, by establishing more effective ways of checking doctors competence and by ensuring that medical watchdogs protect the public.”. He also notes that the current model of CPD for recertification is inadequate, and needs to be based more on the feedback that doctors receive: “Recertification based on the current model of CPD is inadequate. The choice of CPD as a marker for competent practice may be defensible on grounds of pragmatism and expense, but it does not absolve boards of their duty to ensure that every licensed practitioner remains fully competent”.

Competence not only needs to look at the downstream consequences (and identifying the differences between consequences), but also the upstream cause. The upstream initiatives to maintain fitness to practice and competence that have been put in place by the Medical Council of New Zealand (MCNZ) to minimise poor
downstream consequences are important. They require a strategic risk approach, (not only looking at competence but also identifying the causes and size of the risk, as well as whether there are interventions of a risk assurance or quality assurance nature that can make a difference. This is important from a regulator’s perspective, as they have responsibility for improving and maintaining standards around good medicine practice in New Zealand. Current upstream strategies that the MCNZ have in place are CPD and recertification for doctors on the general or vocational register, regular practice review principles, induction/orientation guidelines for overseas doctors coming into New Zealand, CPD, fitness to practise processes (regular practice reviews have been introduced for doctors on the general register and multisource feedback), a curriculum framework for doctors in prevocational years (first 2 years after graduation), stronger stakeholder relations with employers, improved standards and research and analysis of complaints.

Why universal recertification?

Some may question why recertification has to apply to all doctors in some way, whether they are good or poor. In response, there are two key reasons for this:

• To identify doctors with poor competence who have not been identified by the MCNZ competence, conduct and health processes. In terms of MCNZ’s ability to influence practitioner competence, the competence, conduct and health processes only deal with about 2% of doctors (i.e. 450-500 doctors with poor competence); however, there is reasonable evidence to suggest that approximately 5% of doctors fit into the poor competence category, so 50% of those who are not competent are being missed.

• Quality improvement – if someone who is a good doctor doesn’t want feedback about their performance, are they truly a good doctor?

Health professionals need to be careful that they don’t get fixed views around personal competence and how we act professionally. We need regular external review from someone else (a senior colleague in terms of practice) to identify gaps in our knowledge and performance that we can focus on to enhance our skills and capabilities (this is a core component of CPD recertification in New Zealand).

The public view of medical practitioners is really important, and regular reviews of competence increases public confidence in the medical profession. In New Zealand, the public say that knowing that doctor’s performance was subject to regular review would increase their confidence in the medical profession.

A personal view

I don’t want to go to a doctor who thinks knowledge is performance …

Who thinks feedback is for other people, or

Who thinks collegiality is more important than patient health and safety.

Three quarters state that their confidence in doctors would be increased if they knew that doctors performance are subject to a regular review

Professional regulation currently
National law requires that Medical Board of Australia (MBA) and each of the other national boards, can set registration standards for Continuing Professional Development (CPD) and Recency of Practice (which restricts changes of scope without appropriate retraining and sets requirements for re-entry) for their professions. Registration standards must be finally approved by the Council of Health Ministers. The MBA CPD Registration Standard defines CPD as “the means by which members of the profession maintain, improve and broaden knowledge, expertise and competence and develop the personal qualities required in their professional lives”. As well as requiring a good knowledge base, the Standard requires a range of activities to meet individual learning needs, including practice-based reflective elements e.g. audit, peer review or performance appraisal, as well as activities to enhance knowledge. The CPD standards are based on requirements set by specialist colleges for specialists and by the MBA for other doctors. Specialist colleges are accredited by the Australian Medical Council, and are a good means of ensuring that doctors stay competent.

On renewal of registration, the MBA also requires annual declarations of compliance with CPD and recency, any investigation or restriction of practice or any criminal history. Notification is mandatory if, on audit, a doctor’s competence is found to be substantially below standard or impaired. The system is based on annual renewal of registration, not on licensing or issuing an annual practicing certificate. Compliance is monitored by random audits of compliance with CPD and other registration standards.

The MBA CPD Registration Standard sits within a wider context of clinical governance, which includes health service or practice accreditation, credentialing, performance measurement and review, risk management, patient safety and quality improvement processes and collection of data (e.g. audit, incidents). However, not all doctors are included in these processes, and not all processes are well developed.

Is this enough?
The question currently being considered is whether this process is enough or should there be a move towards revalidation in Australia. The MBA started a conversation about this in March 2013. They decided that revalidation is the appropriate term for Australia, because the Australian process is very similar to the UK process and is unlike the process in the US, because there is no medical licence in Australia and therefore no facility for licence renewal.

IAMRA defines Revalidation/Recertification/Maintenance of Licensure as “the process by which doctors have to regularly show that they are up to date and fit to practise medicine” and aims “To give patients the assurance they seek that any doctor is competent and fit to practice, yet do so in a way that does not undermine trust and professionalism”.

Threshold issues that need to be considered by the MBA as part of developing a revalidation process are:
• Can/does College CPD ensure competence and professionalism?
• Would Revalidation address or prevent problems in
  - Assuring competence and performance of individuals
  - trust and confidence in the profession
  - trust in the regulatory standards and processes

However, revalidation requires a lot of time, effort and cost, and we need to be sure that the system is going to work. We also need to consider the value that revalidation would add and consider whether this would justify the cost in time, effort and opportunity gained.

Key questions that the MBA are currently considering are:

i. What would be the interface between professional regulation and health system regulation and clinical governance?
ii. Would the process be diagnostic or developmental or both?
iii. Should the process be for everyone or for high risk groups? Or should there be screening for everyone and greater depth for those picked up on initial screen?
iv. Should assessment be conducted at a specific point in time, or should it be cyclical or continuous evaluation?
v. Should the process be formative or summative?
vi. Should revalidation focus on testing or on learning and demonstrating mastery?
There are no definitive answers to these questions yet!

Possible tools for the revalidation process that have been identified by the MBA include:

- Multi-source feedback – patients, co-workers, colleagues
- Practice visits by peers
- Review of practice data
- Audit
- Self-assessment of knowledge
- Formal testing of knowledge

Given that we have bi-national specialist Colleges, it is important that Australia and New Zealand work together on the process.

It is important that within the revalidation system we focus on patient safety, encourage self-reflective practice and improve performance of everyone over time. We need to ensure that minimum standards are met by all, but recognising that the practice of medicine is complex, contextual and diverse, and mostly can’t be reduced to discrete, measurable outcomes. Thus, we need a variety of tools and approaches to assess whether people are practicing in a competent manner. The aim of revalidation should always be to enhance rather than undermine professionalism (some approaches could undermine).

Next steps

Actions that the MBA are currently proposing in the next financial year are:

- Establishment of an expert working party
- Social research re community expectations
- Commission a paper for discussion that will
- Review the evidence
- Describe possible models
- Suggest range of options
- Piloting and evaluating possible tools

It is now 18 months since discussions with the specialist Colleges on CPD processes started, and we are identifying what processes exist and where there are gaps. We want a system that has intrinsic value and effectively uses dollar and people resources, and does not simply create a bureaucracy. Whether continuing assessment of competence to practice remains as CPD (but a more robust process) or becomes a more formal revalidation needs to be approved by Australia’s health ministers, and requires compelling evidence, argument and high-level support.

We need to continue to stimulate the conversation!
End of Life: Futility of Care

While clinicians and clinician teams predominantly make treatment decisions in patient care, the community looks to senior medical practitioners to play a leadership role in ‘end of life’ and ‘futile care’ discussions and decisions.

It is within the existing power of the medical profession to encourage medical leadership groups to raise and debate this issue, to re-evaluate training from undergraduate level up and to effect change today.

Presenter
Dr Brendan Murphy

Dr Brendan Murphy
MB, BS, PhD, FRACP, FAICD

Dr Murphy has been Chief Executive Officer of Austin Health since 2005. Prior to that, he was Professor/Director of Nephrology and Chief Medical Officer at St. Vincent’s Health. For most of his professional life, he was a physician and nephrologist and is a former President of the Australian and New Zealand Society of Nephrology. During his clinical career, he had an active NHMRC funded research laboratory, working principally in the area of the complement system in immunological renal disease. He retains a position as a Professorial Fellow with the title of Professor at the University of Melbourne.

In his current role, he has developed new interests in health workforce reform and end of life care issues.

He is currently Chair of Health Services Innovation Tasmania and President of the Victorian Hospitals Industrial Association. He is also a Board member of the Florey Institute of Neuroscience and Mental Health and the Olivia Newton-John Cancer Research Institute. Previous Board directorships have included Health Workforce Australia, the Royal Victorian Eye and Ear Hospital and Kidney Health Australia.
The significant problem we have with inappropriate end of life care is largely the fault of poor medical leadership, and I use the word ‘medical leadership’ very carefully because I think the problem is very much in the hands of the leading clinical group, the doctors. It’s probably also time that we started to change our language from talking about “futile” care or withdrawing care (because of pejorative connotations) and instead talk about moving the patient’s care paradigm from active treatment with curative intent to active palliative treatment, as this does not convey a message to patients’ families that we’re no longer actively looking after their relative.

A lot of doctors, particularly those who are younger, will tell you that the problem is not the medical profession, the problem is the community. They believe that the community has changed their expectations and their attitudes and that they’re much more demanding and difficult and unreasonable and unrealistic. Nevertheless, despite there being an increase in the confidence with which some members of the patients’ families will express views, there hasn’t been a really significant change in that space.

Another reason given by doctors for not being firmer in the end of life care discussion is confusion about autonomy of decision making. Everyone accepts that patients and families have the right to make decisions, but that doesn’t necessarily mean that they have the right to make decisions about treatment that is inappropriate and there certainly is no legal requirement for that to happen. Indeed, sometimes putting people in a position of making a decision which is psychologically traumatic, contributes to the problem. While there has been some increase in medical negligence cases in Australia, our medico-legal environment around decisions to not undertake inappropriate end of life care, has not changed at all and evidence from the few court cases that exist suggest that Australian courts are of the view that they should uphold reasonable decisions made to withhold treatment when it’s not appropriate.

Ultimately, these issues are just excuses and the real reason is related to a lack of clinical confidence, in part related to the way doctors are currently educated now and also due to doctors feeling that they can’t be assertive leading clinicians, which in my view, is what the community wants.

There are few people in our health system who would deny that there is a problem around end of life care. There are numerous stories of patients being aggressively treated in a way that they and their families didn’t want; of nurses being asked to continue active treatment when they think it’s inappropriate and of junior medical colleagues having to try and keep going in an increasingly futile situation resulting from a rushed decision from a ward round.

Super specialism, where decisions are often made around what is technically possible, rather than taking an holistic view of the patient, has also contributed to the problems we have in determining appropriate end-of-life care. We have specialization now where none of the sub-specialists involved feel that it’s their role to say that in a global holistic context, ‘This patient is dying.’ In fact, the diagnosis of dying is a diagnosis that we seem to be able to less confidently and less frequently make these days.

Whilst the public has an expectation that we can do wonderful, clever things, the public also has an expectation that their family won’t suffer and there are lots and lots of accounts of families who feel quite disempowered watching their relative being shunted down to the intensive care, being ventilated, being hemo-filtered, when in discussion with the family they are clearly of the view that that’s not what the patient would have wanted. And that’s similarly the impression that we get from many of those patients, when you have the chance to talk to them if they are competent in advanced care directives.

There are also lots of data from studies on the costs of end of life care; a huge proportion of the health budget, particularly in the US, is spent in those last few months of life. It is important, however, that we don’t market the need to fix the end of life care problem from an economic perspective. Rather, we should be talking about what is in the best interests of the patient being treated. All of the evidence that we’ve got from advanced directives suggests that the great majority of people who, when placed in a situation where they’re not able to make a decision, being ventilated, being hemo-filtered, when in discussion with the family they are clearly of the view that that’s not what the patient would have wanted. And that’s similarly the impression that we get from many of those patients, when you have the chance to talk to them if they are competent in advanced care directives.

Dr Brendan Murphy
Presentation Transcript
active clinical leadership in the medical profession to effectively manage the situation.

When dealing with end-of-life care, it’s important to have a conversation that leads to the best decision for the patient, being made. Often we are faced with a patient who had been sent into hospital for consideration of therapeutic treatment (e.g., dialysis), when they have numerous comorbidities. A not atypical patient would be elderly, bed-bound, with diabetes and advanced microvascular disease, cardiac disease, having had a stroke or limb amputation, for whom dialysis is suggested when their kidneys begin to fail. While such patients’ families have an expectation that dialysis was going to happen because this was what they’d been told was going to happen, this is not always best for the patient.

An appropriate discussion leading up to telling that family, that as a clinician, you have made a decision not to offer dialysis, but would provide a referral to the palliative care service and make sure that they received appropriate end of life care. ‘Dialysis’ is incredibly burdensome; it would be likely to result in the patient spending months, their last months, in hospital not knowing what was happening, with invasive procedures and not really being able to participate and not having a good quality of life. It certainly might prolong their life by some months but with no ‘quality’. In my clinical experience, families generally say, ‘Well, okay, we understand that, the doctors can do no more,’ and they would accept that decision and not be in a situation of psychological burden. In contrast, if clinicians, after having the conversation about the difficulty and the problems with dialysis, say to the family, ‘Well it’s your decision, what do you want to do?’ They put patients and families in the difficult position where they are left with the psychologically burdening decision that they have decided to end their relative’s life. In my view, families are much more comfortable passing that decision off to the medical practitioner. While that does go against some current teaching and patient/family autonomy, I think our duty of care is to do what’s right for the patient primarily, and also for the family.

CPR is a similar situation. Rather than asking a family to consent to a ‘Not for CPR’ approach, clinicians should decide whether or not CPR is appropriate care and should share that decision with the families, explaining the reason for it. We shouldn’t specifically ask them to consent to something that might put them in a psychologically damaging situation. This is a medical decision that the community clearly expects the medical profession to be involved in. I also strongly believe it’s a senior medical responsibility; we cannot delegate or abrogate this responsibility to junior medical staff.

It’s important to note that there is no obligation at law to provide active treatment that has no reasonable or likely prospect of success. At Austin Health we have had a few cases in the last 10 years where a family, for various reasons (usually profound guilt), has challenged the decision to withdraw active treatment. Once or twice this has been tested in the courts and the courts have very strongly and unequivocally said that the decision was reasonable and in the best interests of the patients.

While hospitals have the bigger problem with end-of-life care, there are also problems in primary care. While hospitals probably have the most significant incidence of inappropriate end of life care, many of those problems could be prevented by better communication with GPs. In the hospital system, we don’t necessarily communicate well with GPs to find out what the patient would have wanted and we also haven’t engaged GPs in decision making for palliation, or to not send to hospital someone who clearly has little chance of surviving active treatment.

This is particularly the case with the large number of people who are transported from residential aged care facilities to our hospitals for their terminal illness. Many of them have had advanced care directives, their treating physicians (GPs, ED doctors) that they have little to no hope of survival and yet they’re put through a hugely burdensome process of being loaded into an ambulance, taken to hospital, possibly having a couple of days of inappropriate active treatment, dislocating the family and then dying in hospital. Instead, with outreach services and the sensible involvement of GPs who are prepared to say, ‘Well this is what is right for this patient, sorry residential aged care facility, you have to look after this patient, we’ll provide palliative care and the in-reach services if necessary and look after the patient in this environment’, they can die with dignity.

Hospitals do seem to have this inevitability of some sort of intrusive intervention, e.g., the patient with bed-bound dementia, with terminal pneumonia, who is pushed into an ambulance, sent to hospital, given a few days of ceftriaxone, may have a Medical Emergency Team (MET) call because someone hasn’t made them ‘Not for CPR’, who then dies after 3 days, in a situation of discomfort and indignity, when they could have stayed at their aged care facility and been looked after very well. A decisive position from the doctor who knows the patient best, in this case the GP, has huge power. At Austin Health, we’ve started a program where every clinical unit now has a member of the senior medical staff who is part of a consortium looking at end of life care issues and will be the champion for end of life care in their clinical unit.

Some senior medical staff say that they just don’t have time to make decisions; it’s much easier to say, ‘Well let’s have a trial of treatment and then move to the next patient in a ward round.’ But often, taking the time initially, can save a lot of time later by preventing a difficult situation.
End of Life: Futility of Care Debate

The on-line debate had two speakers for the Affirmative and Negative of this debate. The following discussions are supplied from the transcript of the presentation.

1st Debater
Dr Gabrielle du Preez-Wilkinson

I don’t believe inappropriate end of life is all the fault of the medical profession. Patient autonomy also contributes. For instance, trying to respect patient autonomy of wanting to die at home means that you are fighting the whole medical care system: the ambulance trying to take the patient in every time a well-meaning neighbour hears something and rings them; trying to keep them out of the hospital when they get to the hospital; the palliative care unit, an enormous organization. This paternalistic idea that we know where it’s best for people to die or how they should die is long gone and patients do have the right to have a say.

Family and friends definitely have opinions about end of life. There are only two moments in a person’s life that you can’t redo. One is their birth and the other is their death. They are not fixable in any way, shape or form. Whatever happens in those defining moments are finite and are definite. And that is how it is. The family that seems to have the most problem with people dying are the families that have been left estranged during the person’s life. You have to manage and work with those people through the process.

Dr Google is also a significant problem. So many of people who come to see their doctor with various medical problems, especially terminal problems say, “Oh, I looked it up on the internet. And I found this potential solution and I found that potential solution and I found some other potential solution.” The medical profession can only do their best to manage this. Quite often if you don’t give people what they want from their searches, they will go elsewhere to get what they want.

In some situations, people have to work with the information available. For instance, sometimes in nursing homes you have a nurse on nightshift responsible for 60 residents, some of whom are very ill, who has very few people to help her or give her support in terms of assistants in nursing. Often in the middle of the night when there’s nobody else around, the only place that they can get help is the ambulance, who then takes the patient to hospital. While doctors often find out their patients have been transferred to hospital in the middle of the night from the nursing home and shake their heads and wonder how that happened; it’s simply because people tried to do the best that they can.

2nd Debater
Professor Gavin Frost

I want to argue that training of medical professionals has always been about cure and that the subspecialisation you talk about, the one that I talk about on a regular basis, the left atrium specialist can undoubtedly cure your left atrium no matter what ails your left atrium. The challenge, of course, is that the left atrium is only a little part of one of the organs of one person. But we are well-trained to cure. And subspecialisation has produced the ability to cure and, therefore, we are moving in that direction.

When I say that the law doesn’t treat kindly with neglect, clearly the definition of futile care, which is what you were talking about before, is open to debate. And whether or not somebody with persistent vegetative state warrants ongoing care or not, as you know, is being debated in many jurisdictions. So I’m not sure. I guess a lot of doctors are not sure that the law would treat us kindly if we were not to undertake treatment, particularly treatment about which there is some discussion, the definitive randomised, multiple randomised control trials may not have been complete. The evidence isn’t there to say that this treatment is inappropriate. Therefore a lawyer would argue, as lawyers are trained to do, this may well be neglect.

Diagnosing end of life is one of many things we don’t do well, I’ve said. And I think it’s, in a sense, agreeing with Gabrielle that, when does death come? When is death likely to come? We’ve all seen patients who are likely to die tomorrow who are still pale and hearty months, weeks, years from now, and people who die suddenly. So ensuring that end of life is accurately diagnosed is something that I think doctors don’t do well. And, therefore, doing nothing, i.e., advising dialysis or whatever it might be, the hospital can now offer, is one of those things which covers you because you don’t really know whether this is ‘end of life’ or just one of those things from which someone will recover and live for a long time.
The other, I think, we have made a rod for our own back. The public believes, by virtue of social media and even television before that, that we have multiple cures for cancer, that we have artificial kidneys, that we have artificial ears, that we have artificial hearts. Therefore death is something that really is quite avoidable now. The medical profession surely is in a position to be able to ensure that the bits that break can be replaced. Ears can be grown in rats and transplanted. God alone knows what is next because the medical profession have said that we can now defeat death, at least subtly by evening television programs showing the latest cure.

So, in a sense, it is our fault because death is inevitable for all of us. While you’ve clearly set out the argument in favour of not providing futile care, I think the public says, “Well, nothing’s futile anymore because you can cure everything.”

Key issues addressed in the Question and Answer time

The advanced care directive movement is a big part of managing end of life care decisions. In some hospitals there is an internal policy that patients over a certain age will have an advanced care discussion and some clinical units, like the dialysis program, require everyone to have an advanced care directive discussion. Likewise, most of the good residential aged care facilities now have an advanced care directive discussion as a policy position. The big benefit of advanced care directives is not so much the document, which has not much legal value, but it’s the discussion outside of the heat of an acute decision; its families knowing what Granddad would want. It’s also making sure that people have got the right legal instruments in terms of power of attorney in place. There’s nothing easier than having a family who know exactly what a dying relative wanted and it makes them much more at peace with it. At Austin Health, we have the Respecting Patient Choice programme, which is a national programme to promote advanced care directives; however, it will never cover everybody. There will always be situations where acute deterioration occurs, which is where medical leadership needs to be the major factor.

An additional consideration is that different cultures have different approaches to death and dying, including those that don’t even want to have the discussion in the open; they prefer to talk in euphemisms and innuendoes. Ultimately we have to be respectful of those cultures and try and work around them, but our duty as health practitioners in our system, our cultural and medical system, is to do what we think is reasonably in the best interests of the patients. We may modify how we convey that view, or we may even, when appropriate, give people time to make a decision before you cease active treatment.

However, we shouldn’t be doing something that’s not in the patient’s best interests to please the views of family members.

One of the problems when discussing end of life care is the terminology used, which can be confusing. For instance, futile is a really pejorative term that should try to stop using. Palliative care is one of the most exciting branches of medicine I’ve seen and it’s very active and it is very goal-focused and it isn’t just about letting people die. I think we’ve all experienced that recently, so it is entirely active, but it’s not treatment with a curative intent and that’s perhaps the words we should use instead of active care. The palliative care doctors are currently considering whether they should change the name of their specialty, because they’re not just about palliation in the conventional community sense.

In a situation where it’s not been possible to get an advanced care directive or to have any discussion about resuscitate/do not resuscitate, for instance, when somebody presents with an advanced incurable but previously undiagnosed or unknown malignancy, we should make an assessment of what are the reasonable prospects of survival and of any qualitative value if treatment is active treatment; I again use that word of “treatment” where the curative intent is undertaken. Clearly, if you’re faced with that situation where it’s completely previously undiagnosed, you’re not even sure what the primary is, I think you would take a more cautious view there because you could possibly have something which might have histology that’s amenable to treatment. But, if the clear evidence is that there is no reasonable prospect of this patient having a reasonable cure, then my view is you have to act in the patient’s best interest and communicate that to the family.

The overriding principle of acting in the best interest of the patient covers the majority of issues, however, when multiple doctors are treating the patient, we are often not sure that another doctor is making the right decision. To overcome this, a common view on treatment is important. Having families exposed to conflicting medical views needs to be avoided. The decision needs to be thought through properly and sometimes it is helpful to have an independent person present to help facilitate the discussion. Having another doctor in that role, who’s a bit more objective, can be really helpful. Dissent is a problem, but it’s usually avoidable.

ICU outreach programs are becoming more prevalent now, both following up people who have left ICU to prevent them deteriorating and going back and a lot of intensive care units now make sure that the assessment of people is done by a fairly senior group of people. In the whole end of life care space, the MET call is one of the most interesting developments. Austin Health is one of the
pioneers of MET calls and we find a significant proportion of our MET calls are for people who actually have end of life care issues and that they haven’t been addressed or properly documented and the MET team, which has a senior ICU registrar in it, is involved in making those end of life care decisions. Whilst intensivists often have unrealistic expansionist plans (which need to be tempered), they do have huge value in objectively assessing people and I think a more senior outreach program is a good idea.

Things that would enable and support doctors in initiating end of life conversations include:

1. To talk about this issue in a much more practical way in medical schools so doctors understand they’re not being taught from a dry theoretical ethical framework, they’re being taught in real life situations.

2. Junior medical staff need to be exposed to properly conducted end of life care discussions. The discussion should largely be held by senior people, consultants or possibly senior registrars, but the intern should be invited in and should experience the discussion.

3. Run education programs, particularly around this area of medico legal uncertainty. We need to educate people around what the medico legal position really is in this country. We need community debate, with the community having these family discussions, which will mean that the family will almost always initiate the best approach because they know that that’s what the family member wants. It’s unreasonable to tell an intern to go and have an end of life care discussion in an unprepared state. You can’t do this sort of discussion in 10 minutes; it needs sometimes an hour for a discussion, particularly with families that are estranged or feeling guilty.

There have been attempts to get media attention. There have been some very good programs on television and a couple of the print media articles have run it. I think the problem is that we get caught up in the euthanasia debate. You know, the euthanasia advocates are very passionate and I think for a small proportion of patients I can see where they’re coming from, but the community is very frightened of this euthanasia position, and it’s important that discussion around end of life care is separated from the discussion around euthanasia. End of life care has to be seen as an active process of doing what’s right for the patient within our current legal framework, not as an active killing thing. We all have a duty to participate in community forums, to talk to the media, to encourage community debate and to inform the general public.

What happens when there are conflicting views among the family about the best course of action? If we are confident about what the patient would have wanted or views that they had expressed, then this should be the prime decision-making principle. So the member of the family who supports the medical profession should be trying to get the family to come to that position. It’s more difficult if nobody really knows what the patient would want and then you are left in a difficult decision of trying to predict that and to reach a consensus, resolving those issues by having a mature discussion that has to be medically led.

As a final comment, a good resource for all of us is the Medical Journal of Australia supplement “Clinical practice guidelines for communicating prognosis and end of life issues with adults in the advanced stages of a life limiting illness and their care givers” published on 18 June 2007 in Volume 182 (12).
Health Workforce
How can it be maintained in rural areas in the 21st Century?

The Health Workforce webinar discussed the ongoing shortage of doctors and medical staff in rural and remote areas when compared to cities like Melbourne. Offering enhanced life choices, and giving graduates a meaningful career path that is respected and well remunerated could be an appropriate progression.

There is increased risk for rural practitioners coming to the country; operating in a range of settings with variable amounts of support, and yet they’re expected to cover a large number of specialities, often with little or no backup.

The self-sacrificing nature of a practitioner in the country combined with fewer amenities in a rural setting; they can be facing these obstacles and others including the lack of social and support networks.

Presenters
Dr David Campbell
and Dr Robyn Mason
Dr Mason has an extensive background in health services management and has held senior leadership positions in the public and private sectors including the roles of Secretary-General of the Australian Medical Association and CEO of AMA Victoria. Her background encompasses corporate and clinical governance, medico-legal, medical credentialing and scope of clinical practice, community engagement, workforce development and health care funding. Robyn is a director of Health Purchasing Victoria and of North West Melbourne Medicare Local. She was the former chair of the Victorian Doctors’ Health Program and a board member of Southern Health in Melbourne.

Robyn has a part-time role at Skilled Medical as Senior Medical Advisor where she oversees quality standards and medical governance frameworks. Robyn has a master’s degree in administration and holds fellowships with the Royal Australasian College of Medical Administrators and the Australian Institute of Company Directors.

Dr Campbell is the Director of Skilled Medical, a national medical recruitment firm which he established in 2005. He is a former CEO of St Vincent’s Health in Melbourne and in NSW Health his roles included Regional Director of the New England Health Region.

He was a founding Director of the Rural Doctors’ Network in NSW, a Councillor on the NSW Postgraduate Medical Council and an executive committee member on the Victorian Postgraduate Medical Foundation. The company he leads is one of the largest suppliers of locum senior medical staff to rural and remote areas in Australia.

David has fellowships in public health medicine and medical administration and he is a graduate of the Advanced Management Program at the Harvard Business School.

It’s interesting to note that views about the supply of doctors have waxed and waned over the decades.

To go back to the 1990s the official perception was that there were too many doctors. So restrictions were placed on supply and then by the early 2000s, bearing in mind there is always a lag time to the impact of these initiatives, political alarm bells had started ringing as regional communities complained about vacancies in local hospitals and GP practices. Never underestimate the significance of such political alarm bells.

In 2004 there was a change. Australia was declared to now have a shortage rather than over supply and we entered into a period of policies designed to increase the supply and direct these services specifically to the rural areas. And the result, certainly more doctors, many more doctors but mal-distribution persists.

As you can see from the charts in front of you now, in 2012 the regional medical practitioner supply or the medical practitioner supply based on region varied from 418 full...
The Impact

For regional, rural and remote communities compared with city counterparts - higher rates of morbidity and mortality, higher risk factor rates and lower rate of access to medical services but higher rate of hospitalisation.

Key Finding: Number of Medicare services per person in very remote areas is 40% less, and hospitalisation almost 60% more, than those living in a major city.

Service Utilization data relates to place of residence of those receiving service not place where service is supplied
Ref: HealthWorkforce Australia, "Health Workforce 2025 – Doctors, Nurses and Midwives" Vol 1, March 2012

Time equivalents per 100,000 population in the major cities, so very well supplied, to 255 full time equivalents per 100,000 in remote and very remote areas.

And the impact. People in regional, rural and remote communities compared with their counterparts have higher rates of morbidity and mortality, higher risk factor rates and as you can see in this graph, the more remote a person’s place of residence, and this is based on place of residence not the place of delivery of the service, the more remote the fewer the number of Medicare services accessed and these are the light blue bars or the lower line that’s drawn across the graph. The fewer the number of Medicare services, the greater the rate of hospitalisation as indicated by the dark blue bars.

Now instinctively we know that many factors influence a graduate’s choice of first practice site, rural or otherwise. It’s kind of instinctive. This table reflects some of the findings of an American study of over 1,000 new graduates. None of these factors intrinsically favour rural sites however they do suggest initiatives which may encourage rural practice. If you group these factors one could say that the first six relate to social factors from significant others wishes down to schools for children. These social factors clearly outrank first of all the financial considerations, so eight for instance is initial income guaranteed and 14 is maximum potential income. So social factors outrank financial and the other interesting thing is they also significantly outrank the altruistic factors such as need for positions and community service commitment. Considerable research has also been undertaken as to why doctors stay in rural practice once they have started. This slide shows the results of another American study. It predictably shows that doctors who are better prepared both medically and socially for practice in rural areas stay longer than those who felt unprepared. Interestingly however, it also indicates that whilst a rural background or the spouses rural background may make a medical practitioner more likely to take up rural practice, once they are actually in the rural practice, background (rural or metropolitan) of doctor or spouse makes absolutely no difference to the length of their stay.

And moving on to the policy levers. As mentioned at the start, since 2004 governments Federal and State have implemented a vast array of policies designed to increase medical practitioner supply and to direct these services to rural areas. I have to say that collecting information on these policies, and you’ll see at the end of these slides some of the references that David and I accessed and there are many more which we also glanced through, but this led me to a profound take away message.
These policy levers are many, they involve a multiplicity of governing bodies and anyone who has tried to take advantage of these will share this take away message that I gained; they are most commonly complex and there is frequently duplication with often significant Federal State overlap. Very frequently they have simply brought GPs to inner regional areas which may still be defined as districts of workforce shortage but then have not been particularly effective in encouraging GPs or medical practitioners to the areas of greatest needs which are the very remote ones. Time unfortunately doesn’t permit a detailed analysis of these numerous initiatives. There is some detail on the slides I’ll try to briefly cover. I’ve identified some of the policy lever groupings according to the target group. So you have undergraduate, trying to target the undergraduates, vocational trainees, rural and remote workforce and the international medical graduates. And then as I highlighted before in the American study, social support like other initiatives is certainly a very significant factor.

1. The undergraduate target group

Firstly we just look at the total number of medical graduates. Policies and practices have led to a dramatic increase in the total number of medical graduates. As this graph shows it is forecast that from 2014 onwards the number of graduates will plateau at something like 3,700/3,800 per year and the interesting thing to note that there is actually a doubling of the number of graduates from 2004 to 2011 and these have almost trebled since 2001.

The second lever that is focussing on undergraduates is selective enrolment of students from rural backgrounds. Federal funding of universities for medical schools includes the Clinical Training and Support Program which I understand to be quite significant in funding terms. It includes a number of requirements which are specifically aimed to encourage ultimate rural practice. One such target is that 25 per cent of those medical students who receive some Commonwealth support are to be recruited from a rural background. I simply mention that this is the target and have no information at the moment of it’s success.

Still looking at initiatives which are targeted at undergraduates, we have various bonded medical programs, those that give financial relief in the form of various scholarships in return for a rural commitment and those that give additional access to medical training below the cut off academic score, again in return for rural commitment.

## Factors in Initial Choice of Location

**Factors important to Graduating Family Practice Residents in Choice of First Practice Site**

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<tr>
<td>Significant others’ wishes</td>
<td>1</td>
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<tr>
<td>Medical community friendly to family physicians</td>
<td>2</td>
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<tr>
<td>Recreation/culture</td>
<td>3</td>
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<tr>
<td>Proximity to family/friends</td>
<td>4</td>
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<tr>
<td>Significant others’ employment</td>
<td>5</td>
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<tr>
<td>Schools for children</td>
<td>6</td>
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<tr>
<td>Initial income guarantee</td>
<td>8</td>
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<tr>
<td>Need for physicians</td>
<td>13</td>
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<tr>
<td>Maximum potential income</td>
<td>14</td>
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<tr>
<td>Familiar with physicians in area</td>
<td>15</td>
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<tr>
<td>Community Service commitment</td>
<td>16</td>
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Ref: American Academy of Family Physicians Position Paper “Rural Practice - Keeping Physicians In” quoting study published by the Society of Teachers of Family Medicine
Now can I just say here that I apologise for frequently including reference to Victorian schemes as well as the Commonwealth ones but this is simply because that’s my home State and I’m more familiar with the programs here.

Training in rural settings and let me preface my brief discussion about this by saying it’s my view that these initiatives are in fact the more effective but there’ll be more debate about what works and what doesn’t work later. We have regional medical schools such as Deakin and James Cook, we have the medical faculties which have their clinical schools in rural areas, and we have structures where a substantial component of training is outside of the major metropolitan area. And again referring to the Clinical Training and Support Program (CTSP) for Commonwealth funding of medical schools, this includes targets of 25 per cent of Australian medical students undertaking a minimum of one year as clinical training in rural areas. That’s 25 per cent of the medical students across the whole of the medical school. I think it’s intended to be 25 per cent of each year but that may or may not be implemented and effective. And the other component of the CTSP of course is that all Commonwealth supported medical students are required in these targets to undertake at least four weeks of residential rural placement. So this is a multi-pronged mechanism for control of the training experience in medical schools which is implemented under the Commonwealth funding arrangements.

2. Vocational trainees or GP registrar target group

There has been a substantial increase in GP training, as you will see here it’s doubled from 600 in 2010 to something like 1,200 in 2014. And an increase in rural GP training positions but it’s reported and I accept this, that the missing link has been the availability of rural internships so that you have a rurally training medical student but before they can transition directly to rural vocational GP training, it’s thought to be advantageous that they can actually do their intern year also in the rural areas. Now again some of the States have stepped in to specifically address this and the Victorian program which is mentioned here is one of those.

We have rural generalist training programs which are supported by States and Federal governments, we have the GP Rural Incentives Program and this will be discussed later but one of the elements, one of the tripartite elements to this program is the GP registrar component so there’s a Medicare supplement which is dependent upon the practice in rural areas. Then we
have specialist colleges which also are doing some work in
directing their specialist trainees into rural areas.

3. Rural and remote workforce target group

In addition to the GP registrar component of the GP Rural Incentive Program, and I mentioned the GP registrar component previously, this program includes the relocation incentive grant which is the payment to encourage people to move into these more rural remote areas. The reports on this are quite definite in talking about the limitations of effectiveness simply because they seem to be overly bureaucratic.

And then you have a service payment supplement which is a supplement for Medicare payments and the issue here is that this like many other initiatives has been effective in drawing doctors into the outer metropolitan areas rather than the remote areas where they are most needed.

If we move down to the support for continuing professional development program, most rural GPs will be well aware of the Rural Procedural Grants program which is relatively easy to access, that’s my understanding at any rate, and it’s funding that’s available for skills maintenance and up skilling for rural procedural and emergency GPs.

Basically it works out at $2,000 per day with a cap of 10 days for procedural training and three days for emergency medicine training. There are also once again various state programs.

4. International medical graduate target group

Since July 2010 international medical graduates have in general terms been issued with a Medicare provider number only if they work for 10 years in an area deemed to be a district of workforce shortage. Bear in mind that a district of workforce shortage is defined as an area with less access to GP services than the national average. This includes various urban services including for instance after hours as well as regional, rural and remote areas.

As with many like programs there’s a scaling element with this which means that the more remote the area in which a doctor works, the greater the reduction in the time restriction period, such that it’s reduced from 10 years if the practice is in the major city, to five years in a very remote area.

One consequence of this 10 year moratorium is the OTDs constitute a larger proportion of the medical workforce in more remote areas and this is shown in this graph where the first two bars reflect the position in 1999/2000 and...
then 2009/2010. You will see that in each instance the light colour reflecting the IMGs is larger for rural and remote than it is for urban and furthermore, there’s an increase in the proportion of IMGs in both urban and rural and remote areas over that 10 year period.

5. Social support

Now this is very much dependent upon local community, local clinicians, local hospital and the local council. There are just two components which are believed to be particularly important. Firstly, medical input into decision making for the health care facility, I think that’s sometimes overlooked and I feel has a great impact on job satisfaction for the doctors working in these areas and the other is the social support for the doctor and family that starts off with meet and greet and then goes on to ongoing social support. This is very important.

That’s the background of what the current situation is and what the current policy levers are. Just before handing over to David there are just two somewhat radical solutions that I’d like to just put forward in these slides. They’re proposed by two highly regarded researchers, commentators in this space. The first by Bob Birrell of Monash University and for those people who haven’t got access to the slides, quoting Bob, “the Federal and State governments base their GP manpower policies on the assumption there is a shortage of GPs in Australia, particularly in non-metropolitan areas”. Yes agreed. “This assumption is founded on a mindset that dates from the mid-2000s when there really was a shortage of GPs in some of these areas”. This is the bit I like with my background in the AMA. “There is a formidable bureaucracy and powerful vested interest with the stake in preserving the shortage story. However with a few exceptions, mainly in the remote areas, it is wrong.”

He argues that there is already an oversupply of GPs resulting in generalised over servicing with few identifiable regions of exception. The solution to these few exceptions he says involves ceasing issuing new provider numbers in any areas which are currently “oversupplied”, thereby forcing doctors into the undersupplied areas.

There are two comments I would make about that. One is the issue of conscription. The standard response to a proposal such as this is that it’s conscription of medical practitioners and you can’t do this, it’s prohibited under Section 51 of the Constitution which states that Australian governments can make laws with respect to

<table>
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<th>Current Policy Levers continued</th>
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<tr>
<td><strong>B. Vocational Trainees (GP registrars)</strong></td>
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<tr>
<td>▪ Increase in GP training – doubled from 600 in 2010 to 1200 in 2014</td>
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<tr>
<td>▪ Increase in rural GP training positions under AGPT, but missing link is availability of rural internships through which rurally trained medical students can transition directly to rural vocational GP training</td>
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| ▪ Support for Rural Intern training positions  
  - Victoria - Rural Community Intern Training program – 30 places in 2015 which include provision to undertake non-core rotations in community settings |
| ▪ Rural generalist training programs, including  
  - Queensland – first cohort of 40 doctors graduated 2011 and  
  - Victoria - $2.4 mill budgeted over 4 years Victoria |
| ▪ GP Rural Incentives Program – GP registrar component – Medicare supplement dependant upon duration of “rural” training and level of “rurality” of that training (determined by GPET) – ranges from $2,500 p/a/ to over $8,000 p.a. |
| ▪ Specialist colleges – some targeting of selection and/or regional rotations and/or specific funding for rural training |
the provision of medical services but not so as to authorise any form of civil conscription. I suspect that legal review would determine that Birrell’s proposal did not constitute conscription and certainly in 2000 the government passed an amendment to the Health Insurance Act to deal with a similar situation to this.

The other comment that I would make is that Bob Birrell used data from Health Workforce Australia’s “Health Workforce 2025” report and the authors of this report came back quite damning of his interpretation of this data.

To finish my presentation before I hand over to David, the second more radical solution is from Dr Stephen Duckett from Grattan Institute. Again let me just quote his words. “For decades successive Government policies have failed to fix the problem. At current rates of improvement it would take more than 65 years for very remote parts of Australia to catch up to the levels of GP services that big cities have today. Luckily there’s a relatively cheap and simple answer that could be in place within five years if we’re willing to adopt new responses to an old problem.” Dr Duckett’s solution is based on the presumption that alternative health care professionals are available, who could professionally fill the gaps in current health services. It includes the expansion of roles for pharmacists including provision of repeat prescriptions, vaccinations and supporting chronic conditions and the introduction of a physician’s assistant.

So having just put forward those two more radical solutions, I hand over to David to take this further. Thanks David.

David Thanks Robyn. I just want to go into a broad context of what we’re seeing from a historical and social demographic point of view and I think the shortage of doctors in rural areas can be seen in this context. The rural exodus really has been taking place over a period of 200 years, firstly in the Industrial Revolution when people moved to the cities for work and then through mechanised agriculture which reduced work opportunities, and more recently as rural exoduses continue with globalisation and the information age. As less people reside in rural areas, amenities and services and life opportunities diminish and populations age and it’s in this environment that essential services suffer and educational and health professionals are still required but are in fact harder to attract and retain.

This isn’t a new problem in rural areas of Australia and it’s been apparent in many countries for decades that it’s been progressively harder and harder to attract doctors to rural areas. The problem has been documented even a century ago.

Current Policy Levers continued

C. Rural & Remote Workforce

- GP Rural Incentive Program (GPRIP). Financial incentives to locate and remain in regional/rural/remote areas – total 2012-13 budget $116.4m but major growth in inner regional rather than remote. Includes:
  - Relocation incentive grant – but poor response as seen to be overly bureaucratic.
  - Service payment supplements linked to Medicare
- HECS Reimbursement Scheme – provides for scaling to fast track repayment of HECS for doctors practising in outer regional and remote areas
- Scaling of rural commitment linked to Medical Rural Bonded Scholarships and Bonded Medical Places in return for work in more remote areas
- Locum support schemes
  - Rural Locum Relief Program – allows OTDs who have permanent residency/citizenship in Australia to access Medicare rebates in rural and remote areas
- Continuing Professional Development support:
  - Rural Procedural Grants Program – funding for skills maintenance and up-skilling for rural procedural and emergency GPs (up to $20,000 pa for 10 days of procedural training and $6,000 for 3 days of emergency medicine training).
  - Victorian Rural Continuing Medical Education grants (administered through Rural Workforce Agency of Victoria)
  - Victorian Rural Extended and Advanced Procedural Skills program
Rural Exodus

General
The problem of medical professional shortages in rural areas is historic and associated with rural exodus – firstly in the industrial revolution when people moved to the cities for work, then through mechanised agriculture which reduced work opportunities in rural areas, and more recently as rural exodus has continued with the information age. As less people reside in rural areas, amenity and services and life opportunities diminish and populations age. It is in this environment that essential services suffer and education and health professionals are still required, but harder to attract and retain.

Doctor Specific
• The rural medical workforce is ageing and many doctors in rural areas are approaching retirement age or wish to leave or cut back on their work commitments
• There are fewer doctors wishing to relocate permanently to the country where they may see career, family and lifestyle opportunities as more limited
• Half of all medical graduates are female and due to a number of factors female doctors are less likely to seek work in the country or work the hours that their male counterparts previously worked
• The skill levels required for doctors working in rural areas are generally higher than for their metropolitan counterparts and support structures are more limited
• For over a decade in the 1990s and early 2000s there were insufficient new doctors graduating in Australia and as doctors left rural areas they were harder to replace.

A few years ago I attended the medical history conference in London where a presentation was given on doctor shortages in the Isle of Skye and the difficulty attracting doctors there to work. So this is in the 1880s after a 40 year period in which Skye had lost more than half its population during the clearances where crofters were shipped abroad to make way for more intensive use of the land for agriculture.

So coming back to doctor specific issues, what’s apparent because of this rural exodus in Australia is that the rural medical workforce has been aging and many doctors in rural areas have been approaching retirement age or wish to leave or cut back on their work commitments. There are fewer doctors wishing to relocate permanently to the country where they may see career and family and lifestyle opportunities are more limited. Half of all medical graduates are female and due to a number of factors female doctors are less likely to seek work in the country, or work the hours that their male counterparts previously worked. The skill levels required of doctors working in rural areas are generally higher than those in the metropolitan communities and support structures are more limited.

For over a decade in the 1990s and early 2000s there were insufficient new doctors graduating in Australia and as doctors left rural areas they were harder to replace. I lived and worked in Dubbo for three years in the 1980s and most of the doctors were local graduates who lived in town. In my roles I covered a lot of the rural areas of New South Wales and I returned to Dubbo to be the locum Medical Superintendent at Dubbo Base Hospital in 2003. I was amazed at the number of doctors that they were flying into town because a lot of the doctors who had been there for years had retired. I especially noticed the specialist exodus. There was an exodus of specialist doctors, not just GPs, who were working in regional hospitals. And many of these doctors are being flown in and out of Dubbo now.

We’re dealing with a common issue. On the graphic on the right is the full or partial primary care doctor shortage areas in the United States. You can see it’s extensive. Note if you look at the Australian District of Workforce Shortage (DWS) map, its much less “coloured in” compared to the US map. In the United States since the 1940s, this slide shows a breakdown between metropolitan areas at the top and rural areas at the bottom and this is a time-based graph through to 1995. It shows the biggest beneficiaries of the increased graduation of doctors over an extensive period of time of over 50 years has been the metropolitan areas. In fact in the US rural areas have stayed fairly constant in their levels and lower than the ratio of doctors per population.
A common issue

Australian difficulties in getting doctors to live and work in rural areas are mirrored in other countries.

USA

"The impact is especially being felt in rural areas, where doctor recruitment and retention is always a challenge," said Gerald Ackerman, a board member of Nevada Health Centers Inc., which operates several rural clinics in Nevada. "We've had positions in two to three rural communities that have been open for well over a year or two," he said. Ackerman noted that it's especially difficult to recruit doctors with families to rural communities. "The physician may have a wife (or husband) who has a degree, but she may not have an opportunity to work in a small rural town. You also have to consider if they have children in school."

"The Daily Yolder, Knoxville, TN On the Short End of the Doctor Shortage 02/27/2008

"The current surge in physician supply could do little more than add to costs if the twin challenge of unequal physician distribution and improving efficiency of delivery of care through multi-disciplinary teams aren't met. Improving access efficiency to primary health care is a complex problem that requires creative approaches to organisation and delivery of care. There are places in the country that need more doctors but simply cranking up supply will not fill those gaps. The problem isn't a shortage of doctors but rather how and where the skills of those doctors are being used."

This also stresses the need to look at the rural models of care and take a much more integrated approach with a focus on prevention, early intervention and acute and chronic disease management. Whereas a lot of focus at the moment is on managing acute disease with inadequate chronic disease management programs in place as well as early intervention and prevention programs. And that was apparent on the previous slide that Robyn showed before where the numbers of primary medical services drop as you go into more remote areas.

I just want to talk about this actual gap that people talk about, the actual shortage, and we know that there are different views on that. But it's not well defined or quantified.

This graphic on the left was from a MJA paper in 2006 that looked at projections. So we're not very good at projecting. This is projections of general practitioners from the starting point, although it was written in 2006 through to 2012, and they had a high, medium and low. Notice we had a high..."
The actual shortage or “Gap” in availability of medical professionals in rural areas is not well defined or quantified.

The proportion of general practitioners like 140 per 100,000 during the 1990s, it has dropped and the projection was that it would level out at about 130. We actually ended up 2009 at 112 GPs per 100,000 population.

The second graph shows there’s a lot more doctors per population in the metropolitan areas. But notice the red line which denotes the level of GPs. It shows level of GPs per 100,000 of population is pretty constant across all geographical areas.

Maybe this highlights that more primary care services need to be provided in rural areas if you weight the population for morbidity and access to services.

The first question to pose is how much of this gap is simply inadequately funded medical workforce establishment to meet needs? This is a policy and funding issue. If this gap in FTE was funded could the shortage in rural areas be addressed with adequate incentives?

The paper by Duckett at the Grattan Institute estimated the number of doctors for the seven most needy areas to be about 164 doctors.

The second question is how much of this gap is due to lack of doctors on the ground to fill the existing workforce establishment requirements? This is a recruitment or provisioning issue. However, if filled with locums and contractors, the problem is the cost per day may be greater than the budget approved for the establishment focused around permanent FTE. But with over 100 locum agencies in Australia, and thousands of locums, this demand is currently being met and should continue to be filled subject to continued funding.

As far as I know nearly all jobs that come out of the rural health services where they need a locum to fill existing positions are in fact being filled and communities aren’t going without the supply of doctors for urgent medical services. This is not just a headcount issue. Looking at FTEs or full time weighted equivalents, or whatever method you use per 100,000 of population, FTE headcounts are a crude measure in isolation when assessing doctor shortages.

We are lacking research on real medical workforce requirements and what the size or the nature of the gap is and there have been many agencies or programs tackling bits of the puzzle. A lot of programs are being funded and continue to be funded without evaluation as to their effectiveness in tackling the problem, noting the problem is not always well defined or understood.
Some Solutions

<table>
<thead>
<tr>
<th>Solution</th>
<th>Ease/Cost</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase funded medical positions in highest shortage areas.</td>
<td>Requires identifying and prioritising positions. Cost moderate.</td>
<td>Doctors are likely to be available if paid incentives or contract rates.</td>
<td>Budget increase required and mindset change around contract medical labour.</td>
</tr>
<tr>
<td>Substitution.</td>
<td>Requires regulatory and training changes. Cost moderate.</td>
<td>Some work of GPs could be performed by pharmacists, nurses or physician assistants.</td>
<td>Pharmacists have similar shortages. PAs require long term planning and culture change.</td>
</tr>
<tr>
<td>Rural training – undergraduate and postgraduate.</td>
<td>Underway for GPs. Further development across specialist programs required.</td>
<td>Rural trained and committed doctor pipeline.</td>
<td>Many programs, evaluation of effectiveness required.</td>
</tr>
<tr>
<td>Financial and other benefits eg quality housing and facilities to attract and retain rural doctors.</td>
<td>Many incentive schemes often overlapping. A 6/12 retention bonus and accommodation package may help. Cost moderate.</td>
<td>A boost in financial and other benefits may attract some permanent doctors.</td>
<td>Money is not an incentive for most. Current schemes need further evaluation.</td>
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This Canadian comment from 15 years ago says it’s much more complex. Note the comment below that “There are specific areas where further research should help in the development of more accurate measures, provide a substitution, the definition of full time equivalent.” Does this take into account on-call commitments for instance? “The measurement and concepts of distance in terms of access, the potential impact of telemedicine which has been talked about for a long time now and the complex interrelationship between physician availability, utilisation of physician services by population and the health status of the population. None of these gaps can be filled without a significant increase in reliable relevant data.”

I’ve listed here some solutions. I haven’t listed bonded scholarships or Medicare, as Robyn has covered these. But I do, however, think they should be properly evaluated before agreeing that they are in fact solutions, especially in areas of real doctor shortages or are those programs leading to gaming or doctors finding work in outer metropolitan areas and not really in rural and remote areas where there are the greatest needs.

Under solutions I’ve listed these in a table, I hope everybody can see this or have access to it. Some of these were already covered in initiatives but I really think we need to tackle this issue of how many doctors are missing, what the gap is, and try and fund them in the higher shortage areas. Of course this requires identifying and prioritising the positions but the cost is moderate. If you look at our health budget in Australia of $140 billion a year, if you fill all of these 160 doctors as Duckett identified, that will cost about $80 to $100 million a year to have 1.1 million people properly covered with primary and GP services.

Even using substitution would cost $30 million, that is not using doctors but other allied health and paramedical staff to provide GP related services. The pros will be doctors are likely to be available if paid incentives or higher contract rates. We might have to pay more to have a remote rural doctor than a metro one. A quantum budget increase is required and a mindset change is required about contract medical staff because if those positions are created and they’re not filled with permanents they will need locums to fill them. We just have to make sure that the locums are the right people and have the right skill set.

Substitution requires regulatory and training changes; however, the cost is also moderate and cheaper than option one. Some work of GPs could be performed by pharmacists, nurses or physician assistants and estimates
Rural training and undergraduate and postgraduate training is underway for GPs, and there are a lot of programs available. Further development across specialist programs is required. I’ve mentioned regional cities, they need really good specialist services so that the people in more remote communities can be treated more locally in regional hospitals, rather than going to metropolitan facilities. This produces a rural medical capability and a familiar and committed doctor pipeline. There are many programs and we need evaluation of their effectiveness in getting doctors to live and work in rural communities.

Financial and other benefits include quality housing and facilities to attract doctors and retain them. There are many incentive schemes, often overlapping. Maybe something more simple like a six-month retention bonus and accommodation package may help. I’m sure a lot of us would have seen this, but accommodation in rural areas is really important. For some of our long-term locums who have been working in rural locations for years, the quality of the accommodation makes all the difference in the world.

A boost in financial and other benefits may attract some permanent doctors. But money is not an incentive for most as Robyn identified and current schemes need further evaluation. I’ve added this quote from Dr Paul Mara, former President of the Rural Doctors Association. “The government classified Moree the same as Townsville. The doctors in Moree are working 24 hours a day, seven days a week, providing hospital based services and high-risk high-responsibility, very intensive services and they’re getting the same incentive-based pay as doctors in the Townsville area.”

I stress that GPs in country towns often have 24 hour responsibilities and I’m not sure how well this is covered in the FTE data. Because they’re covering their practice as well as the hospital, I’m proposing that lines drawn on paper to say that this area or that area is a shortage area, ignores the wide variation in GP work commitments in rural practice settings.

Given the continuing social demographic changes affecting us all I believe it will continue to be very challenging to attract doctors to live and work in rural areas. The rural medical workforce establishment budget should be reviewed to bridge the gap in the supply of doctors to increase GP ratios and specialist services in

References

- Health Workforce Australia, “Health Workforce 2025 – Doctors, Nurses and Midwives” Volume 1, March 2012.
designated rural communities to a level that addresses service demand and population health status and needs. The funding should also provide suitable incentives to permanent staff to relocate with retention benefits. Existing benefits and incentives could be simplified and streamlined and better targeted. If not filled, medical establishment numbers should be staffed with an experienced and qualified locum or contractor workforce. Bonding, Medicare provider numbers and other measures may be seen as coercive and unlikely to succeed in isolation, when addressing doctor shortages and mal-distribution. I note that the Federal Government’s bonded rural medical places scheme, which is under legal challenge, has funded 4,500 doctors to train in medical school and only one of those recipients had started to repay their rural bond “debt.”

Training programs should continue with ongoing evaluation about outcomes, ie on the actual impact on increasing the number of doctors and levels of GP services in rural areas and improving the health status of rural communities. Substitution is problematic and models of primary care with multi-disciplinary teams can be enhanced and should be enhanced but teams will always need a GP for the community to get the care it needs.

We’ve just listed on the last page a number of references that we’ve used.

Health Workforce Debate
How can it be maintained in rural areas in the 21st Century?

The on-line debate had two speakers, one each for the Affirmative and Negative of this debate. The following discussions are supplied from the transcript of the presentation.

1st Debater
Dr Kathleen Atkinson

Having been asked to address the negative case, I will outline my reasons why I believe that, despite formidable challenges, we can address the issues and maintain a rural workforce into the 21st century.

I started life as a rural generalist in the days before that was considered anything special. I was a rural GP obstetrician for 15 years- firstly in Victoria, then moving to work in Aboriginal health in Western Australia. This was followed by a posting to East Timor as a GP with the Australian embassy then returning to Australia and retraining as a physician in palliative medicine before becoming a RACMA fellow via the accelerated pathway.

During all these career changes, I maintained very strong links with universities and the rural clinical schools in Victoria, WA, North Queensland and even whilst working overseas. I’ve been a rural Fellow and examiner for the RACGP, a foundation Fellow of ACRRM, the college of Rural and Remote Medicine and do my CPD as a rural generalist. I also examine for the AMC so I believe I have a reasonable perspective around the training and assessment environment for local and overseas medical graduates. As a medical director I continue to teach undergraduates and junior medical officers in places like Wagga Wagga and Griffith, where I’m currently working.

The message I would like to get out is one of hope.

Having started in rural medicine in the early ’90’s, I was part of the very first Department of Rural Health at Monash University located in Gippsland, and started Monash University’s very first rural health club with the medical students.

This was an interesting and fairly innovative way of fostering multidisciplinary team education, a unit that was teaching trainee pharmacists, medics, nurses, other allied health disciplines, who were all part of the rural health club. It was described as horizontal and vertical integration and really did foster a cross-disciplinary approach to learning because, whatever else we say about health, it’s a team sport.

In fact, the more remote you are, the more you rely on a small team of clinicians from all health disciplines. In fact, some of my more vivid memories are of managing resuscitation in small rural hospitals where I’m literally using the paramedic to help me with an airway, who happens to have brought the patient in, and extended scope of practice nurse, and if I’m lucky another and...
often very junior or international medical graduate who isn’t necessarily trained in the way that we would view an absolute minimum to work in some of these places.

The message of hope that I would like to convey is that the rural clinical schools are successfully teaching undergraduates and preparing them for rural practice for over 20 years. There are programmes where students spend a year in, as part of their fourth or fifth year of medicine, or their third year in a post-graduate program, where they literally hang out in a rural general practice for the best part of a year.

It’s just an amazing experience for them, and despite the fact that some graduates ultimately work as specialists in the cities, they never lose the fact that they’ve actually worked and experienced a rural practice and lived in a rural community.

So I really applaud the universities for what they’ve done. I think we all need to do more work in the junior doctor space. It’s been rather disappointing seeing the abolition in the latest Federal Government budgets for the PGPPP program which was providing a link from the rural clinical schools into rural general practice, and then hopefully into what’s called rural generalist practice where they try and give people a good generalist experience and hopefully get them to undertake some special skills, extended skills in obstetrics, anaesthetics, emergency medicine, Aboriginal health, mental health.

The other bit of hope that I would like to put up is that having worked with the rural generalist training programs in Queensland and now in New South Wales is that we are training a cohort of junior medical staff who will become true rural GPs who are able to effectively maintain services in our rural hospitals. Whilst I believe we need to be training about three times the number that we are to match retirements, the Queensland program has been unbelievably successful – filling many longstanding vacancies in small rural towns and preventing closures of rural maternity and surgical services.

One of the reasons for the success of the Queensland Rural Generalist Program has been the creation of an attractive, well remunerated, well respected career path. The Queensland industrial awards support these doctors who end up with near specialist equivalent-level remuneration. (Which is as it should be for a highly skilled practitioner, doing everything from obstetrics to emergency to mental health and geriatrics). These programs really support a career decision to work in a rural area. So Queensland’s been a national leader. Western Australia has done a great job too, but again, the numbers that are coming out of the Western Australian medical schools are much smaller.

So my message of hope is that the longitudinal perspective does work, that we are training more Australian graduates, that we are in a position where we can take the ball and run with it, with the increase in numbers of Australian medical graduates, and positioning ourselves so that we can actually train more junior doctors and give them a career path that is meaningful, respected and well remunerated.

We haven’t touched much on the issue; I think Paul Mara’s quote was quite interesting and very apt. But it’s more than just money, it’s a lot more than money; it’s about, asking essentially city-based people to give up the kudos of a specialist career to work 24 hours a day, seven days a week and put their families on the line. Traditionally we’ve sort of expected them to do that in and around trying to make a dollar, and expected them to be super doctors, and to do it with a smile on their face.

I think there are ways to solve these problems; we have to actually be prepared to say that the absolute minimum that anyone can entertain is a 1 in 3 roster, and that the other bit of that roster, if you’re in a really remote place, needs to be taken up by a physician assistant or nurse practitioner, extended scope of practice nurse so that people can actually have a life and can get a break.

I think if we address those challenges we will actually be able to capture and harness the next generation of doctors coming through with something that’s an exciting career for them. I’ve spent my life in rural medicine; I wouldn’t have wanted any other career and I still really like it. So I’m going to hand over to Bernie now who’s going to give you the affirmative position that says that we won’t be able to solve this problem.

2nd Debater
Dr Bernard Street

When it all boils down, Kathleen summed up the argument for the affirmative.

How can we expect people from the city, highly achieving people from the city, sometimes from places like Melbourne which for the fourth successive year has been one of the world’s most liveable cities, to come into the bush where there are rural communities that don’t have the critical mass to support the specialisation of healthcare, there’s not a system to recognise regional and rural practice as being something special by itself, and then work long hours often without a huge amount of support for the family, and attempt to provide outcomes where there is no slack given for being a country practitioner?

The access and outcomes that our patients, funders and governors are expecting, are the same outcomes as we all expect from the big tertiary centres. So very little quarter is given, and that means to come to a rural area you have to be a very, very special person; somebody like Kathleen
for instance. But sadly the people with the rare combination of skills, attitudes, behaviours and cultural empathy are fairly scarce, and certainly the universities don’t train that into them.

There is increased risk for practitioners coming to the country; they operate across a range of settings with variable amounts of support, and they’re expected to cover a large number of specialities in many cases because there’s just not the backup. So the individual responsibility and the risk has increased, not necessarily hugely, but it only takes one major medico legal event, say every decade, to significantly impact on your personal sense of wellbeing.

We know the health of people in rural and remote communities is generally poorer and there have been many studies reinforcing that. Rural people are also less likely to seek medical assistance until their needs are more acute, so they often present sicker, and mental illness and suicide is also higher in rural communities, particularly the ones that are suffering; the unemployment rates are increasing.

We have talked about the self-sacrificing nature of a practice in the country. You need to be a rare person to do that. But there are also lower amenities for people who have trained and been brought up in the city; there are not the same level of social and support networks. Even places that recruit well and have employment for spouses, education for the children, entertainment for everybody, are not the same when benchmarked with the cities.

There is also a focus on recruitment as opposed to retention, which means that the health services are likely to throw incentives at potential recruits - I call it “love bombing”, but once they sign on the dotted line, the opportunity for them to be involved in the hospital system or to have their arrangements tweaked, not necessarily purely for money, is not always there.

Australia has some of the top 10 liveable cities in the world. Melbourne of course was on top, but there was also Sydney, Perth and Brisbane, so that country areas have many places to compete with.

We need more and more people like Kath to come and practice in the country. I’m not sure how we actually train it into the system, and I don’t think, despite all the strategies that are being used, that we can maintain an effective workforce in rural areas. By effective I mean that we have a salaried and engaged medical workforce.

I am sure there will be many, many openings for locums continuing into the future.
Work Life Balance: High Performance Living

Dr John Best spoke about health professionals being high performers with unusual pressures and expectations working long hours and exposed to burnout – similar to the life of the athlete. He discussed acceptance of limitations, approaches to work and strategies to create a more balanced lifestyle. The importance of definitively dividing what we do at work from what we do at home, with safer working hours and regular leave where you switch off your phones and establish appropriate supportive infrastructure that can enable work delegation and work separation.

RACMA Fellow and past president Dr Michael ‘Taffy’ Jones facilitated the session. In 2000, Dr Jones was appointed the first Chair of the Board of VDHP. Dr Jones brought to this role strong recognition as a leader in healthcare services and a compassionate supporter of the medical profession.

Presenter
Dr John Best
Sports Physician
Dr John P Best

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Dr John Best is a Sports Physician in the Eastern Suburbs of Sydney, Australia.

John is a Fellow of the Australian College of Sports Physician and is a clinical supervisor and examiner. He has been involved with elite sport including Australian Rugby, English Premier League Football, PGA (golf), triathlon and motor racing.

He has conducted research in “Athlete Monitoring” - addressing the challenge of “How can an athlete be at their best?” This has led to an understanding of fatigue, burnout and underperformance, which can also be applied to those in certain busy workplaces. The fundamental concept is we are all human beings have physical and psychological limits. We also have personal needs which are of value to our identity.

Player monitoring is an essential part of player care in a professional athlete and allows the medical/high performance team to assess the response of an individual to playing levels, training levels and their lifestyle. This may also be applied to the home or office.

In 2000 John was awarded the Australian Sports Medal for services to Sports Medicine from the Prime Minister and Governor General in 2000.

John is happily married to Megan, also a doctor, and they enjoy two beautiful daughters and a son-in-law.

Dr John P Best

Presentation Transcript

For doctors, the demands of work can make achieving a good work/life balance difficult and for doctors in rural practices, this is especially challenging. Analysis of the Victoria Doctor’s Health Program highlights the difficulties rural doctors have. The number of doctors who are currently being case managed by the Victorian Doctor’s Health Program is close to 50 and of those, a quarter of them are doctor’s from rural parts of Australia.

Perhaps even more concerning is that of that quarter of rural doctors’ who make up that number, 10 of them are on substance misuse programs and one on mental health program. It’s obvious from the experience at the Victorian Doctor’s Health Program, that rural doctors have specific difficulties in trying to look after themselves better and to get help when they need it.

These include being “too busy” to get sufficient relaxation time and they often get a build-up of stress and to manage this, may try to self-medicate with either alcohol or other drugs; usually other drugs.

Rural doctors are often reluctant to seek help because of concerns about maintaining anonymity and confidentiality around consultations and the potential for their patients finding out about the situation via the rumour mill, deciding they do not want to be treated by the doctor in question, if they hear adverse things about them, which then affects the doctor’s livelihood.

The other major problem for doctors in rural areas is that they often feel as if they’re never off duty. Patients frequently see their doctor in the everyday community setting and may approach them for specific medical advice when the doctor is off duty (e.g. in a supermarket, children’s sports events etc) and trying to relax. It’s not surprising that people in this situation burn out, often to the extent that they are unable to work.

It’s important to note that doctors in rural communities usually don’t want to see treatment providers in their local communities, for confidentiality reasons. While the health providers maintain confidentiality, everyone in a country town knows the doctor’s car and if it’s seen outside one of
these health providers the rumour mill starts immediately. Consequently, doctors often have to seek support and treatment away from where they’re practicing, which means taking time off work which they’re often reluctant to do.

For rural doctors who are being monitored for substance misuse, there is frequently a need for chemical monitoring, including urine drug testing, being breathalysed prior to commencing working and hair testing. In rural areas, there are difficulties in organizing such testing, whilst maintaining confidentiality.

As a doctor who has worked full time in sports medicine, I’ve worked with many elite teams. One of the things I’ve learnt that has led into this talk is with athletes who are so talented and so good, many of whom are world standard, they can’t be at their best all the time. There are periods of time where they need to be at their best with certain competitions, events and so on. If you try and have someone at their best all the time they end up being exhausted, they don’t recover very well and their performance is affected.

I then started to see that some of these principles apply in the workplace. This particular talk I’ve given many, many times to lawyers and law firms, to accountants, to elite athletes and to coaches and also to politicians and to ministers of religion. People who are in positions of responsibility, or leadership where there are demands on their time and expectations from others are very much at risk of developing fatigue a little more easily and burning out.

So how are we wired, how do we function best? A common model of how we as people function best is that we’re built as a body mind spirit and all three aspects affect our wellbeing. Physical activity, what we eat, the way we manage our health, the way we sleep are key ingredients that affect our physical health and our mental health. If we live and work well we’re in a better position to help other people. There are different terminologies that are used to describe effective functioning: ‘Wellbeing’, ‘work/life balance’, ‘self-care’, ‘high performance living’. Interestingly, in sports settings and corporate health, this is very topical.

It’s easy for people to stop work and then pull back and switch off from it. So I think there’s sort of like a hangover of responsibility effect that I think exists a bit more with those in rural settings. Professional isolation may be less of an issue these days, but certainly the fishbowl effect I think, is very common particularly if you’re in a smallish town
Where you’re bumping into your patients all of the time. I know that often that can be very enjoyable but if someone is unhappy or you’ve made a mistake, you’re going to be reminded of that all the time and I think it’s very hard to relax. It can be very difficult for a rural health worker to develop good supportive genuine friendship and I think that is something that really impacts on our health and wellbeing.

Unlike city doctors, who have a degree of anonymity in their working and living environment, doctors in rural areas need to take better and more holidays – and away from their rural community – than someone in the city in order to switch off.

So how can the balance be achieved? Exercise has many health benefits. Almost every body system is positively influenced by physical activity. So we know cardio vascular disease is altered and so on. We also know now that there are significantly cognitive and psychological benefits with having an active lifestyle. We know that for a fact and there’s a lot of research showing that there are community benefits particularly if you can influence others positively by exercising.

When you look at the definition of physical activity it’s using your muscles to move so that you use up energy. It can be some sort of formal exercise or it can be informal e.g. gardening and housework. But interestingly the World Health Organization categorizes physical inactivity as a diseased state; if you are not active physically it’s the same as carrying a disease, it impacts you so negatively. There are many options for exercise. When you look at calorie burnout there is a great deal of research on all different physical activities, including activities such as gardening and housework. Interestingly, when you look at gardening where you may be digging or planting trees, the calories you burn and the aerobic benefit is much more than walking, for example.

When you look at how much exercise, how often and how hard it should be, the recommendation is for 30 minutes continuous activity at moderate intensity on most days (it’s better to do 30 minutes of continuous exercise rather than three 10 minute periods, however). Moderate intensity is getting your heart rate to 60-70% of maximum, which is roughly being able to speak a full sentence while exercising.

Gaining muscle mass and strength is beneficial and is associated with fall prevention, protection of joint and tendons and cardiovascular benefits. With strength training you can get muscle soreness when you’re starting, so
initially, it’s very important to make sure that the program is supervised and the technique is correct. The evidence is overwhelming, there’s nothing that replaces physical activity. Sleep doesn’t and medications don’t; nothing replaces it.

Diet and adequate hydration are important. In the early adult years a good diet usually has a higher intake of carbohydrate and protein but as we get older that does change. In people over 50 and 60 years there is evidence that protein requirements are higher and carbohydrate intake should be reduced. Fresh fruit and vegetables are important and consumption of caffeine, alcohol and sweets should be limited. Portion size should be controlled, but occasional relaxation of diet is also important – eating should be pleasurable. Avoiding comfort eating late at night which is a factor when people are starting to get fatigued and burnt out, comfort eating is a very common thing.

Now let’s look again at our body model, body mind spirit. Let’s look at healthy relationships. Communication is important. When our important relationships suffer, recovery from that is very difficult and there are no easy solutions.

While work is important and we love it, it we can look after ourselves well and nurture our relationships based on the season of life we’re in then it makes a difference. Good friends, the types of friends with whom you go through your ups and downs are an important encouragement.

Sleep is very important. It is divided into two phases – REM sleep and non-REM (slow wave) sleep. Basically we need periods of sleep where we go into a deep sleep to be restored. We may not sleep well for various reasons, including travelling a lot, or we have injury or pain, or we have stress. Sleep hygiene is what you do in your last 30 to 60 minutes before you sleep. It’s your ritual that helps slow your body down to prepare it to rest. It includes things like showering, food, any rituals you might have regarding reading, resting, sleeping.

The World Health Organization promotes that in most Western cultures men need eight to nine hours a night and females up to 10 hours. There are many strategies to improve sleep. If you exercise, it’s preferable in the morning rather than in the evenings, the foods and stress reduction strategies are helpful, and making sure we get enough exposure to direct sunshine. Without this, melatonin secretion in our body is not stimulated. If you’re looking at catching up, particularly on weekends, there’s a lot of evidence that power naps (resting or sleeping for up to 20 minutes) mid afternoon has a restorative effect.

Aerobic - how much, how often and how hard??

- >30 mins of (cumulative) physical activity per day of moderate intensity on most days definitely offers benefits
- This may be 3 x 10 minute periods
- Moderate intensity is desirable, but lower intensity is still a benefit
- Moderate = able to speak a full sentence
  - About 70% maximum heart rate
  - This may be effected by medications
What happens when we get overloaded? Well we all have a limit and we can’t keep working and we can’t do without sleep and we can’t let ourselves get unhealthy. Some get cranky, others drink more, some get a headache, get depressed, or withdraw from other people, there’s a whole range of things. There are times when being fatigued is normal.

So if you’re working hard and you’re tired that’s normal but generally you can bounce back. Short term tiredness and being busy is not a problem. But when you don’t bounce back, when you don’t recover well, that’s a problem.

Common symptoms include being emotionally drained, having a sense of reduced accomplishment, being disconnected and having low energy levels.

Once you get to the point of being physically ill it generally takes weeks or months or even longer to bounce back and that is the problem with fatigue and burnout conditions. You get variations in resting heart rate and heart rate variability, you may have mental health problems, psychological problems and relationship problems. So really knowing our limitation’s is important and creating some sort of checklist to look at our lifestyle.

One of the things we need to do is listen to our own body, then plan our work schedule. Monitoring, periodization and planning, listening, knowing and mapping are things we can apply to ourselves.

To monitor yourself, you can use a very basic tool, a self-rating questionnaire that looks at six things that affect energy (I do this three or four times a year):

- my sleep quality,
- my perception of stress,
- my mood,
- my level of fatigue,
- what my performance is in terms of how I think I’m getting through my work,
- my general energy, and
- how irritable I am.

If you pick up a problem early you can look at some interventions. We also have to learn how to relax well. There’s research to show that creativity helps relaxation. Having a holistic view of ourselves and knowing that we have a limit is very important and addressing each part of our being is a factor.

**Strength - how much, how often and how hard??**

- Increase lean muscle mass
  - Toning/endurance
    - 3-4 sets, 12-15 reps, 3 times per week
  - Hypertrophy
    - 2-4 sets, 6-8 reps, 3-4 times per week
- Careful with DOMS (= muscle soreness)
- Better response with previously trained, appropriate diet and a supervised program
- Technique critical
Understanding and Preventing Burnout

- Know your limitations
- Create a ‘check-list’ to look at your lifestyle / balance
- Identify your ‘red flags’ (= fatigue predictors)
- Some health science and performance principles
  - Monitoring (listening to your body)
  - Periodisation (knowing the more hectic times)
  - Planning (mapping out work and rest)

So in summary, the life of a busy professional places risk of burnout. There are self-test strategies to improve health and wellbeing that reduces our risk. If you can identify even today some areas of your own health that are a factor, create a check list and make sure you go to your GP and you have a good GP to address this and try and even narrow it down to the top three if there’s more than one. Also I’d suggest that even though you might be going through a very busy period of life there are seasons where things do change and don’t neglect those deep bits as well whichever is the case.
Subjective Tools
Self-rating questionnaire

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<th>2</th>
<th>3</th>
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<tr>
<td>Sleep Quality</td>
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<td>Not too bad</td>
<td>Perfect</td>
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<td>Perceived Stress</td>
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<td>Normal</td>
<td>No problems coping</td>
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<td>Mood</td>
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<td>Normal</td>
<td>Cheerful</td>
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<td>Fatigue</td>
<td>Always tired</td>
<td>Bounce back well</td>
<td>Lots of energy</td>
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<tr>
<td>Performance</td>
<td>Struggling badly</td>
<td>Getting through</td>
<td>Very happy</td>
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<td>Irritability</td>
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<td>Usual level</td>
<td>Not easily irritated</td>
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Closing Summary

- The life of a busy professional places risk for burnout
- Self-care strategies to improve health and well-being reduces the risk of burnout
- Create a check-list and have a check-up if needed (**have good GP**).
- Any areas for concern? What are the top three?
- Remember there are seasons in life
- Don’t neglect your soul.....
The on-line debate had two opposing speakers, one each for the Affirmative and Negative of this debate. The following discussions are supplied from the transcript of the presentation.

1st Debater
Dr Robert Grogan

I think the answer to achieving work/life balance requires management of both work and home. However, we tend to spend more time in the workplace than we do anywhere else, therefore it is easier to make changes that are significant in the workplace than at home.

The first and most important factor is to be aware that there is a need for work/life balance – awareness of a problem is often half way to resolving it. This closely followed by the need for doctors to have a GP. Thirdly, there is a need for both junior and senior staff to maintain supportive groups, both medical and non-medical. It’s important that people take regular leave, three or four times a year, at least two weeks on each occasion.

There are other things that can be done, especially in the situation of isolated rural practitioners who do seem to be on-call 24/7. There’s the need for ways in which on-call can be shared across regions (this has been applied more effectively in some areas than others), the need to be able to delegate clinical (there are very good resources for triaging the remote nurses; documentation very good even in non-remote areas) and non-clinical work.

2nd Debater
Dr Simon Fraser

I strongly believe that workplace/life balance begins at home. I’ve been in the workforce for 31 years, and I currently still work clinically as a Paediatrician and as a Medical Administrator. I’ve worked in a rural setting now for nearly 10 years and can compare that with working in the city. The worst scenario that I have had in terms of work/life balance was when I lived three minutes from the hospital I was working in. It was very easy to come home late, go in early, take work home and if I forgot something go back and pick it up. I think the ability to divide one’s life as much as possible between the workplace and the home is very important.

We probably spend at least two thirds of our time at home, particularly if we include the weekends and, in general, home is where non-work activities occur and where I feel that I can really switch off. To achieve a good work/life balance, work should not be taken home and as senior administrators, need to lead by example. I’ve worked for a number of CEO’s over the last 10 or 15 years and the good ones don’t give you work to take home or work at short notice. They give you, I think a reasonable amount of work and give you time to do what you need to do, so that you don’t have to take work home. I now rarely take work home unless I have to, unless I’ve got something critical that I have to work and I actively work to protect the time that I have at home. Unlike my first hospital job, currently I work about 40 minutes’ drive from home. I find this very positive because I can unwind, think and de-stress in the car. When I get home, I have no inclination to go back to work again. Having that little distance between the home and workplace is important.

It’s very important to work on one’s own stress levels – if I’m less stressed then I can have that same effect on others. This is harder in the country in the rural setting where you are recognized in the supermarket or walking down the street. For me, the advantage of living 40 minutes’ drive from where I work means that from a clinical perspective, I don’t have that problem.

It’s very unusual now, except in remote areas, for GPs or specialists to be ‘on-call’ 24 hours a day, seven days a week and I would suggest that for those who work in the public sector we use annual leave, long service leave and personal leave effectively. I think it’s important that not being ‘on-call’ in such settings means that you’re able to switch off, including the phone. From a personal point of view, although in my role as Chief Medical Officer of a regional hospital I have to be contactable 24/7. I’ve worked hard to ensure that there’s a good infrastructure around and below me so that I’m only called when my expertise is required, not to solve every problem that’s occurring and I get called infrequently. A little strategy that I put in my recent contract renewal was that when I’m on annual leave I’m not available.

Each of us needs to ask the question “where do I fit in?” I had a great experience a number of years ago at a workshop where one of the local experts in mental health had us reflect in relation to work/life balance on who the
most important people in our life are and who we need to look after. Most people came up with spouses and partners, children, parents and family, friends, pets and work colleagues in their top five, but none of us really thought about ‘me’. However, we were told that if we were to list the top ten people in our lives we really should put ourselves as one, two and three. I’ve learnt is that if I’m satisfied and happy with what I’m doing then that tends to have an impact on others. I’ve also had to learn to say ‘no’. Looking after number one is very important and I think that can best be done in the home setting.

Conclusion

The real challenge is implementation. We have to be very pre-emptive and wise in the way we decide on how we want to organize ourselves and live, including putting good boundaries in place, and looking at recreation, important relationships, and finding a good GP. Rather than implementing strategies to prevent burn-out and stress, most people make changes once they have a problem. Once present, fatigue states that may lead to burn out with or without mental illness take weeks or months to recover from well. Regular self-review and creating boundaries around work and life outside of work (including not giving in to demands from other family members because you’re the medical person in your family) are helpful.
Notes
Further Resources

For further information and resources related to these E-dgy Issues or to view the Podcasts, please refer to the RACMA website: http://racma.edu.au/documents/eip/index.php?maestro

For E-dgy Issues contact: info@racma.edu.au

For further information and resource links concerning RHCE programs please see the following website: http://www.ruralspecialist.org.au/