

EVALUATION OF STRATEGIES TO SUPPORT THE RURAL SPECIALIST WORKFORCE: *SUMMARY OF A CONSULTANCY COMMISSIONED BY THE COMMONWEALTH*

In December 2001, the Office of Rural Health of the Department of Health and Ageing commissioned a consultant to undertake research and evaluation designed to provide the Department with advice on the types of support strategies that would effectively attract and retain specialists in rural areas, and appropriate ways to deliver this support, to assist in future policy planning. The consultancy, undertaken by James Cook University in collaboration with Flinders University and Monash University.

The consultancy included:

- a literature review;
- a description of existing initiatives to support rural specialists;
- an account of consultations with resident rural specialists in Western Australia, Victoria and Queensland, and with other stakeholders concerning priority needs for support to enhance recruitment and contribute to retention of rural specialists;
- lessons from the Commonwealth Rural and Remote General Practice Program;
- opportunities for integrated approaches and linkages with existing programs; and
- advice on the priority support needs of rural resident specialists and strategies for delivering such support.

An overview of the findings of the consultancy follows.

FINDINGS OF THE LITERATURE REVIEW

The review and analysis of the literature found that the main *incentives for rural specialist practice* were:

- the attractions of the rural lifestyle;
- the opportunities for professional autonomy and scope of practice;
- the financial rewards; and
- the opportunities to work as part of a multi-disciplinary team.

The key *disincentives for rural specialist practice* included:

- the negative image of rural lifestyle and practice;
- undergraduate selection processes that favoured metropolitan students;
- lack of exposure to rural practice in post graduate education;
- professional isolation,
- long hours of work and on call demands;
- lack of locum relief;
- poor infrastructure support and back up;
- spouse and family issues; and
- pessimism about the viability and future of rural practice.

Additional disincentives were:

- the barriers to re-entry to metropolitan practice;
- the problems associated with solo practice;
- financial issues such as higher establishment costs and lower remuneration than in metropolitan areas;
- the stigma attached to and lack of recognition of rural practice;
- the lack of access to continuing medical education activities;
- the increasing sub-specialisation of specialist medical practice; and
- the need for generalist specialist training to meet the demands of rural practice.

The literature provided a number of *options for dealing with the disincentives*.

The development of a critical mass of specialists in a particular locality was seen as crucial to sustainability. ('Critical mass' was defined in one study as at least two specialists of the same discipline in one location.) This would overcome the disincentives of professional isolation, lack of locum support and time demands, and would enable the specialists to enjoy the rural lifestyle that initially attracted them.

The traditional role of the medical specialist was seen as inadequate to meet the needs of rural communities. The preferred model was one of integrated, or coordinated, care, where specialists are not expected to provide all the care themselves. Instead they adopt the role of 'consultant', which includes mentoring, teaching, advising and supporting existing practitioners, plus coordinating the care with other health professionals, using a multidisciplinary team-based approach.

Telehealth was seen as having the potential to improve the access of rural primary health practitioners to specialist advice.

When recruiting, opportunities for spouse employment and children's education should be addressed, and consideration should be given to the lifespan stage of the applicant to ensure an ability to maintain a family life while in rural practice.

Attracting people with a rural background into specialist training and establishing specialist training posts in rural and regional areas were seen as useful strategies. The stigma attached to rural practice could be overcome by including rural experience during training.

EXISTING INITIATIVES TO SUPPORT RURAL SPECIALISTS

College programs

Some specialist Colleges have identified and developed initiatives to address service imbalances by organising networks or outreach services to rural populations to ameliorate the disadvantage to rural communities of low numbers of resident specialists. These initiatives have raised the profile of rural practice, and have contributed to reducing the stigma associated with rural practice.

The *Royal Australasian College of Physicians* maintains a locum service for physicians and paediatricians practising in rural and regional areas, and metropolitan fellows also offer consultancy services to regional colleagues.

The *Royal Australasian College of Surgeons* supports rural recruitment through its Rural Surgical Training Program and a locum program. The training program has been effective in meeting its objective of establishing and maintaining training positions.

The *Australian and New Zealand College of Anaesthetists* provides a locum support program for rural fellows.

The three locum support initiatives mentioned above, whilst achieving some successes, have experienced barriers to recruitment such as State registration requirements, the cost of medical indemnity insurance, and the cost and availability of locums.

The initiatives of the *Royal Australian and New Zealand College of Obstetricians and Gynaecologists* provide some innovative approaches with a strong public health and indigenous focus that could be applied across other disciplines and broadened:

- the Maternal Health Skills Transfer program, which targets the factors associated with poor peri-natal outcomes by the provision of maternal health education;
- the Basic Obstetric Ultrasound training for rural medical practitioners program aims to equip health workers to perform basic ultrasound skills in remote communities in Cape York and Palm Island;
- Audit Support for provincial and rural practitioners and hospitals;
- the Flying Obstetrician and Gynaecology service (FROGS) in North Queensland;
- the Practice Improvement Program for rural obstetricians and gynaecologists whereby training in advanced skills is provided in the specialists' own locations with follow-up support.

The *Australian College of Rural and Remote Medicine* provides web based materials suitable for continuing medical education (CME) activities for all rural specialists include a range of public health, emergency medicine, obstetric, ultrasound and radiology programs and accredited workshops that apply across the differing roles of the rural doctor. An excellent example is the Population Health for Clinicians (PHEC) Program. This College sees itself as providing rurally relevant educational services to all rural doctors including specialists. They have looked into the development of conjoint awards with other learned Colleges and are developing a professional development program that is designed to accommodate participating specialist needs.

Hospital-based initiatives

In an effort to attract and retain specialists to rural and remote hospitals several different groups have developed their own *recruitment strategies*. The Broome, the Atherton and the Mt Isa Hospital incentive packages include salaried positions for the specialists that include some of the following features: cars, accommodation, study leave, return airfares, additional 2 weeks leave, assured leave (the hospitals arrange locums) as well as initiatives such as family support and spouse employment. In one hospital consideration is also being given to time off in lieu, instead of a loading, for overtime.

Rural telemedicine

Telehealth approaches are increasingly be used to provide health services, and professional training and support in rural areas. Specialities include psychiatry, ophthalmology and obstetrics and gynaecology.

Commonwealth initiatives

The *Advanced Specialist Training Posts in Rural Areas* (ASTPRA) program is a cost-shared Commonwealth-State initiative. It supports the recruitment and retention of rural specialists by establishing and maintaining advanced specialist training posts in regional areas.

Specialist registrars receive accredited training, and provide professional support to rural specialists by contributing to professional ‘critical mass’.

Rural Clinical Schools and *University Departments of Rural Health* are being established in rural areas to create a better infrastructure for rural medical training, and to increase the prestige of rural practice. The academic positions will increase the number of clinicians practising in rural areas, and will provide existing local practitioners with clinical support, research capacity, and CME opportunities. However, these institutions will have a long lead-time before they have a substantial and sustained effect on the rural medical workforce.

FINDINGS OF CONSULTATIONS ON PRIORITY SUPPORT NEEDS OF RURAL RESIDENT SPECIALISTS

A total of 87 semi-structured interviews were conducted of which 60 were conducted with rural resident specialists in Queensland, Victoria and Western Australia. Six main themes emerged.

The significance of rural training and rural background

Several rural specialists who regularly recruit staff suggested that the best way to attract staff was to target those with potential during a rural rotation. Providing a positive rural experience and encouragement to consider rural practice has proved to be an effective recruitment strategy. Eight-four per cent of the resident specialists interviewed reported undertaking rural training as part of their undergraduate or post-graduate training. Of these 59 per cent reported this rural rotation as having a direct influence on their decision to practise in a rural area. Thirty-seven per cent of the rural resident specialists and 56 per cent of their spouses had a rural background.

The attractions of rural practice

The rural specialists reported being attracted to live in rural areas mainly because of the rural lifestyle and the type of medicine rural practice entails. They reported high levels of satisfaction with living rurally, excellent relationships with the local GPs, and good community support.

Reasons for leaving rural practice

The most common reasons given by rural specialists for considering leaving rural practice were conflict with or lack of support from the local/State Health Department, or on call demands and the associated workload.

Professional isolation and lack of recognition

The consultants found that rural specialists saw themselves as a ‘faceless group’. They generally felt they needed more support from their respective Colleges, felt undervalued by governments, and felt overworked to the point of exhaustion. The situation became worse the more remotely located they were, and where the health status of the community was also much worse. Ninety per cent perceived a very strong stigma attached to rural practice stating their non-rural peers saw it as ‘second rate’. They felt that there were strong barriers to their re-entering metropolitan practice.

The effect of increasing sub-specialisation

A key barrier to rural specialist practice is the sub-specialisation that has occurred in the past twenty years. The general specialist has almost become extinct in favour of highly sub-specialised practice. Changing training patterns also support this trend, with trainees having to choose their sub-specialty in their first year of training. This has a huge impact on the recruitment processes for the general rural specialist who needs to be able to handle most things with the more sub-specialised work being referred to the major tertiary referral centres.

Unmet support needs

The top six unmet needs identified by the rural specialists interviewed were:

- the existence of a critical mass of rural specialists;
- opportunities for professional development, CME, and upskilling in tertiary teaching hospitals;
- adequate relief, locum support, and peer support;
- sufficient funding for trainee and rural specialist positions;
- family and spouse support/employment; and
- financial support.

LESSONS FROM THE EXPERIENCE OF THE COMMONWEALTH RURAL AND REMOTE GENERAL PRACTICE PROGRAM

The consultants considered that a number of the elements of the Commonwealth Rural and Remote General Practice Program, which are implemented by the Rural Workforce Agencies (RWAs), could usefully be extended or adapted to meet the support needs of rural specialists. They mentioned in particular:

- the Family Support Network;
- the Doctor for the Rural Doctors Scheme;
- the Mix and Match process;
- locum support programs; and
- CME activities for GPs such as satellite broadcasts, emergency medicine weekends, and family weekend workshops. In WA rural specialists are invited to attend and expressed high levels of satisfaction with this involvement.

The consultants also felt there was potential for specialists to be involved in the ***Divisions of General Practice rural special interest groups*** for their peer support.

ADVICE ON THE PRIORITY SUPPORT NEEDS OF RURAL SPECIALISTS

The unmet support needs of the rural specialist workforce as identified by the consultancy focus around one key factor – establishing a critical mass of rural specialists in a locality that equates to the population need. The consultants advised that the implementation of the Australian Medical Workforce Advisory Committee specialist/population ratios would provide a good starting block for establishing this critical mass.

The consultants identified six priority support needs.

1. Establishing a critical mass

More than 90 per cent of the rural specialists interviewed identified establishing a critical mass as their top unmet need. A critical mass is considered to be a minimum of three specialists (or two specialists and one trainee) of the same type with different sub-specialty interests in one community, supported by population demand, i.e. 3 physicians to 30,000 population. This is seen as necessary for recruitment (to make it attractive), retention (for supervision arrangements, support, and professional development opportunities), and for sustainability in the long term. Solo practice was seen as not sustainable, and should be discouraged unless the role of the consultant has been reviewed in consultation with the GPs in that community.

2. Professional development, CME and opportunities to upskill

The need to meet professional development requirements was reported as the second highest unmet need by the rural specialists interviewed. The greatest barrier to this was the lack of locum support to enable them to take time off to attend available opportunities, which tend to occur in metropolitan areas. The establishment of a critical mass of specialists would result in greater access to professional development and CME. A significant problem exists in this important area and innovative multi-pronged solutions and support are required. Approaches should include opportunities to upskill in tertiary teaching hospitals.

3. The provision of adequate relief, locum support and peer support

The third highest reported unmet need was the provision of adequate relief, locum support and peer support. The establishment of a critical mass is the key to resolving the problems associated with locum relief, which can then be handled internally.

The locum support programs conducted by the Colleges of Anaesthetists, Physicians and Surgeons, whilst providing some relief, provide only a small number of locums and the situation will only worsen with the increasing push towards sub-specialisation. The Colleges are also limited in what they can achieve due to the barriers such as State registration requirements, medical indemnity insurance, the cost of locums for private practice, and the inability of advanced trainees to access provider numbers. The lack of a career structure for locums and the associated low status of being a locum provide further disincentives.

4. Education and training

The fourth highest reported unmet need, also closely related to establishing a critical mass, was the establishment of sufficient specialist training posts in rural and remote areas.

Colleges play a significant role in education and training, as do State and Commonwealth health departments. The consultant identified a potential role here for the Australian Medical Council (AMC) to include minimum rural training/practice benchmarks in the accreditation

of specialist Colleges. The emphasis however must be on the provision of quality training opportunities, which rural posts certainly offer, rather than initiatives to solve workforce shortages. Therefore these posts should provide positive incentives for the trainees who use them, as well as assisting in raising the status of rural practice. Initiatives around more flexible supervision arrangements for trainees also require investigation.

The consultant recommended that the Colleges review the training needs of their trainees and to find ways to start working 'with' rural specialists and trainees to ensure specialist services are provided equitably for the whole community and not predominantly for metropolitan people. This should include reviewing the way in which training occurs by tertiary teaching hospitals that place value upon and teach patterns of sub-specialisation. Therefore broadening the required training opportunities to include rotations in the community, areas of need, and particularly rural rotations should be seriously investigated and supported.

Rural selection processes that attract those with a rural background, and the different role of the rural consultant also require review, as does rural representation on College councils, the support of grassroots rural initiatives and the simplification of barriers including State registration processes, medical indemnity costs and the time-consuming processing of overseas trained doctors.

The consultant indicated that opportunities exist for Colleges to adopt a collaborative approach to the process, with the Australian College of Rural and Remote Medicine playing an important role. More horizontal approaches across the disciplines, and innovations such as the development of joint awards and rural recognition to raise status may be useful. The AMC is in the process of developing guidelines for accrediting specialist Colleges, and this would provide a timely opportunity for Colleges to develop standards on rural training.

5. Family and spouse support

Whilst family support was the fifth top unmet need identified, it should be noted that 90 per cent of those interviewed were male. The few female specialists interviewed who had children raised the issues of childcare and being 'on call', as key disincentives to rural practice. Initial recruitment and retention is also based on family contentment and it is known that the female medical workforce is more likely to go where the husband works, rather than vice versa. Current recruitment and retention strategies were developed for a predominantly male workforce. To encourage more women to work in rural areas, these models need to be reviewed to allow for sex differences and female participation.

In some States there were reports of some family support initiatives being used by rural specialists through the RWA's family support networks. These were the 'doctor for the doctor' initiatives, family interviewing and orientation programs, and the CME activities. Whilst these activities are GP focused, many would easily translate to meet the needs of rural specialists who are often much more isolated due to their small numbers.

Spouse employment is also a key recruitment issue, and some initiatives are now in place to also find employment for the spouse as part of the recruitment package. Two States reported using highly successful spouse employment initiatives that involved the community. These models could be easily replicated by all employing agencies.

6. Financial support.

Financial support was not among the primary issues raised by the rural specialists but it was mentioned, and the financial discrepancies between the disciplines were seen as quite significant. This was particularly evident for non-proceduralists, in particular paediatricians, psychiatrists and obstetricians, who often needed to bulk bill, and who also had a higher female patient load. All initiatives and incentives to attract and support resident specialists should recognise and acknowledge:

- the different context in which rural specialists work, favouring those communities of greatest need and remoteness, those with the highest morbidity rates, and bearing in mind the distance the specialists need to travel, and the particular needs of the indigenous population;
- the differences between the disciplines;
- the differences between proceduralists and non-proceduralists;
- the difficulties experienced by and higher demand for the rural consultant;
- the differences between private and public work; and
- the need for structures to be put into place to facilitate succession planning for older specialists.

Other factors affecting rural specialist practice

The consultants identified a number of other issues related to rural specialist practice.

Key differences between major specialities

The differences noted between the disciplines are largely content related and discipline specific. This includes their differing legal and ethical responsibilities, supervision requirements, medical indemnity responsibilities and support needs.

Psychiatrists have particular supervision requirements which means those working in solo practice have difficulty meeting.

Medical indemnity insurance for obstetricians is a key factor in attracting, training and supporting their needs and will be an even greater factor in the future.

Support issues such as locum relief also differ between the disciplines. Locum relief for surgeons and anaesthetists seems less disruptive to the practice than it is for psychiatrists or paediatricians, who report their patients just wait for them to come back from their leave, rather than seeing the locum.

The effects of geography

While the consultations revealed some differences in the unmet needs between specialties, the similarities were more significant. In fact the differences between geographic areas were more significant than the differences between the disciplines in terms of support needs. One could draw similar conclusions about the situation facing those living anywhere in northern Australia north of the 26th parallel. This is mostly due to morbidity of the population, isolation, transport issues and problems of access to tertiary teaching hospitals and major centres. These factors affect access to CME and professional development, and transferring patients; and should be taken into account in any support initiatives that are State based.

Differences in rural and remote practice

The more remotely located the specialists are, the greater the difference in their practice from metropolitan practice, and the more expensive it is to employ and maintain them. This is due to the distances they have to travel to provide their services, the additional costs of travel and accommodation, and additional time and costs associated with accessing CME activities.

The perceived barriers to success

The consultant was of the view that key barrier to establishing a critical mass is the stigma associated with rural practice. Ninety per cent of the rural specialists interviewed perceived an extremely strong stigma attached to 'going rural'. This was confirmed by the literature and through attitudes observed as part of the consultation process. As with any minority group, changing the culture, attitudes and perceptions of the majority is a complex task and requires multi-pronged solutions by all parties.

Deskilling of rural GPs

One of the issues raised during the consultancy, mainly by the RWAs and the GP proceduralists interviewed, was that specialists practising in rural areas can lead to the deskilling of rural GPs. Deskilling was reported to have occurred in areas well supplied with medical services, while in areas of significant undersupply of medical services, the specialist was more likely to take on the role of mentor, advisor, teacher and clinician in difficult situations. In the development of strategies to support the rural specialist workforce, it is important to ensure that any initiatives do not result in the deskilling of GPs and other health professionals. This could be done through reviewing the role of the rural specialist consultant, and the development of initiatives that support and acknowledge the important role they play.

STRATEGIES FOR THE SUPPORT OF RURAL SPECIALISTS

A. Strategies for establishing a critical mass of specialists in rural areas

These strategies include support such as building links to academic institutions especially University Departments of Rural Health and Rural Clinical Schools, encouraging academic appointments; providing opportunities for teaching and supervision through accredited rural trainee positions, community support for spouse employment, links to the family support networks that currently exist for GPs, and access to internal locum support for professional development and leave, or dedicated locum support, study leave and conference leave.

The consultants also suggested that, after 5 years, the specialist be able return to a position in a tertiary teaching hospital, or have the opportunity to upskill in a major tertiary teaching hospital, on the same salary for up to one year, with relocation expenses included.

B. Strategies for professional development, continuing medical education and opportunities to upskill

These strategies include the provision of financial support for rural specialists for attendance and travel expenses for CME activities with priority given to those with furthest to travel. It was also suggested that rural specialists be included in professional development, CME, and to upskilling in currently existing programs already provided through the RWAs, specialist Colleges, University Departments of Rural Health, and Rural Clinical Schools; and links should be made with Divisions of General Practice.

The consultants recommended the adoption of measures to support and encourage rural peer networks by means of teleconferencing, accessing web-based resources and telehealth to cover the associated administrative costs necessary to continue this work. Also valuable would be the development of rural specific, innovative distance learning initiatives, such as telehealth, access to grand ward rounds, and the development of web based educational materials.

C. Strategies for relief, locum support and peer support

The consultant suggested several measures related to relief, locum support and peer support. These include the exploring of opportunities be explored for the streamlining of the State registration processes, tackling medical indemnity insurance issues for locums, and standardisation of locum fees to reduce the cost to practices of employing locums. The establishment of a national specialist locum service similar to the state based GP locum services administered by the RWAs could be investigated.

D. Strategies for sufficient rural training posts and strategies for rural training

The consultants suggested that more rural training posts be established taking into account the following:

- they are placed in the areas of greatest undersupply and need;
- the morbidity of the population and the distance travelled by the specialist should be taken into consideration in deciding the number of posts to be established;
- educational support should be provided by innovative web-based education mechanisms;
- the richness of the training experience should be measured by rural models of practice not metropolitan models of sub-specialist practice; and
- there is adequate and flexible supervision.

They also suggested that opportunities for more flexible distance supervision and support arrangements be investigated in collaboration with the respective specialist Colleges.

E. Training strategies involving the Colleges

Among the training strategies involving Colleges suggested by the consultants were the development of conjoint awards to raise the profile of rural practice, to better train rural specialists, and to provide supportive mechanisms for specialist Colleges. The Australian College of Rural and Remote Medicine (ACRRM) could have a role in investigating this approach.

Other possible strategies include the review of selection processes to ensure they attract candidates with a rural background, consideration should be given to rural representation on College councils to inform decisions and reduce the stigma associated with rural practice.

It was also recommended that the Colleges should work with the AMC to develop a set of minimum College standards on rural training, and that work be undertaken horizontally across the disciplines in the development of joint rural curricula and rurally specific distance learning resources that could build onto currently existing programs and infrastructure.

F. Strategies for Family and Spouse Support

These strategies include utilising the established RWA family support networks to support rural specialists, especially those around the ‘Doctor for the Doctor’ strategy, family support and liaison, and the provision of applicable linkages. It is suggested that a collaborative approach by health departments, communities and local/regional health authorities be adopted to provide opportunities for spouse employment be included as part of recruitment packages, and that the models for rural recruitment and retention should be reviewed to ensure they allow for sex differences and female participation.

G. Strategies for financial support

Among the financial support strategies suggested were the development of a package of incentives to address the unmet needs incorporating the key features of the GP support programs which are applicable to specialists and would improve recruitment and retention.

OPPORTUNITIES FOR INTEGRATED APPROACHES AND LINKAGES WITH EXISTING PROGRAMS

The consultants identified a number of opportunities for integrated approaches and linkages.

Rural Workforce Agencies

Potential linkages clearly exist between the RWAs for initiatives to provide and coordinate State based locum support, CME activities, recruitment initiatives, and family network support. Any initiatives need to be well promoted and marketed to the rural specialists, as they see the RWA as being particularly GP focused. The RWAs would also need to be more orientated towards the needs of rural specialists. This would ensure a ‘one size fits all approach’ that is not bogged in inflexible rules, and acknowledges disciplinary differences. RWAs would also need to work much more closely with the specialist Colleges to ensure differing disciplinary specific understanding.

Rural Clinical Schools and University Departments of Rural Health

The Rural Clinical Schools and the University Departments of Rural Health have the potential to be the heart of activities to recruit and support the rural specialist workforce. The introduction of strategies such as participatory academic appointments (not just adjunct) should prove an incentive to initial recruitment and encourage positive relationships to be built with rural undergraduates in these early years. Opportunities such as the implementation of professional development, CME, family support networks, and peer support networks that are locally driven, should be investigated regionally. Peer support initiatives that are currently undertaken to support GPs by Divisions of General Practice could also be coordinated through these schools, or through the local Divisions.

The specialist Colleges

The consultant identified the need for Colleges to look more horizontally across rural practice to avoid ‘silos of sub-specialty practice’. As many of the issues relate to context, rather than content, the Colleges have more in common with each other on this issue than they do within their own specialty. Therefore a joint group such as the rural sub-committee of the Committee of Presidents of Medical Colleges with ACRRM involvement could provide an avenue for potential linkages to oversee and support the development of any initiatives. Such

a group would need to be represented by real ‘rural and remote specialists’ from each State, and not metropolitan members speaking on their behalf.

The Australian College of Rural and Remote Medicine

ACRRM also has a potential and significant role to play in assisting other specialist Colleges to provide greater linkages and support to their rural members. The development of conjoint awards that would raise the status of the specialist qualification as well as reduce the significant stigma associated with rural practice should be investigated and supported. There are also opportunities for the development of joint curricula and rurally specific distance learning resources that could build onto Colleges’ currently existing programs and infrastructure.

Tertiary teaching hospitals

Tertiary teaching hospitals have a key role in the education of young specialists and provide ongoing linkages to future rural programs. However, tertiary teaching hospitals tend to value specialisation and therefore teach patterns of practice that are less likely to be appropriate in rural communities than in metropolitan practice. Therefore training opportunities that also include structured training rotations in the community, areas of need, and/or rural rotations should be encouraged, and mandatory rotations considered. Meeting these requirements could be linked with the teaching hospitals’ accreditation requirements, in an effort to broaden the experience for the trainee, and raise the importance and status of rural practice.

Opportunities for swapping arrangements with tertiary consultants who often influence the career decisions of trainees and play a role in the ongoing stigma associated with rural practice could be investigated. For instance, the tertiary consultant could provide locum relief for a week, whilst the rural specialist undertakes CME in an area of need. The ‘Adopt a Hospital’ initiative proposed by the Australian and New Zealand College of Anaesthetists could also provide a model. This involves a system whereby the metropolitan city hospital adopts a regional hospital. The metropolitan hospital then sends the specialists to the regional hospital for anything from one to four weeks, to work and teach there, and in return the regional hospital may from time to time send someone to the city for a week or so for upskilling.

Another possibility is for the adoption of a ‘buddy system’ for regional teaching hospitals whereby the tertiary hospital is responsible for standards of practice and final year registrars provide outreach services and support for rural resident specialists. This approach also provides a two-way learning opportunity whereby the resident specialists can maintain their skills and knowledge of the latest techniques and information. It may also enable those who were unsure about practising in rural areas to have a positive experience.