The road less travelled: supporting physicians to practice rurally

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Supporting physicians to practise rurally is complex and should be part of a multifaceted strategy to provide more health care in the bush

The distribution of health professionals between metropolitan, regional, rural and remote areas is a key issue for access to health care for rural populations. Increasing reliance on domestically trained doctors rather than international medical graduates, the backbone of medical care provision in rural areas, is expensive and will require effort over decades. Clear short term policy solutions do not exist,[1] and long term solutions rely on fundamental changes to the way doctors are recruited, trained and supported,[2] which require a high level of coordination between the many stakeholders involved in medical training.

There has been much emphasis on getting general practitioners into rural areas, with the rural generalist pathway for GPs now a reality to support the provision of both primary care and procedural hospital services in towns of 20 000 people or less.[3] There are many different types of health professionals and other specialists who work outside of metropolitan areas. The supplement accompanying this issue of the *MJA*[4] focuses on physicians who work in regional towns and cities and provide outreach and services to smaller communities.[5,6]

Sustaining the supply of rural physicians is becoming increasingly difficult, with the need for a generalist skillset against a background of high levels of subspecialisation and metropolitan-based training.[7,8] Policies currently in place to ensure there are more rurally intending medical students and doctors in prevocational training are moving in the right direction and are necessary but seemingly not sufficient.[9]

Using new data, the four supplement chapters[4] highlight a number of key issues facing rural physicians, many of which have been previously described in studies of rural general practice.[10] While physicians who choose to remain rural have similarly high rates of professional satisfaction to their urban colleagues (Chapter 1), professional isolation and poor support networks are highlighted throughout the supplement. Physicians have described the detrimental effects of rigid accreditation processes and the role of a pervasive culture of undermining of rural practice and generalism, rather than them being valued

within college structures and by health service employers (Chapter 3).

The fundamental role of leadership being able to showcase and champion positive rural practice for the physician workforce is required (Chapter 3), along with the need to increase and scale up rural training options and pathways. Along the journey, supportive supervision models should be prioritised along with addressing many of the inflexibilities related to undertaking rural training. The majority of the next generation of the workforce will be women, and focusing on their needs could greatly increase the workforce distribution of physician consultants.

Chapter 4 outlines eight foundational principles that should be used to guide policy. The advent of the National Medical Workforce Strategy, which is in its final stages of review, potentially provides a mechanism by which such principles can be used to implement new nationally coordinated policy.[11] The National Medical Workforce Strategy presents a rare opportunity to demonstrate a nationally collaborative approach to workforce policy based on pooled data and evidence shared between all stakeholders.

Collaborative long range effort with sustained investment in regionally based training, including supporting investment in supervisors and service capacity, is required. Support for generalist models of training and flexible career pathways is essential, so that those who prefer to train and work part-time are not disadvantaged. As the supplement chapters note, multiple interlocking strategies are required, with the data highlighting factors such as spousal employment, family support and social and professional connections to address the identified geographic and professional isolation.

The opportunity that this body of work identifies should be built upon. The doubling of medical graduates in the early 2000s has not solved rural maldistribution of the medical workforce. Physicians,

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like GPs, work alongside other health professionals and providers who should together be more integrated into rural models of care. Telehealth has proved to be an asset that, in some cases, has reduced the need for a physical face-to-face consultation, has introduced many patients to a more convenient way of accessing health care, and should be integrated into rural medical training and work models.[12] The complementary use of telehealth could play a large part in reducing medical workforce shortages in rural areas if clinical models and funding drivers are brought together.

Ensuring that rural patients in need receive an appropriate range of health care will require a number of broad solutions and innovations based on a clear understanding of population need and a more effective distribution of human and other resources. Rural physicians are important travellers on this road ahead and, with support and a clear path, many more will reach the destination.

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