INITIAL PROPOSAL FOR RECOGNITION OF RURAL GENERALIST MEDICINE AS A FIELD OF SPECIALTY PRACTICE WITHIN THE DISCIPLINE OF GENERAL PRACTICE UNDER THE HEALTH PRACTITIONER REGULATION NATIONAL LAW

Jointly submitted by
the Australian College of Rural and Remote Medicine and the
Royal Australian College of General Practitioners

DECEMBER 2019

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

RACGP
Royal Australian College *of* General Practitioners

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Identifying information

Applicant Details

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Specialty or field of specialty practice details

Specialty or field of specialty practice:

Rural Generalist Medicine as a field of specialty practice within the discipline of General Practice.

Verify proposal

The information present is complete, and it represents an accurate response to the Guidelines for the Recognition of Medical Specialties and Fields of Speciality Practice under the Health Practitioner Regulation National Law.

……..
Signature

Nick Williamson, RACGP Chief Executive Officer

Name……..

……..
Signature

Marita Cowie, ACRRM Chief Executive Officer

Name……..

Executive summary

- This is a combined application of the general practice colleges proposing that 'Rural Generalist' (RG) be recognised as a protected title, as a Specialised Field within the Specialty of General Practice.

  The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) are accredited by the Australian Medical Council (AMC) as the Fellowship education providers in the recognised speciality of general practice. Both colleges recognise the importance of Rural Generalist medicine in delivering best quality care for Australian rural and remote communities.

  This application operationalises a key recommendation of the National Rural Generalist Taskforce Report, which was accepted by Minister Bridget McKenzie in December 2018.

  "A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in hospital and community settings as part of a rural healthcare team."

  This definition was agreed to by the two colleges in collaboration with the National Rural Health Commissioner (the 'Collingrove Agreement') and part of the Taskforce report.

- The key issue this proposal seeks to address is the persisting inequity of access to comprehensive healthcare for people living in rural and remote areas.

  Australians living in rural and remote communities continue to have poorer access to healthcare services and have poorer health outcomes compared with those living in urban and metropolitan areas. Data show that people living in rural and remote areas have higher rates of hospitalisations, mortality, and injury while having poorer access to, and utilisation of, health care services, compared with those living in metropolitan areas.[1]

  Access to equitable and comprehensive healthcare in Australia's rural and remote populations is complex given the challenge of distance and geography. Rural and remote areas have significantly fewer doctors per capita and less access to specialised healthcare resources. While there has been a substantive increase in the number of medical graduates from Australian medical schools, this has not resulted in sufficient doctors being based in rural and remote communities.[2]

- The distinctive RG workforce model with a robust and well-trained RG workforce can make a substantial contribution to solving these issues in rural and remote communities.

  RGs are primary healthcare providers with advanced/additional skills enabling them to work in secondary and tertiary arenas in collaborative networks with other health professionals. They are specifically trained for expert service provision in rural and remote clinical contexts. A workforce trained in this way can enable delivery of high quality and safe care close to home for rural and remote Australians. The workforce model recognises the importance of primary care and generalist scope to quality, cost-effective healthcare delivery and within the limitations of distance, can enable access to patients in a context adaptable way to a broad scope of services that may not otherwise be available to them.

- A highly trained RG workforce of several thousand practitioners is established and providing vital services across rural and remote Australia. This workforce's promotion, growth and sustainability however continues to be impeded by a range of structural barriers.

  Many doctors and medical students considering an RG career option are beset by excessive complexity, inconsistency and inefficiency having to negotiate a complex system across different jurisdictions often involving multiple colleges, curricula and professional standards. Furthermore, the lack of a single recognised title, renders it very difficult to scale-up national policies with respect to promoting, supporting or effectively regulating the workforce.

  Title recognition and by extension recognition of the National Rural Generalist Pathway (NRGP) will alleviate the inconsistency across jurisdictions in support of the pathway for training this workforce and provide a national process for recognising and supporting existing practitioners.

  In particular, title recognition will:
  - provide medical graduates and junior doctors with a nationally-recognised endpoint with status equivalent to other training endpoints, and one that can deliver cross-jurisdictional portability
  - benefit health services in recruiting suitably trained RGs to work in their community
  - create a more structured credentialing and titling framework which can provide clarity regarding best practice quality and safety for RG practice

- This application is preceded by a comprehensive national consultation by the National Rural Health Commissioner on behalf of the National RG Taskforce, (co-led with the two colleges). The consultation included education and training providers (colleges, universities, academics), Commonwealth and jurisdictional governments, Aboriginal and Torres Islander groups, professional bodies, agencies, consumer representatives, clinicians, trainees, medical students and community leaders from across rural and remote Australia. The Taskforce Recommendations including this application, were based on feedback from these, and the advice of the over 200 expert stakeholders of the Taskforce, Working Groups and Expert Reference Groups.

- The consultation confirmed a high level of consensus, goodwill and commitment across government, community and health sectors for implementing and establishing the NRGP. The Commonwealth Government is committed to implementing the NRGP and has supported this application. It has established dedicated RG training and 300 RG positions within its nationally-funded GP training scheme (AGPT) which support the colleges' training programs and the various jurisdiction-funded RG programs.

- A strong RG national workforce can provide a sustainable solution to critical healthcare needs. Recognition of Rural Generalist Medicine as a field of specialty practice is a necessary step toward enabling its growth and retention. It will directly remove specific structural barriers. More broadly it will facilitate health service/training systems, health personnel and the community at large working toward a thriving national network of these practitioners.

1. Describe the function of the organisation(s) lodging the preliminary proposal and its/their interest in the proposal.

- Describe the current role of the organisations, with reference to the organisation's statement of purpose, and the functions it performs
- Provide a brief history of the organisations relevant to the application
- Provide brief information on the applicant's governance structures
- Current number of Fellows/Members of applicant bodies
- Provide a current annual report(s)
- Provide a declaration of the organisation(s) interest in the proposal, including agreements and arrangements with funding bodies and MoUs with other entities

The Australian College of Rural and Remote Medicine (ACRRM)

Mission and Functions:

The College vision is for - *the right doctors, in the right places, with the right skills, providing rural communities with excellent healthcare.*

Its purpose is: *to improve the quality and safety of care for rural and remote communities by setting professional standards for practice, and delivering lifelong education, support and advocacy.*

Its mission is: *to provide a vibrant professional home for specialist General Practitioners and Rural Generalists that delivers: inspiration, collegiality, value, and social accountability.*

The College membership includes ACRRM Fellows, registrars training to ACRRM Fellowship, junior doctors and medical students interested in careers in RG practice, and Fellowed General Practitioners (GPs) with an interest in the College and its work.

The College provides a Fellowship training program which it delivers both independently and in conjunction with government supported programs. The program has been designed to prepare Fellows for practice as general practitioners in the RG model of care.

The College also delivers its Professional Development Program (PDP) which is designed to enable and assure currency in the skills associated with the Fellowship. The program includes services to manage Fellows' Maintenance of Professional Standards and reporting requirements for clinical credentialing in a range of advanced skill areas associated with the Fellowship.

The College supports members in learning and applying their skill set in their practice.

- It advocates on behalf of its members and their rural and remote communities
- It facilitates and supports peer networking and communities of practice for members
- It provides educational/clinical support resources, courses and events relevant to RGs and rural and remote practice.

Integral to all these activities is the College's continuous program of development, review and advocacy for appropriate professional standards of quality and safety for ACRRM trainees and Fellows and their model of practice.

History:

ACRRM has established in 1997 with some 660 foundation members. It was formed to provide professional standards, training and CPD reflecting the model of care practiced by its rural doctor membership. This has come to be known as rural generalist practice. The College now has over 5000 members including, Fellows, registrars, junior doctors and medical students interested in pursuing rural careers.

The College formerly commenced delivery of its national Fellowship training and professional development programs in 2001. It was awarded provisional Australian Medical Council (AMC) accreditation in 2007 and full accreditation in 2011 which it has maintained to the present time.

From the outset, ACRRM's Fellowship program has been delivered both autonomously through its self-funded Independent Pathway and through a supported delivery model which has been auspiced variously through the Commonwealth Government's GPET (from 2001-2015), the Australian General Practice Training (AGPT) and the Remote Vocational Training Scheme (RVTS) programs.

From 2022 ACRRM will assume responsibility for the management functions of the AGPT and RVTS programs as they pertain to supporting registrars in the ACRRM Fellowship program.

Governance:

The College is oversighted by ACRRM Board which holds ultimate authority for all corporate governance. There are four peak councils which report to the Board each with their own respective reporting committees and working parties. They are the College Council, the Finance, Audit and Risk Management Council, the Quality and Safety Council and the Education Council. The College has dedicated governance structures to represent its registrar, medical student, junior doctor, and Aboriginal and Torres Strait Islander members. It also has a series of reporting RG Clinical Working Groups which provide expert guidance in key focus areas for RG practice.

Information on ACRRM Governance and Board and College Council members can be found at the following link:
https://www.acrrm.org.au/about-the-college/board-council-and-committees

ACRRM Strategic Activities and Logic Map (2018-21) can be found at the following link:
https://www.acrrm.org.au/about-the-college/history-of-acrrm/college-vision-and-values

The ACRRM Reconciliation Action Plan can be found at the following link:
https://www.acrrm.org.au/the-college-at-work/reconciliation-action-plan

ACRRM Annual Report (2018-19) can be found at the following link:
https://www.acrrm.org.au/about-the-college/annual-reports

Current number of Fellows/Members:

As at October 2019[3], the College has some 1760 ACRRM Fellows and 5150 members. This included 701 trainees, 937 medical students, 9 Fellows identifying as Aboriginal and Torres

Strait Islander, 19 trainees identifying as Aboriginal and Torres Strait Islander, 74 members identifying as Aboriginal and Torres Strait Islander.

For further detail of the ACRRM,

See: Appendix 1.1 ACRRM functions, history and governance

The Royal Australian College of General Practitioners (RACGP)

RACGP function, history and governance

The Australian College of General Practitioners (ACGP) was formed in 1958 becoming the Royal Australian College of General Practitioners (RACGP) in March 1969. Vocational education and training for general practitioners was formalised in 1973 with the Family Medicine Programme. In 1984-1985, as the first step toward accreditation, a Certificate of Satisfactory Completion of Training was introduced with the award of Fellowship of the College (FRACGP) as the endpoint of the Family Medicine Programme. In the 1990s, the College began a phase of refining its early initiatives including Quality Assurance, Fellowship examinations, a more defined training program, vocational registration, standards of general practice, a greater focus on rural, and Aboriginal and Torres Strait Islander health. By 1996 vocational training and registration became mandatory and were tied to Medicare payments for GPs. In 2017, Federal Health Minister Greg Hunt announced that the RACGP and ACRRM will resume delivery of general practice training in Australia commencing with a transitional period from January 2019 – December 2021. Both the RACGP and ACRRM will deliver training, encompassing the Australian General Practice Training (AGPT) from January 2022.

The RACGP is a not-for-profit company limited by guarantee, governed by the RACGP Council (board of directors), and headquartered in East Melbourne. The RACGPs vision is 'Healthy profession, Healthy Australia'. The mission is to improve the health and wellbeing of all people in Australia and to support General Practitioners (GPs), GP registrars and medical students through:

- Education and training for general practice Fellowships – FRACGP and FARGP, standards, quality, selection, international accreditation, curriculum, assessment, continuing professional development.
- Innovation and policy - for general practice, quality care, technology, practice standards and accreditation, knowledge and evidence, research, RACGP Foundation, policy and practice support.
- Advocacy - a strong voice advocating for general practice and patients in the community and across all levels of Government and stakeholders.
- Collegiality Member engagement, conferences, student to mentor opportunities, digital communities and united professionals.

The evolving nature of general practice has meant that there is a greater emphasis on advocacy, rural and Aboriginal health which have contributed to the broadening focus of the college and its membership. The RACGP established the National Rural Faculty in 1992 in response to the growing need for educational and training support for doctors entering and working in rural practices. In 1996, the Faculty of Rural Medicine, as it was first known, worked closely with the RACGP Training Program to develop a support program for GP registrars interested in rural general practice. This is known as the Rural Training Stream. GP registrars who satisfactorily completed the Rural Training Stream, including its extra, fourth year of vocational training in Advanced Rural Skills, were awarded the Graduate Diploma in Rural General Practice accredited as a formal tertiary award with the equivalent to an Office of Higher Education in each state and territory.

The Fellowship of Advanced Rural General Practice (FARGP) was launched in 2008. The FARGP provides the skills and qualifications for GPs working in rural areas. The College is in the process of developing an integrated RG Fellowship based on the FRACGP and the FARGP. Central to addressing rural disadvantage is the capacity of, and equitable access to, general practice and its role in bringing lasting change in rural communities. RACGP is committed to overcoming long-standing rural disparities and believes that rural health reform must lead to increased support for general practitioners and their communities and work to address current barriers to recruitment and retention. A more responsive and better coordinated health system in the future will need to foster rural innovation, improve access to high quality health care, provide for better coordination and reduce duplication and gaps. RACGP Rural supports and advocates for 19,000 members with over 8,500 registered GPs in rural and remote Australia.

RACGP Rural is committed to addressing rural disadvantage focusing efforts toward strategies which lead to more equitable access to healthcare. The capacity of the health system to respond to current and emerging pressures in rural and remote Australia is a central focus for RACGP Rural.

RACGP's Governance structures can be found at the following link:
https://www.racgp.org.au/the-racgp/council/council-members

The *RACGP Strategic Plan* (2018-2022) can be found at the following link:
https://www.racgp.org.au/the-racgp/about-us/vision-and-strategy/vision-statement-and-strategic-overview

The *RACGP Reconciliation Action Plan* can be found at the following link:
https://www.racgp.org.au/the-racgp/about-us/reconciliation-action-plan

The *RACGP 2018-19 Annual and Statutory Reports* can be found at the following link:
https://www.racgp.org.au/the-racgp/about-us/annual-reports

RACGP Current number of Fellows/Members:

Membership	
Fellows:	22,471
Doctors in training	4,693
Other	8,221
Students	5,493
Total:	40,878

Aboriginal and Torres Strait Islander Fellows:	65
Aboriginal and Torres Strait Islander Registrars:	55
GP Members working in rural	8,500.

2. Present a clear statement of the issue or issues that the proposal for the recognition of a new or amended specialty is intended to address

A. Present a summary of the issues that the proposal is intended to address and state why you consider the existing arrangements cannot address these issues.

This application proposes that 'Rural Generalist' (RG) be recognised as a protected title, as a Specialised Field within the Specialty of General Practice.

The key issue this proposal is addressing is the persisting inequity of access to comprehensive healthcare for people living in rural and remote areas. Australians living in rural and remote communities continue to have poorer access to healthcare services, utilise fewer health services, and have poorer health outcomes compared with those living in urban and metropolitan areas. Data show that people living in rural and remote areas have higher rates of hospitalisations, mortality, injury and poorer access to, and use of, primary healthcare services, compared with those living in metropolitan areas[4]. A robust and well-trained Rural Generalist (RG) workforce can make a substantial contribution to solving this inequity by enabling access to high quality care.

Access to equitable and comprehensive healthcare in Australia's rural and remote populations is complex given the challenge of distance and geography. Rural and remote areas have significantly fewer doctors per capita. They also have fewer and less specialised healthcare resources and supporting healthcare professionals. This context necessitates a distinctive workforce model that can optimise the support available to rural and remote Australians. An RG workforce can improve access to preventative care and emergency and hospital care in rural and remote communities leading to better health outcomes.

While there has been a substantive increase in the number of medical graduates from Australian medical schools, this has not resulted in sufficient doctors being based in rural and remote communities to provide the medical services required.[5] The promotion, growth and sustainability of this rural workforce however continues to be impeded by a range of structural barriers and award of protected title would go some considerable way to removing these.

RGs are primary healthcare providers with advanced/additional skills enabling them to work in secondary and tertiary arenas in collaborative networks with other health professionals. The scope of practice of an RG comprises a distinct combination of General Practice, emergency and advanced/additional skills appropriate for rural and remote clinical contexts. Communities can expect enhanced quality and safety through a workforce specifically trained for rural and remote practice with appropriate advanced/additional skills. A sustainable supply of workforce with appropriate skills also contributes to better health outcomes.

This approach recognises the importance of primary care and generalist scope to the future of cost-effective, quality healthcare delivery in Australia. Within the limitations of distance and smallness of scale, it can also enable access to patients to a broad scope of services in a context adaptable way. A medical workforce trained this way will deliver higher quality and safer care closer to home for rural and remote Australians.

There are currently several thousand doctors in rural and remote settings practising across an extended scope of medical care that have attained Fellowship qualifications and training through the general practice colleges reflective of their model of practice.

By necessity, across the country there is a complex of training programs, industrial recognitions and other systems and processes that have evolved to regulate and enable these doctors' practice. Currently these processes are not tied to a nationally registered standard recognising this distinctive practice and its link to the general practice colleges' training, assessment and professional development standards.

Without the clarity and cohesion that this can provide, the RG workforce is beset by excessive complexity, inconsistency and inefficiency. Doctors and medical students considering an RG career option as well as RG qualified doctors seeking to continue their advanced skilled practice, must negotiate a complex system across different jurisdictions often involving multiple colleges, curricula and professional standards. These systems issues are a disincentive to prospective new RGs and are leading many RG trained doctors to either narrow their practice scope or leave rural practice.[6]

Furthermore, the lack of a single recognised title, renders it very difficult to scale-up national policies with respect to promoting, supporting or effectively regulating the workforce. Title recognition and by extension recognition of the National Rural Generalist Pathway (NRGP) will alleviate the considerable inconsistency across jurisdictions in support of the pathway for training this workforce and provide a national process for recognising and supporting existing practitioners.

Under this proposal, recognition of Rural Generalist medicine as a field of specialty practice can facilitate a solution to critical workforce needs. It is a necessary step toward addressing these issues and enabling the growth of this workforce. It will directly remove specific structural barriers. More broadly it will facilitate health service/training systems, health personnel and the community at large working toward a strong and thriving national network of these practitioners.

This proposal outlines how these issues will be addressed through implementing the NRGP with an endpoint of a Fellowship in the nationally recognised specialised field of Rural Generalist medicine. It outlines the Pathway, including the RG training model and the principles on which it is based.

B. Provide a clear definition of the specialty/field of specialty practice as:
i. Understood by the applicant; and
ii. Used by other local and international authoritative sources to demarcate this area of medical practice.

> *"A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in hospital and community settings as part of a rural healthcare team."*

This definition was agreed to by the two general practice colleges in collaboration with the National Rural Health Commissioner (the 'Collingrove Agreement') and formed an essential element of the National Rural Generalist Taskforce report, which was presented to, and, accepted by Minister Bridget McKenzie in December 2018.

An international consensus statement has been developed and widely endorsed - Cairns Consensus statement on Rural Generalist Medicine (2014) which aligns with the Collingrove Agreement. The Queensland, Northern Territory and Tasmanian state/territory governments have included definitions of a 'Rural Generalist' in their respective legislation.

See: Appendix 2.1 Definitions of Rural Generalist Medicine

C. How will recognition of the proposed new or amended specialty within the National Scheme advance the objectives of the National Scheme, that is:

- To enhance protection of the public, including improvement in the quality of health services
- To facilitate workforce mobility
- To facilitate access to health services in the public interest
- To enable the development of a flexible, responsive and sustainable health workforce and innovation in service delivery

Specialist title recognition will facilitate growth of a robust RG workforce which can enable access to quality care for rural people[7].

Objective 1: Enhanced protection of the public including through healthcare quality improvements

Enabling a scope of practice to address rural medical service gaps

The RG practitioner has evolved as a direct response to ensuring communities have access to services that meet their healthcare needs that might otherwise be unmet. People living in rural and remote communities face unique challenges due to their geographic isolation and the relatively small pool of doctors, healthcare professionals and healthcare resources in their local area. Their limited access to healthcare services is likely to be a factor in their recording lower health status by all key indicators than their urban counterparts.[8]

People in rural and remote communities typically do not have locally-based medical professionals from the full range of specialties and may have to travel long distances to access non-GP specialists. This can be costly and can cause major disruption to families.[9] It may lead to families deciding to forego care[10] with national surveys finding that most people in remote areas view the lack of a non-GP specialist nearby as a barrier to seeing one.[11] Delays to obtaining appropriate care can exacerbate some conditions and create anxiety for patients. Travelling long distances to access care creates additional patient safety risk[12,13,14] and in emergency scenarios such as accidents and obstetric and psychiatric emergencies it may not be a safe or viable option.[15,16,17]

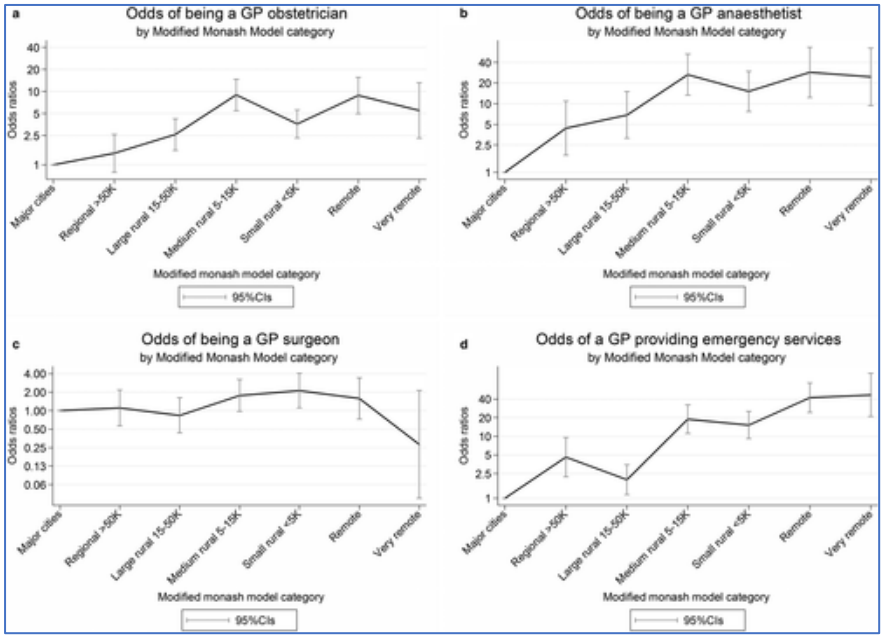
RGs provide an extended scope of practice which addresses the service gaps in rural communities in the skilled areas which in urban centres would typically be considered the purview of other specialties. As well as providing comprehensive general practice and emergency care, rural communities often depend on their doctors having advanced/additional skills for an extended scope of practice to meet their needs. These include skills in the fields of anaesthesia, obstetrics, surgery and more advanced emergency medicine as well as fields such as Aboriginal and Torres Strait Islander health, mental health, aged care, palliative care, addiction medicine, adult internal medicine, paediatrics, and remote medicine. The development and use of these general practice, emergency and advanced/additional skills represent the broad scope of practice of an RG[18].

These service gaps exist because it is not economically nor professionally viable for sustainable teams of all the relevant specialties to be based locally. The RG model enables teams of these

doctors to commit part of the working week to these specific areas of extended scope and to provide the also needed broad scope general practice and emergency services. In this way it is sustainable in both business and professional terms.

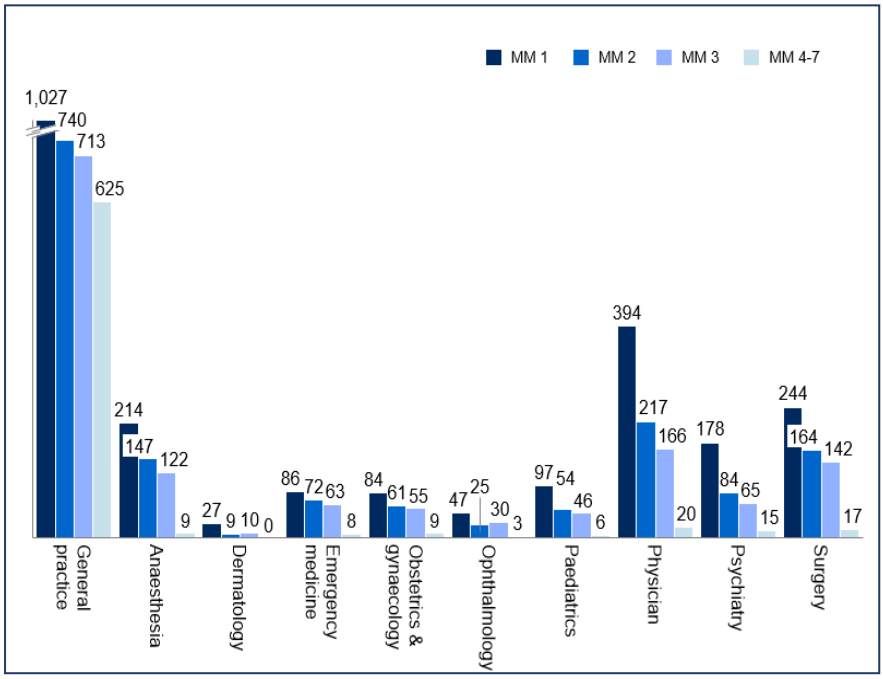
The Australian Institute of Health and Welfare (AIHW) have noted that, *"the higher rate of GPs in Remote/Very remote areas may be due to them having a broader scope of practice, given lower levels of supply for almost all other health professionals"*.[19] MABEL data has shown significantly increased likelihood of rural GPs providing anaesthetics, emergency or obstetrics services as geographical remoteness increased and population size decreased (see Figure 2.1).[20] This corresponds with decreasing numbers of anaesthetists, emergency medicine specialists and obstetricians as remoteness increases (see Figure 2.2).[21]

Figure 2.1 Odds of being a procedural GP by MM categories



Source: MABEL dataset, from Russell D et al (2017)[18]

Figure 2.2 Locations of specialists, by MM classification



Source: Commonwealth Health Workforce Data Set 2019, from Dept of Health (2019)[19]

Enabling promotion of medical career with exceptional rural outcomes

Currently there is no nationally recognised 'RG job title' nor nationally recognised employment positions following what is typically a 10 to 14-year training journey. This makes it difficult to promote rural generalism as a career to early stage doctors. Recognising a protected title will provide formal national recognition of the attainment of additional and extended training and its associated assessment requirements for the RG.

An RG career is a highly attractive value proposition to many aspirant doctors and practicing to the RG scope strongly correlates with rural retention. Removing these barriers to effective promotion of these careers can enable substantial expansion of this workforce and strengthen health services across rural and remote Australia.

There is substantial evidence to demonstrate the attractiveness of the RG model to Australian doctors.[22,23,24,25,26] Further, National AGPT Registrar Surveys of ACRRM (rural) registrars have consistently reported key features of the RG model such as 'practice variety', 'rural location', and 'procedural practice' as the most appealing aspects of training.[27-28] The MABEL survey studies found in particular that procedural practice is a significant predictor of rural retention and that where rural general practice doctors work in hospitals this correlates with an 18% increase in rural retention.[29]

In Queensland where the state government has formally recognised the RG role in legislation, workforce retention outcomes have been exceptional. From commencement of the Queensland Rural Generalist Program (QRGP) in 2007 to 2018, 144 Fellows had completed the program with a 70% retention rate in rural of remote areas (i.e. MM 4+).[30] All Australian jurisdictions should be enabled to attain equivalent positives workforce outcomes for their rural and remote communities.

Incorporating RG into credentialing and other quality and safety systems

A nationally recognised title linked to appropriate national qualifications can facilitate consistent, informed decision-making regarding RG doctors' safe, quality practice. Protected title for the RG workforce establishes a link between the field of specialty practice and its accredited qualifications. This will enable creation of consistent industrial and regulatory language to describe the role and its scope and address the considerable variability in the terminology currently used to differentiate the services that RG doctors provide.

Protected title can provide a basis for improved reliability and validity of credentialing decision-making. RGs' qualifications are often not recognised or understood by credentialing committees and RGs are commonly not included on these committees to make assessments. This practice (as well as preventing an opportunity to streamline compliance processes) can lead to erroneous determinations due to credentialing committees failing to understand the RG scope and skill set. Currently, many trained and able rural practitioners are being prevented from providing vital services to rural and remote communities due to such scenarios.[31]

Protected title clarifies the appropriate qualifications of RGs and their scope of practice informing quality and safety standards around their distinctive skill set. It clarifies the appropriate professional home for RG practitioners to ensure their continuing professional development (CPD) needs and other professional standards issues are supported by a fit-for-purpose, peer-led professional framework. This is consistent with the single designated CPD home specification of the new Professional Performance Framework.[32]

The end result of all these developments will be safer care for patients and patients being able to know that when they need RG care, they actually have an RG delivering it.

Enabling a valuable model of care for Aboriginal and Torres Strait Islander peoples

The RG model of care is an important part of creating a healthcare workforce which can meet the needs of Aboriginal and Torres Strait Islander peoples living in rural and remote areas. The RG model is designed to provide advanced care services to Aboriginal and Torres Strait Islander peoples *on country* leading to improved health outcomes. It is a preference of many Aboriginal and Torres Strait Islander people particularly those in remote underserved communities to receive advanced care such as renal dialysis, end-of-life-care and birthing services[33,34] *on country*. This arises where they may not have access to social and financial supports in city centres, they may need to stay at home to look after children or family members, or where they may have cultural and spiritual beliefs that make remaining *on country* important.[35]

RGs are well positioned to build effective, continuing relationships of trust with Aboriginal or Torres Strait Islander patients. By working in both hospital and primary care settings (and often other settings such as with retrieval services, aged care services and Aboriginal Community Controlled Health services), the RG can build a stronger doctor-patient relationship with their Aboriginal or Torres Strait Islander patients. RG medicine involves taking a flexible, community-responsive approach to defining each practitioners' role in their collaborative local healthcare team. This lends itself to working effectively with Aboriginal and Torres Strait Islander Health Workers, cultural advisors and other personnel important to providing culturally appropriate healthcare in every local context.

Better informed patient/community decisions about their safe, quality care

The national adoption of the RG title will facilitate patient and community awareness of the profession and enable doctors to easily and simply communicate their training and qualifications for providing advanced skilled procedures and services within their appropriate scope of practice.

The designation "Rural Generalist" provides the rural patient with clarity regarding their doctors' credentials and scope. The title also makes explicit that that their extended skills are for provision of necessary/appropriate care in their rural/remote clinical context. Understanding their RG's skill set is especially important for people in rural and remote communities in making decisions about their treatment options. People in the many communities that do not have locally based non-GP specialists, need to know and compare their local doctors' scope of services against the substantial risks and personal costs of travelling to cities for care, which as outlined above, may involve dangerous, physically painful, or financially prohibitive travel or substantial delays in receiving care.

Objective 2: Facilitating Workforce mobility

Protected title of the RG designation will facilitate more efficient processes for enabling the safe practice of RG doctors - including in areas of extended skill in which they have been specifically trained and assessed.

A nationally registered protected title will provide a common administrative structure which is tied to a College qualification and will be linked to streamlining the processing of hospital and health service employment and credentialing decisions.

As outlined above, the current administrative complexity and unpredictability of hospital credentialing is a recognised barrier to RGs providing procedural services.[36]

This will also provide a basis for consistency across jurisdictions and address current portability issues for RG doctors wishing to move from one state to another. Presently there is no consistency in terms of whether state or territory governments, or even different hospitals and health services within each jurisdiction formally recognise the skills that an RG has acquired. This currently presents considerable barriers to prospective RGs in accessing necessary training in the diverse skills areas as well as in finding employment.

Objective 3: Facilitating access to health services in the public interest

Enabling provision of safe, quality in-situ services for rural communities

Specialist title recognition will facilitate growth of a robust RG workforce which can enable access to quality care for rural people[37].
While there are relative shortages of GPs in rural and remote communities, non-GP specialists are virtually absent in many areas.[38] People in rural and remote areas commonly view not having a specialist nearby as a barrier to seeing one (30% of people in outer regional areas, 58% in remote/very remote areas compared with 6% of people in metropolitan areas).[39]

Rural and remote communities can and should have access to local doctors who can meet their primary care needs and as many as safely possible of their emergency, and secondary/tertiary needs either individually or through working effectively with healthcare teams (both local and distal). The RG skill set is designed to meet all these needs. Local access to doctors who can provide advanced care services such as palliative care, mental health, obstetrics and anaesthetics is especially important to the people in rural and remote areas that have the highest needs particularly for people in socio-economically disadvantaged communities and for people who are socially-isolated, from single parent families, older Australians, or chronically ill patients. These are the people most likely to find the social, economic costs and practicalities of travel to cities prohibitive. As outlined above, locally-available advanced care services are also of particular importance for many Aboriginal or Torres Strait Islander peoples living in rural and remote communities.[40]

As outlined at objective (1) above, RG provides a sustainable business and professional model in rural and remote communities where more specialised professional models may not be viable (or may not be viable without the support of local RGs) and is strongly associated with positive rural retention outcomes. An RG workforce can thereby stem the increasing trend toward high reliance on a rural locum workforce with its attendant inadequacies for quality and safety of patient care.

RGs based in the rural community can enrich the quality of care for their patients by enabling continuity of care in receiving their extended care services. Continuity of care is especially valued by people from rural and remote communities[41] and alongside safety, often a key consideration in their decision to stay in their home town for advanced care such as obstetric services.[42,43]

As further detailed below, it is important to note that preservation of rural hospitals can often be a vital aspect of maintaining rural communities and the ongoing safety and well-being of the people in them.[44] RGs together with nurses and midwives are often the only economical way to ensure the continuing viability of rural hospitals and rural emergency response capability.

Objective 4: Enabling development of flexible, responsive and sustainable health workforce and innovation in service delivery

The RG model is designed to enable RGs to adapt to the diverse environments presented by rural and remote communities. RG trainees are selected, trained and assessed with consideration of their personal propensity to work in rural and remote settings. The RG scope is comprised of a core skill set which enables practitioners to provide general practice care plus emergency care in a clinical context of relative professional isolation, and in addition, at least one additional area of advanced skills related to the needs of their communities. [45]

As outlined above, RGs can reduce the increasing reliance on locum-led models of care for rural and remote communities with all of the attendant issues of this in terms of both costs and the quality and safety of care that can be received by communities.

Their broad and flexible practice scope allows RGs to practise in the rural locality and continue to maintain a viable business even where the local community demographics and associated demand for medical services may change. RGs can provide advanced specialised care within their scope but are not restricted from offering general practice primary care to flexibly meet the breadth of local patient needs. The RG model builds local capacity to meet the breadth of community needs with available staff and resources by taking a flexible, team-based approach. RGs are trained to work effectively with their local healthcare team which may include nurses, allied healthcare workers, other RGs and non-GP specialists. They are also trained to work effectively with distal specialists, through digital health, collaboration with specialist outreach services and other collaborative models.

D. The extent to which health services are established in the proposed specialist or field of specialty practice and the demonstrated and/or potential ability of this proposal to improve the provision of the service, including:

- Describe the extent to which the area of practice is already established and acknowledges a specialty/field of specialty practice in Australia
- Describe the scope of practice relevant to the discipline and the settings of practice with particular relevance to regional, rural and remote Australia

Established RG Training programs

AMC accredited specialist training and CPD

The ACRRM has a Fellowship training and CPD program designed to describe the RG scope. These programs have been operating with provisional AMC accreditation since 2007 and with full accreditation since 2011. Over 700 registrars have been trained through to Fellowship though these and some 1800 doctors hold and maintain their Fellowship of ACRRM (FACRRM) compliance.

The RACGP has developed its Fellowship of Advanced Rural General Practice (FARGP) program which has been designed in combination with the FRACGP, to reflect the RG skill set.

Measures of the extent of Rural Generalist practice

The Rural Procedural Grants Program is a Commonwealth Government funded program to assist RGs to maintain their extended skills. It is oversighted as a joint-collaboration of the general practice

colleges. Eligible participants must be Vocational Registered (VR) GPs credentialled to provide regular services in their area of procedural practice.[46] As at 30 June 2019, the program had 6023 registrations[47] to undertake CPD training in the areas of emergency medicine, obstetrics, anaesthetics, and surgery. Between August 2018 to June 2019 its registrants undertook 2849 training courses.

Commonwealth Government sponsored RG training

The Commonwealth Government made a commitment to developing and implementing a national framework to support RG training and practice in 2016[48] and following the recommendations of the National Rural Health Commissioner and the National RG Taskforce presented in 2018 is progressing the implementation of the NRGP including through provision of funding to support this application.[49] The commitment to the NRGP also forms part of the National Medical Workforce Strategy Scoping Framework.[50] This application is consistent with the recommendations of the National Rural Health Commissioner's Report and it is viewed as an essential element of the package of required actions to implement the NRGP.

In parallel with these developments, the Australian General Practice Training (AGPT) has established dedicated RG training places and the RG policy. The policy comprises a range of variations to the established AGPT requirements that reflect the RG curricula and standards, including a facility for additional training time and more flexibility in location of training.[51] The Commonwealth Government is funding 300 dedicated RG positions in 2019 and 2020 and is looking to increase these numbers in future years. The doctors awarded these places are supported to train to the Fellowship end point of a FRACGP+FARGP or FACRRM.

Jurisdiction sponsored RG training

New South Wales
The NSW Government launched the NSW Rural Generalist (Medical) Training Program in 2013 through the Health Education and Training Institute (HETI)[52]. Fifteen positions were funded in 2013, expanding to 30 in 2015 and 50 in 2019. The pathway targets PGY2 entry (termed foundation year) and provides support through PGY2, advanced skills training and vocational training. The recognised endpoint is FACRRM or FRACGP plus FARGP.

Northern Territory
The Territory Government has recognised RGs and RG Trainees in its Enterprise Agreement (See Appendix 2.1)[53] [54] These 'recognised' positions are available in locations such as Tennant Creek, Katherine and Gove Hospitals. The Territory Government is also supporting a pilot training program targeting remote RGs with FACRRM or FRACGP plus FARGP as training end points.

Queensland
The Queensland Rural Generalist Pathway (QRGP) was established in 2007. The recognised endpoint is FACRRM or FRACGP plus FARGP (including specific certification of advanced specialised/rural skills).[55,56]

Queensland formally recognised the discipline of RG Medicine in its State Industrial Award in 2008 (See Appendix 2.1), adopting a state specific definition of Rural Generalist Medicine based on the knowledge and skills of recognised Rural Generalist Medicine contained in the ACRRM curricula statements.[57] An industrial framework is also supported with an appropriate remuneration schedule for doctors employed in the public health system who hold the prescribed Rural Generalist Medicine credentials and are granted scope of clinical practice for these credentials.

The QRGP recruits and selects final year medical students, with training commencing during internship. Additional postgraduate entry points also occur at PGY1-3 and provides a range of supports for them to the end point of Fellowship. The program selects 80 trainees per year and 124 Fellowed doctors have been supported through the program to date with 70% of these continuing to use their additional/advanced skills. [58]

South Australia
South Australia has established its Road to Rural GP Program [59] which includes support to enable doctors seeking general practice qualification to gain advanced skills in procedural practice areas. This has been in place since 2012.[60]

The Health Minister has signalled his support for progressing the South Australian RG pathway plan and the state's new Rural Health Workforce Strategy which includes the following strategy:

"1.2. Prepare for the National Rural Generalist Training Pathway in South Australia:
1. Collaborate with the Commonwealth Department of Health to roll out the proposed National Rural Generalist Pathway in South Australia
2. Prepare and cost proposals for recommended elements of the National Rural Generalist Pathway within SA, in conjunction with SA rural workforce stakeholders. [61]

Tasmania
The Tasmanian Rural Medical Generalist Pathway (TRMGP) was established in 2014[62]. A small number of rurally-based dedicated TRMGP RMO positions has been made available each year which is accessible to doctors at any year level. The recognised endpoint is FACRRM or FRACGP plus FARGP. Tasmania has adopted the Collingrove Agreement definition of the RG.

Victoria
The Victorian Department of Health and Human Services is currently working to strengthen its established RG training. From 2020, all RG related rural medical workforce programs, including the Rural Community Intern Training (RCIT) program, and the Victorian GP-RG Program are to be merged into one program and rebranded as the 'Victorian Rural Generalist Training program'[63].

The Victorian Government's consultation draft, 'Strengthened Rural Generalist Training Plan' includes the key aims of better linking-up of the disparate elements of the existing programs, stronger overarching governance, stronger health services involvement, greater workforce outcomes focus, and greater emphasis on 'Rural Generalist' brand recognition.[64]

The previous Victorian GP-RG Program was operational from 2013 with a minimum annual intake of 11 trainees.

Western Australia
The Western Australian Rural Generalist (WARG) Program commenced in 2019 as a joint-initiative of the Commonwealth Government, the Western Australian Government, and a number of partners including Western Australian General Practice Education and Training (WAGPET), WA Country Health Service, Rural Health West, the Rural Clinical School of Western Australia and the Western Australian Primary Health Alliance (WAPHA). The Program supports 30 trainees each year in accordance with the AGPT Rural Generalist policy[65].

The WARG Program is a reshaping of the WA Rural Practice Pathway which has been in operation since 2010. It aims to improve its alignment with the imperatives to train RGs. This is intended to

enable WAGPET to meet its obligations under the new AGPT RG policy and also to form part of the state's wider strategy for rural health.

Scope of practice and its relevance to regional rural and remote Australia

RG Medicine provides a broad scope of medical care in the rural context encompassing the following[66]:

- Comprehensive and continuing primary medical care. This includes comprehensive management of acute ambulatory presentations, management of chronic illness, paediatric, adult and aged care, care of common psychiatric illness, and preventative health care. Settings in which this might occur include general practice clinics, hospital and community health service clinics, aged care homes, and/or Aboriginal Medical Services.
- Hospital in-patient and/or related secondary medical care. This may occur in the institutional, home, or ambulatory setting.
- Emergency care – settings which may include general practice clinics, hospitals or retrieval settings.
- Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain required health services locally among a network of practitioners. This may occur across the diversity of work settings.
- A population health approach that is relevant to the community which would be applied irrespective of the work setting.
- Working as part of a multi-professional and multi-disciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs. This often involves telehealth and collaborative care arrangements with nurses and specialists, (both local and distal) including FIFO specialists.

RGs commonly work in one or a combination of different work settings and employment arrangements to fulfil the diverse needs of their rural or remote community. Some of the most common areas include:

- Practise in private GP clinics
- Practise in community health services, Aboriginal Medical Services/Aboriginal Community-Controlled Health Services, aged care homes, and hospital-based primary care services
- Practise in hospitals to provide general hospital inpatient care and emergency services as a Visiting Medical Officer (VMO), Medical Superintendent with Right to Private Practice (MSRPP), rostered/salaried Hospital Medical Officer (HMO), RG Senior Medical Officer (SMO) or equivalent. Most RG employment includes on-call rostered work
- Working for aero-retrieval services
- Working for the defence forces
- Working in a broad range of (non-rural) remote clinical contexts such as on ships, in prisons, on islands, refugee camps and for the Australian Antarctic medical services.

The breadth and flexibility of the RG scope of practice uniquely equips RG doctors to maintain a financially and professionally sustainable rurally-based practice adapted to the needs and changing circumstances in their community. It can thus provide the patients in these communities with the safety and well-being benefits of knowing they have locally-based doctors available to provide help when needed across an extensive range of medical services including in emergencies.

3. Describe alternative options (both regulatory and non-regulatory) for addressing the issues outlined in point 2

In addition to recognition under the National Law, the proposal must present and compare the advantages and disadvantages of:

- Existing arrangements (no change)
- Other regulation that exists that may be used to address the problem listed in point 2
- Other non-regulatory mechanisms to achieve the desired outcome, for example: self-regulation of practitioners through professional (voluntary) codes of conduct

The options discussed below outline key mechanisms which seek to alleviate the inequity of access to quality medical services that continues to be experienced by people living in rural and remote areas especially in areas outside essential primary care.

Existing arrangements

The following options all represent a continuation of the status quo in terms of provision of health services to rural and remote communities. It is the strong contention of this application that current inequities and trends with respect to the quality and safety of services available and accessible to people in rural and remote communities are unacceptable and that substantive, structural change is needed in order that these be addressed.

Provision of medical services in rural areas by (non-GP) specialists, locum-specialists and patient transport to major centres

Advantages:

- Patients that are able to access the services they need will continue to be serviced by doctors that have highly specialised knowledge in their respective disciplines.

Disadvantages:

- *Non-general practitioner specialists in situ* - It is unlikely that many rural/remote communities will ever be able to attract or support permanent non-GP specialists. This specialist scope of practice in many cases presents an unsustainable practice and business model for rural and remote communities which have a small and geographically limited patient catchment. Further, this model relies on availability of a complex mix of supporting specialist staff and resources and also on a high patient turnover across a narrow range of medical presentations. Even where specialists may be based in rural locations, they may still rely on the support of local RGs to maintain work rosters. The current system failure is evidenced in the data which show that despite the increase in Australian medical graduates, shortages are worse and gaps are greater.

- *Patients travel to non-general practitioner specialist care* – The tyranny of distance means that patients may need to travel long distances to access emergency and advanced care. Patient transport presents time delays in care which can increase patient risk [67,68,69] and extended travel arrangements represent an impost to rural people in terms of time, stress and financial cost which can act as a prohibitive barrier to their receiving appropriate care. [70,71,72] This is especially so for rural patients that already face significant disadvantage (e.g. poor, aged, chronically ill, socially isolated, etc.).[73-74] The RDAA notes that cost savings to governments of *not* establishing specialist services in rural communities represent a cost

transfer from health budgets to the people living in those communities who are expected to fund their own transport, as well as the costs of living away from home often for extended periods of time (e.g. loss of income, childcare, city accommodation).[75] This can be a particular barrier for Aboriginal and Torres Strait Islander people who may (apart from any social or economic barriers) have cultural reasons for choosing to stay on-country.

- *Provision of locum non-general practitioner specialists* – Many rural and remote communities are now relying on visiting or short-term locums to enable provision of referred, secondary and emergency care services to their local population. This presents a poor health service outcome for rural and remote communities and an expensive model of care for jurisdictions. It has been identified as a key issue in the National Medical Workforce Strategy:

  "Rural hospitals are overly reliant on locum doctors. The relatively lucrative income from locum work means that some doctors prefer working in the locum system, rather than taking up full-time, longer working hours. Locums are transient so it can be difficult to ensure accountability for their actions and continuity of care for their patients…" [76]

  This excessive and increasing reliance on a locum workforce for rural patients, is an inevitable consequence of the current systemic barriers to growth and sustainability of the RG workforce that specialist recognition will assist in addressing.

Other regulation that exists that may be used to address the problem listed in point 2

1. Rural Generalists recognised only as General Practitioners with advanced skills

Advantages:

- Scope of practice and specialised knowledge sets are determined by credentialing committees providing a local solution specific to needs of community.

Disadvantages:

- This would only enable recognition of the individual extended skills held by the RGs that are subject to hospital credentialing processes. It would not recognise extended skilled services that are not provided in hospitals including national priority areas such as mental health, aged care and palliative care. This would forego the opportunity to professionally recognise the distinct and broad, overarching skill set that RGs attain. This disincentivises doctors from attaining the extended skill-set and misses the opportunity for RG doctors' titles to accurately inform employment, resourcing and patient decision-making.

- No uniform or national approach to credentialing. Jurisdictions operate locally rather than referring to a nationally recognised qualification which articulates scope of practice. Local determinations regarding practice are assessed under local credentialing processes rather than under a national approach based on a common understanding of an RGs knowledge, training and skillsets. Ad hoc hospital credentialing on a case-by-case basis would continue under the status quo, however without formal recognition of their professional title, the opportunity is lost to provide a more structured, predictable and facilitated approach. Under current arrangements, the RG profession is frequently not represented on rural and remote hospital credentialing committees and decisions and these can be made in ignorance of the profession and its full scope and training.

- This approach does not formally recognise the RG's as a cohesive scope of practice. This is incompatible with the Medical Board of Australia's requirement for RG practitioners to have a single professional home for the purposes of meeting their ongoing continuing professional development requirements across the range of advanced skilled areas in which they practice under the new Performance Management Framework.[77]

- This approach foregoes the opportunity to develop a clear, well-coordinated and structured training pipeline associated with a defined RG career path. As is currently the case, aspirant doctors will continue to be required to negotiate their way through the training pathways, standards and policies of multiple colleges. Likewise, their training providers may continue to need to negotiate with disparate colleges and education providers to ensure supervision and training posts are made available and meeting disparate standards.

- Under these arrangements there is a significant administrative burden borne by individual practitioners. Rural doctors are already the disproportionately overworked practitioners and the ongoing additional and separate administrative burden presents a substantive disincentive to continue advanced practice.[78]

2. *Rural Generalism is a standalone specialty*

Advantages:

- Provides clarity of professional identity, peer networks and professional home.

- Enables clarity of recognition of the profession by authorities and communities and for them to appropriately know, value and reward the requisite training and practice standards that have been attained

- Enables simplification of credentialing and incentivisation approaches due to the consistency of standards and training that could be achieved

Disadvantages:

- There is potential for difficulties in professional mobility, particularly for RGs who may wish to revert to practicing as GPs as their scope of practice may change due to circumstances

- Many doctors view themselves as belonging to both General Practitioner and Rural Generalist professions.

- Disaffection of GPs who practise in rural environments.

3. *Endorsements of additional advanced skills within general practice without protected title*

Advantages:

- Provides transparent and consistent information to public and authorities regarding practitioners' areas of capacity for advanced practice

Disadvantages:

- As at (1) above, this would not provide any recognition of the broad and distinctive core skill set that RGs would have attained. It is imperative to quality, safety and efficacy that patient, employer and health service planning decisions can all be based on an understanding of the full scope of the doctor's training and practice and not just isolated aspects of it.

- As above, as RGs would need to seek separate endorsements for each successive extended skill any recognition that would be attained would involve considerable administrative compliance which may prove a prohibitive barrier to already overworked rural doctors.

- This approach would not incentivise or encourage RGs doctors to maintain their broad, multifaceted scope and take the flexible, adaptive and community-responsive approach to defining their practice scope that is at the core of the RG concept as a workforce solution.

- As above, as this approach does not formally recognise RG it is incompatible with the Medical Board of Australia's requirement for practitioners to have a single professional home for the purposes of meeting their ongoing continuing professional development requirements across the scope of advanced skill areas in which they practice under the new Professional Performance Framework.[79]

- This approach is not consistent with the historic approach by medical disciplines to recognising specialty fields and may therefore create confusion.

4. *Industrial recognition within each jurisdiction*

Advantages:

- Provides clear employment opportunities; appropriate recognition of the RG skill set attained and provides a clear basis for reward in terms of remuneration and appropriate job terms and conditions.

Disadvantages:

- This model, (which is in place in several jurisdictions already including Queensland and Northern Territory) is a positive development but offers only a partial solution to the problems raised in this submission as there are different requirements and differing assessment processes across and within states and territories.

- Recognition is limited to RGs that work in jurisdictional services. It is not transferable to employments contacts with other potential employers such as Aboriginal Medical Services, local government financed health centres, private employers etc. (Noting that RG training and practice is characterised by this movement between different workplaces.)

- Recognition is inconsistent across jurisdictions and does not enable transferability unless it were linked to a common nationally recognised standard. The 10-14-year training journey from medical school to RG Fellowship typically involves considerable movement across jurisdictions and workplaces.

Other non-regulatory mechanisms to achieve the desired outcome, for example: self-regulation of practitioners through professional (voluntary) codes of conduct

There are no alternative non-regulatory mechanisms which would effectively address the issues outlined in this application.

The general practice colleges have already prescribed a wide range of self-regulatory mechanisms and standards relevant to their members' training and practice in addition to those imposed by the Medical Board of Australia's Codes, Guidelines and policies. The key issues this proposal seeks to address however relate to the external systems and processes that are impacting RGs training and practice and these processes' inability to recognise the Colleges' standards.

External regulatory change is needed to remove current barriers to developing a medical workforce and service delivery model for rural and remote communities and to assist in improving the disparity of access to medical care experienced by rural and remote communities where medical services are limited or absent. Regulatory change is also necessary to provide for a dedicated nationally-recognised RG training pathway.

4. Describe the existing professional standards that are relevant to training speciality practice in the speciality

A. If education programs and continuing professional development programs exist, provide a short outline of them and a link to more detailed information. The short outline could include but is not limited to:

- Name of qualification awarded (if a formal qualification is awarded)
- Length of education and training program
- Program structure, teaching and learning methods and locations (including how the program is organised by year, terms, or phases)
- Number of trainees entering the training program/s for the last five years
- Organisation responsible for training and CPD, if different
- CPD program structure
- Numbers of CPD program participants for the last three years

The Australian Medical Council (AMC) has accredited the RACGP and the ACRRM to deliver general practice Fellowship training.

To be recognised and work independently as a specialist GP, doctors need to qualify as a Fellow of the ACRRM (FACRRM) or as a Fellow of the RACGP (FRACGP). Both Fellowships lead to Vocational Recognition (VR) and registration under the Specialist (General Practice) category with the Medical Board of Australia. These qualifications allow a doctor to work unsupervised as a GP anywhere in Australia and with some exclusions enable MBS eligibility.

General practice training is undertaken in an apprenticeship model where registrars train as a GP under the supervision of an experienced supervisor. This practice-based learning is supplemented and consolidated through discussions with the general practice supervisor, teaching visits from medical educators, workshops with peers, and personal study.

There are different pathways to achieving Fellowship of either of the general practice colleges. All pathways are delivered in conjunction with the respective Colleges' curricula, assessment and standards. Registrars apply and enrol to training through different streams with differing funding, training services delivery and support arrangements.

The available training pathway options include:

RACGP Fellowship Training	ACRRM Fellowship Training
- Practice Eligible Pathway	- Independent Pathway
- AGPT (rural or general pathway)	- AGPT (rural pathway only)
- RVTS	- RVTS

Registrars that enroll in either the RACGP or ACRRM Fellowship pathways may be awarded places on the AGPT which is a Commonwealth Department of Health funded program. These registrars are supported in the delivery of their training by the Regional Training Organisations (RTOs). RACGP and ACRRM in conjunction with the Department of Health contracts nine RTOs to deliver a range of their training functions across the 11 training regions according to standards set by the Colleges. Registrar assessment is conducted by the Colleges.

Registrars that enroll in either the RACGP or ACRRM Fellowship training pathways also have the opportunity to be awarded places on the Remote Vocational Training Scheme (RVTS) which similarly to the AGPT is funded by the Commonwealth Government to provide supported training services toward Fellowship with either of the GP colleges with the College conducting their respective Fellowship assessment.

Further information on the AGPT can be found at the following link:
http://www.agpt.com.au/

Further information on the RVTS can be found at the following link:
https://rvts.org.au/about

Table 4.1 Summary of Fellowship Training Programs

	RACGP	**ACRRM**
Qualification	Fellowship of The Royal Australian College of General Practitioners (FRACGP) FRACGP + Fellowship of Advanced Rural General Practice (FARGP)	Fellowship of the Australian College of Rural and Remote Medicine (FACRRM)
Duration	3 years – FRACGP 4 years – FRACGP+FARGP	4 years* **5 years for Fellowship with AST in surgery*
Program Structure	12 months Hospital Training Time 24 months in RACGP accredited facilities/training practices: • 3 x 6-month terms in general practice (GPT1-3) • 6 months Extended Skills For FARGP: • 12 months in a rural general practice setting (MMM3-7) • Completion of a 6-month 'working in rural general practice' community-focused project. • Completion of the FARGP emergency medicine modules which includes a series of case studies, skills audits and satisfactory completion of two advanced emergency skills course. • Plus a 12 months advanced skills (ARST)	36 months Core Generalist Training* This is based in a combination of the following work locations in MM2-7** areas: • General practice and community-based primary care clinics • Hospitals • Retrieval services • Aboriginal Medical Services Training on AGPT must commence with 12 months hospital training and on all training pathways must include a minimum: • 6 months community /primary care • 6 months hospital and emergency care • 12 months rural/remote experience (MM4-7) 12 months in Advanced Specialised Training (AST)*** **Changes associated with revised*

		curriculum to take effect from 2020 ***Unless MM1-based training needed for specific skill* ****24 months for surgery*
	ARST can be undertaken at any time after completing the Hospital Training Time. It is recommended that the needs of the community in which candidates intend to practice be taken into consideration when making the choice.	AST can be undertaken after completing at least 12 months of the Core Generalist component with consideration to special requirements of respective AST fields. It is recommended that the needs of the community in which candidates intend to practise be taken into consideration when making the choice.

Continuing Professional Development programs

The RACGP and the ACRRM both have Medical Board of Australia compliant continuing professional development programs which enable AHPRA reporting for Fellows continuing compliance for vocational registration purposes:

- The RACGP Quality Improvement and Continuing Professional Development program, and
- The ACRRM Professional Development Program

For detailed information on the RACGP and ACRRM Fellowship and CPD programs:

See: Appendix 4.1 RACGP Fellowship and CPD
Appendix 4.2 ACRRM Fellowship and CPD

B. Indicate what new standards or requirements are anticipated if the proposal results in recognition of a new or amended specialty of field of specialty practice under the National Law.

There will be no changes to standards or requirements.

5. Impact of recognition

A. Identify the stakeholder groups likely to be affected by the recognition of the speciality including groups within the regulated profession or segments of the profession, other health professions, health consumers and the community, health service providers, funding bodies education providers and Aboriginal and Torres Strait Islander Peoples.

National Rural Health Commissioner Consultations - Stakeholder Groups

The National Rural Health Commissioner undertook an extensive consultation at a national, jurisdictional and local level as well as representing the contributions of more than 200 expert stakeholders of the Rural Generalism Taskforce, Working Groups and Expert Reference Groups in the development of the RG Pathway. A list of Health profession and National organisations that were consulted is included as **Appendix 5.1.**

B. Describe the consultation which has been undertaken to determine the stakeholders affected by the proposal.

National Rural Health Commissioner Consultations

Throughout 2018 (and continued in 2019), the National Rural Health Commissioner undertook an extensive consultation on behalf of the National RG Taskforce which he co-led with the general practice colleges. This application is based on the recommendations of the Taskforce which were informed by the consultation and developed by the Taskforce working parties.

The consultation was conducted at the national, jurisdictional and local level as well as representing the contributions of more than 200 expert stakeholders of the Rural Generalism Taskforce, Working Groups and Expert Reference Groups in the development of the RG Pathway. Briefly, the consultation process obtained feedback from key stakeholders working in rural and remote health workforce, Aboriginal and Torres Islander people, education and training (including students, trainees, colleges, universities, academics), Australian Government, State and Territory Governments, and industrial groups, professional bodies, agencies and consumer representatives. Extensive consultations with National Rural Generalist Taskforce, Working Groups and Expert Reference Groups were conducted with local rural clinicians, trainees, students and rural community leaders across regional, rural and remote Australia has relayed strong support for the National Pathway. Membership and representation of these additional consultations by Taskforce, Working Groups and Expert Reference Groups are included in **Appendix 5.2.** There is a high level of consensus, goodwill and commitment across the rural sector for implementing and establishing the National Rural Generalist Pathway.

The Commissioner held 167 meetings and 33 presentations on the RG pathway with various stakeholder groups. Feedback was collected including the development of a set of principles that underpin the National Pathway. Based on the principles, the Commissioner developed broad advice containing 19 recommendations.

The advice including recommendations can be found at the following link: https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications

Consultation process

Jurisdictions and Colleges provided written submissions to the Commissioner. The jurisdictions were essentially supportive of all recommendations. Jurisdictions provided comments in relation to the following areas:

- development of transition plans
- development of funding plans and agreements
- supervision plans
- MBS specialist code access
- process development to recognise existing GP proceduralists
- support for flexible entry and exit points

Medical Colleges were also supportive of the National Rural Generalist Pathway. Colleges offered the following suggestions:

- broader consultation required with further details of the pathway
- supportive of creating the Rural Generalist protected title
- further clarification of how additional skills training will be delivered
- very supportive of an evaluation framework
- details of supervision arrangements to be provided and a need to address supervisor shortage
- details of selection processes
- the funding follows the trainee for the duration of training
- development of infrastructure and jurisdictional arrangements
- support for flipped training models

The AMA supports the development of an NRGP, recognising the pressing health needs of our rural and remote communities and the potential for the NRGP to support improved recruitment and retention in these areas and contribute to improved health outcomes. The AMA notes that there are already many doctors in rural and remote settings practising across an extended scope of medical care, they also agree with the Taskforce view that there is currently no nationally recognised pathway for training this workforce for the future, or any national process for recognising and supporting existing practitioners. The NRGP has the potential to bridge this gap by integrating rural training for general practice, emergency and additional skills, which rural and remote communities need, into a single training program. https://ama.com.au/system/tdf/documents/AMA%20Response%20to%20National%20Rural%20Generalist%20Taskforce%20Advice%20to%20the%20NHRC.pdf?file=1&type=node&id=49718

RACGP invited feedback on the new Rural Generalist Fellowship from the General Practice Regional Training Organisations (RTOs) who undertake GP Fellowship training across Australia in association with AGPT. Feedback was generally positive emphasising the importance of a flexible model of training with the ability of RG registrars to enter and exit at different points which are important factors in the long-term sustainability of the rural health workforce. Any model included in the NRGP should maximise options for rural doctors to gain recognition as a RG at any point in their career.

The National Rural Health Student Network (NRHSN) developed a position paper in parallel with their involvement in the National RG Taskforce. The paper expresses their support for *the current development of a national rural generalist pathway in medicine.* It recognises the

complexities faced by medical students interested in pursuing RG careers and emphasised the need for medical students to be well informed of the pathways to careers in rural generalism. They also stressed that recognition should occur in a manner which ensured that existing RGs training and qualifications were able to be recognised.[80]

C. Identify extant medical specialties and/or fields of specialty practice that have significant overlap in scope of practice, required knowledge, skills and competencies with the proposed new or amended specialty or field of specialty practice; and describe what differentiates the proposed new or amended specialty from these existing specialties.

As well as providing comprehensive General Practice and emergency care, RG's will acquire additional skills for an extended scope of practice to meet rural community needs. It is the nature of general practice that it extends across all specialist fields and this is especially true for many doctors working in rural and remote clinical contexts where patients may have limited access to alternative specialised health and medical personnel. RG training and assessment reflects the need for doctors to have this broad and extended scope as part of their core learning even in areas where they have not chosen to do an advanced skill.

Advanced skills in emergency medicine in particular are viewed as essential skills to ensure the safety and protection of rural people.

The RG curriculum makes a clear extension into fields which would typically be delegated to separate specialties in an urban context. The RG curriculum and training programs offer advanced skills training which have some cross over into the following specialities or fields:

- Anaesthetics
- Obstetrics
- Surgery
- Advanced Emergency Medicine
- Aboriginal and Torres Strait Islander Health
- Mental Health
- Aged Care
- Palliative Care
- Addiction Medicine
- Adult Internal Medicine
- Paediatrics / Child Heath
- Remote Medicine
- Population Health and Health Administration.

The development and use of these General Practice, Emergency and Additional/advanced Skills represent the broad scope of practice of a Rural Generalist.

An outline of each additional/advanced skill for an extended scope and knowledge and skill requirements have been mapped and is included in **Appendix 5.3.**

6. Impact of options for addressing issue or issues covered by the proposal for the recognition of a new or amended specialty

A. Identify expected impacts of each option (described in 3) on the various stakeholder groups, including impacts on coordination and continuity of healthcare and the quality and safety of care, workforce impacts, financial impacts, business impacts and competition impacts.

1. Recognition of Rural Generalist as a specialist field of general practice

This option would not involve new models of training or practice, it is expected however to be an enabler to supporting and expanding the number of RG practitioners and extent to which this workforce model is practiced across rural and remote Australia. This RG workforce can make a transformative impact on the pervasive issues of inequitable access to services in rural and remote areas.

There is a well-documented maldistribution of medical practitioners in rural and remote Australia. The doubling of the number of Australian medical graduates has led to an oversupply of doctors in metro and urban areas but has done little to address doctors' shortages for Australians living in rural and remote areas.[81] Australian trained medical graduates today are less likely to work either as GPs or in rural communities compared to graduates of the 1970s–1980s and rural areas continue to remain substantially dependent on International Medical Graduate doctors, that comprise 36-38% of all general practice doctors in small rural centres (>50,000 population).[82]

The maldistribution is especially apparent in the supply of non-GP specialty fields. For a range of reasons, the more vertically specialised a practitioners' scope becomes, the less likely they are to be based in rural and remote communities. The Medical Workforce Reform Advisory Committee (MWRAC) Framework notes that less than 5 per cent of most non-GP specialists are based in rural and remote Australia.[83] From 2005 to 2017 however for every new GP in Australia, there have been almost 10 new doctors in non-GP specialties. And among non-GP specialists, since 2013, new registered practitioners have been three times more likely to be registered as sub-specialist practitioners.[84]

Workforce maldistribution and resulting lack of access is reflected in the substantially lower utilisation of health services by people in rural and remote areas. Rural people's lower per capita health service use (compared to that received by people in cities) is estimated to result in an annual health services funding shortfall of $2.1 billion, including an estimated annual shortfall of $0.811b in MBS spending and $0.85b in PBS and pharmacy spending.[85]

The maldistribution is likely to be contributing to the considerable and persisting disparity between health outcomes for people in rural and remote areas relative to those in major cities:

- Disease burden as measured in Disability Adjusted Life Years (DALYs) worsens with remoteness across most disease groups.
- Both mortality rates and potentially avoidable death rates increase with remoteness. Potentially avoidable death rates for people in very remote areas are 2.5 times higher than for people in major cities.

- Rates of Potentially Preventable Hospital admissions (PPHs) increase with remoteness across nearly all categories with remote and very remote people recording the highest rates across all categories and 1.6 and 2.4 times the overall rates for major cities.
- Hospitalisation rates are much higher in remote and very remote areas, with very remote areas 1.8 times higher than in major cities.[86]

The attainment of title recognition will serve to mitigate against these trends and support the growth of a robust RG workforce, with key expected outcomes, including:

- increased awareness of RG and attractiveness of pursuing RG careers
- improved, nationally-cohesive support across health systems for RG training and skills maintenance
- the RG workforce being visible and explicit in policy, planning and resourcing
- simplified, quality-assured, nationally-consistent credentialing and employment for RGs
- improved understanding by rural communities of their RG doctors and their skill set

As outlined above, the RG training and scope of practice is designed to enable doctors to flexibly and responsively, meet the needs of their diverse rural and remote communities, including Aboriginal and Torres Strait Islander communities. RGs are explicitly trained to become long-term rural doctors. As outlined above, the model of practice can be shown to be both highly attractive to prospective rural doctors and to have exceptional workforce outcomes in terms of rural retention.

The RG scope of practice model can enable continuation of hospitals, emergency care capability and other critical aspects of local health service capacity in rural and remote communities even where non-GP specialists or sufficient numbers of non-GP specialists cannot be recruited or supported. This has important implications for the safety, health and social well-being of people in rural and remote communities. Local hospitals and particularly maternity care facilities have been widely acknowledged as a lynchpin for sustainable communities, medically, socially, and economically.[87]

A study conducted in 2015 found that a trial at the Central West Hospital and Health Service, near Longreach, was able to attract medical students, junior doctors and RG trainees each bringing an advanced skillset to the Health Service, thereby enhancing the local capacity and capability. Furthermore, they were able to contribute to the afterhours / procedural services without on-site supervision. This redesign has seen the local dependence on locums decline drastically, with substantial budgetary savings (e.g. a $7M locum budget is now around $1M). In addition, the authors concluded that changes to teaching and research-intensive health services – in a sense replicating the traditional metropolitan model of a teaching hospital in rural and remote locations – was accompanied by stronger local workforce and clinical capacity, enhanced models of clinical governance with a focus on quality and patient safety, and a self-sustaining approach to developing local workforce.[88] The same study found that of the 48 trainees who enrolled in the Queensland Rural Generalist Medicine program, all completed Fellowship requirements of ACRRM and/or RACGP and that 30 doctors continued to practise in rural and remote Queensland. 5 other doctors worked in rural parts of other States / Territories and one in New Zealand. The study also found that the pathway was also having a positive impact on local communities and health services with the development of similar innovative models of service redesign in other sites as Longreach, Cooktown, Emerald, Mt Isa, and Stanthorpe. In Mt Isa, for example, 9 trainees were recruited compared with none in 2009, with trainees indicating their willingness to continue in local practice beyond the end of training.

Financial analyses of the RG Program are limited. However, an Evaluation and Investigative Study of the Queensland Rural Generalist Program (QRGP) Queensland Health, Office of Rural and Remote Health in Queensland, was conducted in 2013 by Ernst and Young. The evaluation found that the award structure in Queensland Health made provision for the employment of non-specialist senior medical officers – which is the position RGs were previously appointed to. By providing recognition for advanced or additional skills training and deeming the RGs position as a specialist discipline position, the differential in payment (i.e. moving from non-specialist award rate to specialist award rate) on the base salary represented an additional cost injection of $12,150 per capita by the state government. This additional cost represents an annual figure for each RG appointed to a salaried position in a rural hospital. The differential increases to approximately $23,800 when differences between the overall packages are considered. Furthermore, the additional investment associated with the remuneration of the team involving advanced skilled credentialed medical officers totalled $47,660. Savings in travel costs borne by the government (ambulance and helicopter) and accommodation costs covered by the patient assistance transport scheme (PATS) were identified together with an estimated 42.5 bed-day efficiency gain. The total estimated savings was approximately $104,600 which represents a return on investment ratio of 1.2. This implies that for every $1 investment the QRGP returns a saving of $1.20. This estimate does not include expected savings to the system in reduced VMO services or changes to locum arrangements[89].

Models of care where the RG provides additional/advanced skills in proportion to the degree of remoteness are supported by quality and safety outcomes. Australian studies have shown excellent health outcomes for rurally-based RG-led services across a range of locations and advanced skills areas.[90,91,92] Similar outcomes have been seen by RG models in other comparable countries. A Canadian study found similar safety outcomes when comparing caesarean sections provided by rural GPs with specialists[93] while in Nova Scotia, RGs have shown lowest perinatal morbidity and mortality rates in rural hospitals[94]. The implementation of RG services in rural and remote communities offers improved coordination and continuity of healthcare that may not otherwise be available.

Under the RG model, the ongoing role of non-GP specialists in regional settings is not impacted from a workforce, financial, business or competition perspective as the RG model proposes to provide healthcare in areas where none presently exists or is provided on a limited basis. Where patients require specific specialist care offered outside of the scope of practice of an RG, the non-GP specialist is still available to provide specialist care and works in collaboration with the RG. This model is in place in rural locations across Australia and has been shown to work successfully internationally including in Canada.[95] Outside metropolitan contexts, the RG has an important role in supporting and collaborating in provision of care by non-GP specialists. The local availability of RGs qualified to provide services in areas such obstetrics, surgery, emergency care and anaesthetics can ensure that there are enough local doctors to cover work rosters and comprise the full healthcare team in either full-time or part-time roles.

2. Existing Arrangements

The following options or combinations thereof signal a continuation of the existing arrangements and can be expected to continue the current trends with respect to workforce and health services provision for rural and remote communities.

- *Reliance on non-GP specialists in situ*

Rural non-GP specialists provide highly valued services to rural communities. As discussed previously, the approach of relying *only* on non-GP specialists to provide care in rural and remote communities is unsustainable and unlikely to ever enable locally-based provision of services in many rural and remote communities.

A narrow-specialised scope of practice in many cases presents an unsustainable practice and business model for rural and remote communities which have a small and geographically limited patient catchment. Furthermore, it is unlikely that communities will be able to attract or support permanent staff in most non-general practice specialties. This is partially because it relies on supporting specialist staff and high patient turnover across a narrow range of medical presentations. The approach has merit in many larger rural centres but even in these locations this would forego the opportunity to include RG workforce which can value-add the quality of services available and assist in maintaining work rosters.

- *Patients travel to receive non-GP specialists care*

The requirement to travel for care has significant and broad ranging negative outcomes for rural and remote communities and their health and safety. Lack of provision of local hospital and advanced care services effectively transfers the burden of patient safety and healthcare costs from health systems to rural and remote patients and their families.

Extensive literature documents the risks associated with patient travel to access distant health care.[96,97,98,99] One study of stroke care for example found that the clinical risks of longer journeys outweighed the benefits of accessing the tertiary service.[100] Another study found that for every mile a seriously injured person had to travel to hospital, the risk of death increased by one per cent.[101] Studies have clearly linked the need for extended travel time to access maternity services to increased rates of mortality and adverse outcomes.[102] Canadian studies have found that women with no local access to maternity services have worse maternal and newborn outcomes than women from similar communities with local access to even limited birthing services.[103]

Travel also involves personal, social and financial costs to patients. As outlined above, these can be especially burdensome and potentially prohibitive to the most vulnerable people, who are already socially and financially disadvantaged.[104] International studies have shown that longer journeys discourage the use of healthcare services.[105] The much lower utilisation of both Pharmaceutical Benefits Scheme and Medicare services recorded by rural people relative to people in major cities would suggest that this is also the case in Australia.[106]

A study by Asthana and Halliday[107] found that rural and remote healthcare service providers have less chance of achieving the economies of scale available to their urban counterparts. They conclude that regardless of where patients reside, they should be provided with an acceptable level of service in terms of quality, effectiveness and accessibility. In addition, as discussed previously, patients and communities still face healthcare inequities with rural and remote workforce shortages because of the inability to sustain an adequate health service. Patients travel large distances and can be displaced from their homes to attend non-specialist appointments in regional areas. Patients may also be subjected to long waiting lists to see a non-GP specialist.

- *Provision of locum non-GP specialists*

  The current over-reliance by jurisdictions on locums rather than a permanent long-term local workforce to provide referred, secondary and emergency care services to rural and remote people is a widely recognised problem. This presents a poor health service outcome for rural communities and a very expensive model of care for jurisdictions. This has been identified as a key issue in the National Medical Workforce Strategy[108]:

  Rural hospitals are overly reliant on locum doctors. The relatively lucrative income from locum work means that some doctors prefer working in the locum system, rather than taking up full-time, longer working hours. Locums are transient so it can be difficult to ensure accountability for their actions and continuity of care for their patients…

  There may be a financial and business impact for locum non-GP specialists and incomes of some locums may potentially be reduced.

  For rural and remote communities, these policies have the effect of transferring the economic benefits of government/rural patients' payments to these specialists from the rural or remote community to the city where the specialist resides.

  Gruen et al[109] examined the role of specialist outreach to health care in remote Indigenous populations in Australia. The study identified the barriers faced by people in accessing hospital-based specialist services as follows:

  - Geographical remoteness of patients
  - Cultural inappropriateness of services
  - Poor doctor-patient communication
  - Poverty; and
  - Health service structure.

  With respect to impacts on quality care and safety, other issues of locum non-GP specialists included gaps in service delivery including frequency of service, the consistency of service provision and a complete absence of some disciplines. A lack of notice with respect to visiting service providers, the short length of some visits to communities, consistency of visiting personnel, cultural awareness and language communication were also identified as relevant issues and disadvantages of the locum model[110.]

  The opening statement to a public hearing of the Standing Committee on Regional Australia on the use of 'fly-in, fly-out' workforce practices in rural and remote Australia, the National Rural Health Alliance concluded that additional costs including the high cost of travel, the provision of appropriate accommodation and the need to engage more experienced health professionals all impose additional cost on health and aged care services. The submission argued *"this all adds up to a set of fees and wages that are well above baseline*".[111]

3. *Other existing regulation that could be used to address the problem*

- *RGs advanced skills recognised but not their RG title*

As described in Section 3, under this approach, there would be no formal recognition of an RG and it foregoes an opportunity to develop a clear, well-coordinated and structured training pipeline for aspiring doctors seeking a career in RG medicine. The impact will continue to be felt by doctors who will have to negotiate different training pathways, standards and policies of multiple colleges. Likewise, they will have to negotiate with different jurisdictions, training providers, and other colleges and education providers to ensure supervision and training posts are made available. Furthermore, under this approach, doctors may need to meet multiple practice standards. This creates an added burden for doctors and acts as a disincentive if a GP is required to deal with multiple components of the system. Many doctors may simply decide to not bother with an overly onerous process while communities will continue to face significant health inequities. The RDAA reports that this is already occurring across rural and remote communities.[112]

Communities will be impacted under this approach if ad hoc hospital credentialing based on a purely case-by-case basis continues under existing arrangements. Without formal recognition of an RG professional title, credentialing committee decisions may well be made in ignorance or misunderstanding of the profession and its scope.

- *Rural Generalism as a standalone specialty*

As discussed in Section 3, the advantages of applying for a standalone specialty of rural generalism include providing clarity of recognition of the profession enabling a simplification of credentialing processes and incentivisation approaches along with a consistency of standards and training. However, RGs are also GPs working in communities providing general practice continuity of care. Many GPs view themselves as belonging to both General Practitioner and RG professions and may feel disenfranchised and de-valued.

- *Endorsements of additional/advanced skills*

As previously discussed, endorsements provide transparent and consistent information to public and authorities regarding practitioners' areas of capacity for advanced practice. However, it would foster a binary and inflexible view of the RG scope. It would provide no recognition of the broad and distinctive core skill set that RGs would have attained. It would not incentivise or encourage RG doctors to take the flexible, adaptive and community-responsive approach to defining their practice scope that is at the core of the Rural Generalist concept. Finally, this approach is inconsistent with the structure and historic approach of other medical disciplines in recognising specialty fields and may therefore create confusion.

- *Industrial recognition within each jurisdiction*

Recognition and credentialing is the domain of hospital sites and is linked to clear employment opportunities. This model (which is in place in several jurisdictions already including Queensland and Northern Territory), is a positive development but offers only a partial solution to the problems raised in this submission. It is limited to RGs that

work in jurisdictional services and is not transferable across states and cannot enable transferability unless it were linked to a common nationally recognised standard. The 10-14-year training journey from medical school to Fellowship typically involves movement across jurisdictions. An RG may be unable to move around their state to practice elsewhere. An RG cannot readily move to an employment contract with other potential employers such as Aboriginal Medical Services, local government financed health centres, private employers etc.

State-based and individual hospital-based determinations regarding practice standards and credentialing differ across states (and within states). Ad hoc hospital credentialing based on a case-by-case basis would continue under the status quo, however without formal recognition of the RG professional title, this process becomes more situational, unpredictable and offers little security for RG doctors. Under these arrangements the administrative burden will be borne by individual practitioners. It adds a costly inefficiency to the system and places a disproportionate burden on overworked doctors and presents a substantive disincentive for their continued provision of extended skills care. [113] There continues to be a significant financial impact on rural health services having to provide locum services rather than rely on local supply of junior doctors and RG trainees who each can contribute from a workforce perspective with advanced skillsets and who can contribute to the afterhours/procedural without supervision.

This approach does not solve the issue of a paucity of rural health workforce shortages and health inequity in rural and remote settings and further foregoes the opportunity to develop a clear, well-coordinated and structured training pipeline associated with a clear career path. Aspirant doctors will be required to negotiate their way through multiple training pathways, standards and policies of multiple colleges. It is ineffective and costly and poses a greater burden on funding bodies including taxpayers.

The training pipeline empathises recruitment and training in rural and remote areas which provides a strong foundation for attracting medical students to rural practice[114]. International studies have also found that rural training pipelines increases access to comprehensive health care services in rural and underserved communities[115]. Likewise, their training providers need to negotiate with different colleges and education providers to ensure supervision and training posts are made available and meeting disparate standards.

Glossary

Advanced/additional skills	These refer to range of skills incorporated in the Rural Generalist skill set that are extended beyond those typically viewed as the essential skills for general practice/family practice. These may reflect intensive or extensive expertise in a broad range of areas of medical practice which may be primarily procedural or non-procedural in nature. Some advanced/additional skills are part of the core Rural Generalist skill set while others are optional and ideally reflective of the service requirements of the practitioners' community.
General Practitioner	A medical practitioner who is vocationally recognised in the discipline of general practice.
Modified Monash Model	The Modified Monash Model (MMM) is a system adopted by the Commonwealth Department of Health to define whether a location is a city, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) category MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote. MMM classifications are based on the Australian Statistical Geography Standard - Remoteness Areas (ASGS-RA) framework.
Non-General Practitioner Specialist	A doctor with Australian specialist registration in any specialist field other than general practice. This terminology has been used to assist in readability. It is acknowledged that the specification encompasses a diverse range of practitioners.
Rural Generalist	A medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in hospital and community settings as part of a rural healthcare team.
Vocationally Registered General Practitioner (VR GP)	A doctor with specialist registration with the Australian Health Practitioner Regulation Agency (AHPRA) in the specialty of general practice.

Acronyms

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community-Controlled Health Service
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMC	Australian Medical Council
AHPRA	Australian Health Practitioner Regulation Agency
ARST	Advanced Rural Specialised Training
AST	Advanced Specialised Training
CPD	Continuing Professional Development
DALY	Disability Adjusted Life years
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
FRACGP	Fellowship of the Royal Australian College of General Practice
FARGP	Fellowship in Advanced Rural General Practice
GP	General Practitioner
HETI	Health Education Training Institute
HMO	Hospital Medical Officer
MABEL	Medicine in Australia – Balancing Employment and Life (data set)
MBA	Medical Board of Australia
MBS	Medical Benefits Schedule
MMM	Modified Monash Model
MSRPP	Medical Superintendent with Right to Private Practice
MWRAC	Medical Workforce Reform Advisory Committee
NRGP	National Rural Generalist Pathway
NRHA	National Rural Health Alliance
NRHSN	National Rural Health Students Network
PATS	Patient Assistance Transport Scheme
PBS	Pharmaceutical Benefits Scheme
PDP	Professional Development Program
PGY	Post Graduate Year (e.g. PGY1, PGY2 etc.)
PPH	Potentially Preventable Hospital (admissions)
QI CPD	Quality Improvement and Continuing Professional Development
QRGP	Queensland Rural Generalist Program
RACGP	Royal Australian College of General Practice
RCIT	Rural Community Intern Program
RDAA	Rural Doctors' Association of Australia
RG	Rural Generalist
RMO	Registered Medical Officer
RTO	Regional Training Organisation
RVTS	Remote Vocational Training Scheme
SMO	Senior Medical Officer
TRMGP	Tasmanian Rural Medical Generalist Program
VMO	Visiting Medical Officer
VRGP	Vocationally Registered General Practitioner
WAPHA	Western Australian Primary Health Association
WARG	Western Australian Rural Generalist (Program)
WAGPET	Western Australian General Practice Training

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Appendix 1.1

The Australian College of Rural and Remote Medicine (ACRRM)

- *ACRRM Statement of Mission, Purpose and Functions:*

  The College vision is for - *the right doctors, in the right places, with the right skills, providing rural communities with excellent healthcare.*

  Its purpose is: *to improve the quality and safety of care for rural and remote communities by setting professional standards for practice, and delivering lifelong education, support and advocacy.*

  Its mission is: *to provide a vibrant professional home for specialist General Practitioners and Rural Generalists that delivers: inspiration, collegiality, value, and social accountability.*

  Its values are: *to be visionary, inclusive, courageous, and expert*.

- *ACRRM Functions:*

  The College membership includes ACRRM Fellows, registrars training to ACRRM Fellowship, junior doctors and medical students interested in careers in RG practice, and Fellowed General Practitioners with an interest in the College and its work. All ACRRM members are united in their interest in rural and remote practice. All Fellows are skilled and experienced rural practitioners that have attained the skill-set commensurate with rural generalist practice, and some 80% of ACRRM Fellows continue to be based in rural and remote areas.

  The College provides a Fellowship training program which it delivers both independently and in conjunction with government supported programs. The program has been designed to prepare Fellows for practice as general practitioners in the RG model of care.

  The College also delivers its Professional Development Program (PDP) which is designed to enable and assure currency in the skills associated with the Fellowship. The program includes services to manage Fellows' Maintenance of Professional Standards (MOPS) and reporting requirements for clinical credentialing in a range of advanced skill areas associated with the Fellowship.

  Integral to all these activities is the College's continuous program of development, review and advocacy for appropriate professional standards of quality and safety for ACRRM trainees and Fellows and their model of practice.

  The College engages in a broad range of activities to support members in their learning and in applying their skill set in their practice.

  - It advocates on behalf of our members and their rural and remote communities
  - It facilitates and supports peer networking and communities of practice forums and events across its membership

- It provides extensive educational and clinical support resources, activities and events relevant to RGs and rural and remote medical practice.

- *History of ACRRM:*

  ACRRM has established in 1997 with some 660 foundation members. It was formed to provide professional standards, training and Continuing Professional Development (CPD) reflecting the model of care practiced by its rural doctor membership. This distinct model has since come to be known as rural generalism. It commenced with some 660 foundation members.

  In 2005 as a step toward attaining national accreditation for its programs, ACRRM applied for new speciality recognition of Rural and Remote Medicine. The Commonwealth Health Minister did not accept this application but supported ACRRM to further develop its programs and apply to attain accreditation within the established specialty of general practice. The College undertook these processes and was awarded provisional Australian Medical Council (AMC) accreditation in 2007 and full accreditation in 2011 which it has maintained to the present time.

  Attainment of the ACRRM Fellowship is thus accredited as meeting requisite standards to qualify Fellows for Vocational Registration as General Practitioners. The Fellowship training program however includes an integral and assessed focus on rural proficiencies. The assessment standard requires competency to perform skills in relatively professionally isolated clinical contexts, high levels of emergency medical and general hospital care competency and assessed proficiency and training experience in advanced skills in at least one selected broad field of practice.

  The College formerly commenced delivery of its national Fellowship training and professional development programs in 2001 in association with the establishment of the regionalised national General Practice Education and Training (GPET) system.

  From the outset, ACRRM's Fellowship training program has been delivered both autonomously through its self-funded Independent Pathway and also through a supported delivery model which has been auspiced variously through the Commonwealth Government's GPET (from 2001-2015), the Australian General Practice Training (AGPT) and the Remote Vocational Training Scheme (RVTS) programs. Since 2019 ACRRM has also received some government funding to support its trainees on its Independent Pathway through the Non-VR Fellowship Support Program.

  From 2022 ACRRM will assume responsibility for the management functions of the AGPT and RVTS programs as they pertain to supporting registrars in the ACRRM Fellowship program.

- *ACRRM Governance:*

  The College is oversighted by ACRRM Board which holds ultimate authority for all corporate governance.

  The Directors of ACRRM Board are:

- A/Prof Ewen McPhee MBBS (Hons), FACRRM, FRACGP, DRANZCOG (Adv) - *President*
- Dr Mike Beckoff MBBS, FACRRM, FAICD, Assoc. Dipl. Agric (Dist)
- Ms Annabelle Brayley - *Community representative*
- Dr Sarah Chalmers, FACRRM, BSc (Hons), PG, DipEd, MBBS, FRACGP
- Dr Dan Halliday BBioMedSc, MBBS, FACRRM, DRANZCOG
- Dr Michelle Hannan BMedSc (Hons), MBBS, FACRRM, DCH - *Registrar Director*
- Dr Suzanne Harrison DA, FACRRM, MSP Medicine (UNSW, 2006), Grad Certificate Health Professional Education (Monash Uni, 2010)
- Dr Anthony (Tony) Hobbs MBBS (1st Hons) FACRRM DRANZCOG-Advanced DTM&H DCH GAICD
- A/Prof Ruth Stewart MBBS, FACRRM, PhD (Flin), DRANZCOG - *Immediate Past President, ex-officio*
- A/Prof David Campbell MBBS, FACRRM, DRANZCOG, DCH, FRACGP - *Censor in Chief, ex-officio*
- Ms Marita Cowie BA (Psych), BBus (Com), MEd (T&D) - *Chief Executive Officer, ex-officio*

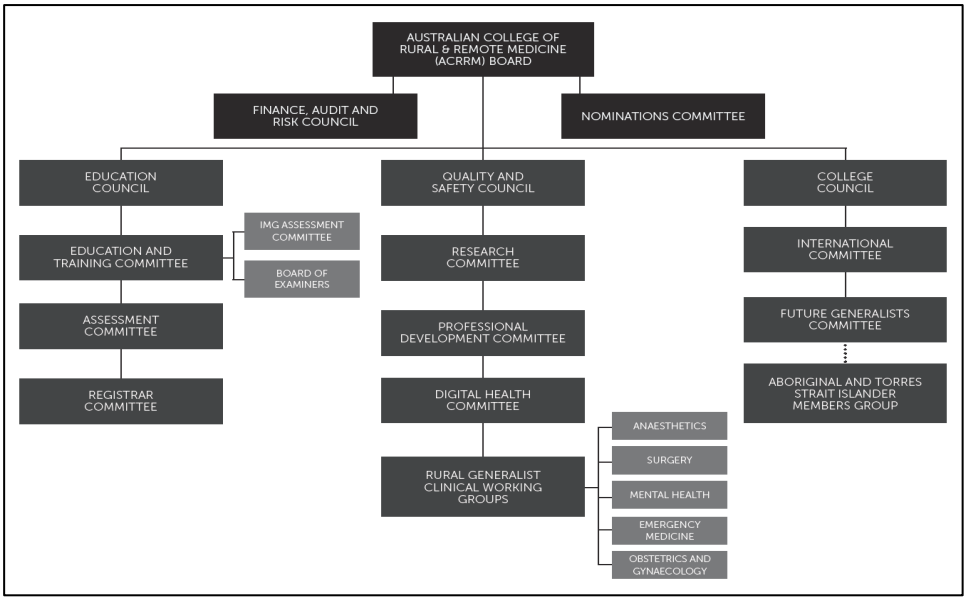
There are four peak councils which report to the Board each with their own respective reporting committees and working parties. They are the College Council, the Finance, Audit and Risk Management Council, the Quality and Safety Council and the Education Council.

The College has a Registrars Committee that have representation on all key committees, Councils and the Board. It also has Future Generalists - its students and junior doctors committee which is also widely represented on College committees.

ACRRM has an Aboriginal and Torres Strait Islander Members' Group which acts as both a member support and expert reference group and has a nominated representative on the College Council.

The Quality and Safety Council has an expanding series of reporting RG Clinical Working Groups which provide expert guidance in key focus areas for RG practice.

Table 1.1 ACRRM Governance Chart



Information on ACRRM Governance and Board and College Council members can be found at the following link:
https://www.acrrm.org.au/about-the-college/board-council-and-committees

ACRRM Strategic Activities and Logic Map (2018-21) can be found at the following link:
https://www.acrrm.org.au/about-the-college/history-of-acrrm/college-vision-and-values

The ACRRM Reconciliation Action Plan can be found at the following link:
https://www.acrrm.org.au/the-college-at-work/reconciliation-action-plan

Appendix 1.2

The Royal Australian College of General Practitioners (RACGP)

RACGP Statement of Mission, Purpose and Functions:

The RACGP is a not-for-profit company limited by guarantee, governed by RACGP Council (board of directors), and headquartered in East Melbourne. The RACGPs vision is 'Healthy profession, Healthy Australia'. The mission is to improve the health and wellbeing of all people in Australia and to support General Practitioners (GPs), GP registrars and medical students through:

- Education and training for general practice Fellowships – FRACGP and FARGP, standards, quality, selection, international accreditation, curriculum, assessment, continuing professional development.
- Innovation and policy for general practice, quality care, technology, practice standards and accreditation, knowledge and evidence, research, RACGP Foundation, policy and practice support.
- Advocacy A strong voice advocating for general practice and patients in the community and across all levels of Government and stakeholders.
- Collegiality Member engagement, conferences, student to mentor opportunities, digital communities and united professionals.

RACGP is Australia's largest professional general practice organisation and represents urban and rural general practitioners.

The RACGP has a proud history of achievements, including the development of the *Standards for general practices* and introducing continuing professional development.

The RACGP carries its activities within the following areas of strategic focus:

- collegiality
- education and training for general practice
- innovation and policy for general practice.

The RACGP Core Strategic Objectives:

Our members and staff aim to improve the health of all Australians through:

- quality general practice – appropriately funded and resourced, sustainable and vibrant, at the heart of an effective and efficient healthcare system
- equitable access throughout Australia to quality general practice
- a forward-thinking organisation, leading and advocating improvement through clinical, education and technology advances providing service, value and broad engagement for all members.

The RACGP's Principles:

As guiding principles, our members and staff:

- value our patients and their communities
- achieve quality and excellence in standards, research and education
- promote a unified voice for general practice
- are forward thinking and collaborate widely with all stakeholders
- support fairness, diversity and equity
- work with integrity, ensuring ethical, honest and transparent communication.

History of the RACGP

The Australian College of General Practitioners (ACGP) was formed in 1958. Its stated aim was to improve the health and wellbeing of all Australians by supporting general practitioners. This remains the College's primary role. The College was first located at 203 Macquarie Street, Sydney, and in its first year the College attracted 874 foundation Members. In his first year as inaugural President of the Australian College of General Practitioners, William Conolly wrote in the Annual Report to members that the college aimed to ensure that the GP continue to be the family doctor who would remain as counsellor, guide and friend to his patients. It aspired to see that general practice was maintained 'on the highest plain' in Australia and 'to safeguard the health of the nation'.

The inaugural College Council was made up of representatives from each state faculty and the first office bearers were elected. A Coat of Arms, with the motto 'Cum sciential caritas – 'with skill, tender loving care' was approved by College Council in 1960 and granted by the College of Arms in May 1961. On 24 March 1969, Her Majesty the Queen granted the prefix 'Royal' to the Australian College of General Practitioners. The College's name was appropriately changed to The Royal Australian College of General Practitioners.

The Postgraduate Fellowship Plan, was instigated in 1962. Postgraduate education and training, one of the major aims of the College, has underpinned the activities of the College for over 60 years. The overall directive to Fellows was to concentrate on country general practice. As far back as the 1960s it is clear that general practitioners in rural locations were greatly in need of assistance and support in their work. This was to be achieved by input from the newly established RACGP.

Vocational education and training for general practitioners was formalised in 1973. This occurred with the introduction of the Family Medicine Programme. In 1982, the Family Medicine Programme Mark 2 was developed. The training program's curriculum was 2 years' hospital experience; two 13-week terms of subsidised experience in a teaching general practice; a further period of experience in general practice under supervision; and, concurrent with in service training, a 2-year cyclical program of educational courses accredited by the RACGP. In 1984-1985, as the first step toward accreditation, a Certificate of Satisfactory Completion of Training was introduced. In March 1987, two Council resolutions were agreed: first, that the endpoint of Family Medicine Programme training should be Fellowship of the College, the FRACGP. Secondly, that by 1992 Fellowship of the College would only be attained following the undertaking of 'an approved course of training', that is, the Family Medicine Programme.

In the 1990s, the College began a phase of refining its early initiatives. Quality assurance, the examination, a training program, vocational registration, publications, standards of general practice, Aboriginal health, services division, joint consultative committees with other colleges, as well as other projects and enterprises were introduced. The RACGP established a Faculty of Rural Medicine in 1992 (later named the National Rural) and a Rural Training Stream within FMP in recognition of the need for extra training — especially in procedural skills — for those preparing specifically for rural practice and to provide support to them and their families and was established in response to the needs of rural GPs. The College also established the Fellowship of Advanced Rural General Practice (FARGP). The FARGP provides the skills and qualifications for GPS working in rural areas.

In 1993, the RACGP redeveloped the Fellowship examination and was described by Professor Cees Van der Vleuten of Maastricht University, The Netherlands, as 'the gold standard assessment in general practice around the world'. By 1992, the number of vocationally registered members had risen to 11 290. In 1993, the number of candidates who sat for college examinations was 679. The

number of doctors on the Vocational Register rose to 15 344. In 1995, 1265 candidates sat for examinations, a fourfold increase from 1991. One further change took place: from January 1996, trainees became known as general practice registrars.

By 1996 vocational training and registration became mandatory and were tied to Medicare payments for GPs. In 1999, RACGP Council decided to concentrate all the college business in one area. The national headquarters was transferred to Melbourne. All this change resulted in substantial financial cost, the loss of the Training Program, disposal of some college real estate and the disturbance of its core business of services to members. The government, at the same time, set up an independent organisation to supervise the provision of general practice training. In June 2000, the then federal Minister for Health and Aged Care announced that the delivery of education and training for GPs will move towards a regionalised approach over the next 18 months, which will be overseen by a new Board of General Practice Education and Training (GPET).

GPET was established in 2001 and their prime role was to establish a regionalised training program — the Australian General Practice Training (AGPT) program. Training consortia were developed within regional boundaries and different training environments. Regional Training Providers (RTPs) (now known as Regional Training Organisations – RTOs) were required under the conditions of their contract with GPET to provide training according to the standards of the profession delivering the new AGPT along very similar lines to the preceding RACGP Training Program using the College's curriculum to help their registrars prepare for its examination, which remained the sole end point of training. This left the college to set the standards and examination for entry into general practice.

In 2002 the RACGP commenced the process of accreditation by the Australian Medical Council (AMC). The RACGP is the fourth Australian specialist medical college to seek accreditation of its medical education standards, curriculum and procedures by the AMC. The RACGP's objectives in seeking accreditation were to demonstrate that general practice specialist education and training program standards are evidence based, reliable and valid and provide a basis for continuing, safe and high-quality general practice.

In 2017, Federal Health Minister Greg Hunt announced that the RACGP and ACRRM will resume delivery of general practice training in Australia commencing with a transitional period from January 2019 – December 2021. Both the RACGP and ACRRM will deliver training, encompassing the Australian General Practice Training (AGPT), from January 2022.

As Australia has changed in the past 60 years, so too have the aims and objectives of the college evolved to better reflect Australian society and its needs. However, the evolving nature of general practice and, in recent years, a greater emphasis on advocacy, rural and Aboriginal health, have contributed to the broadening focus of the college and its membership. Social and political events, and public policy and their outcomes, have also impacted upon the activities of the college. The RACGP now represents more rural GPs than any other general practice organisation in Australia. The College has also witnessed major developments in its education, research and preventive medicine programs, making them available to enthusiastic GPs using the latest innovative technology. Education, research, publications and preventive medicine have underpinned the activities of the college. The College continues to champion the diverse skills of GPs and believes that generalist skills are the foundation of the profession.

Today, additional aims and objectives have expanded the College's goals to include the support of registrars, practice nurses and medical students; supplying ongoing professional development activities; developing resources and guidelines; helping GPs with issues that affect their practice; and the development of standards that general practices use as part of the accreditation process.

RACGP Rural

RACGP Rural is committed to addressing rural disadvantage focusing our efforts toward strategies which lead to more equitable access to healthcare. The capacity of the health system to respond to current and emerging pressures in rural and remote Australia is a central focus for RACGP Rural. Central to addressing rural disadvantage is the capacity of, and equitable access to, general practice and its role in bringing lasting change in rural communities.

The faculty is working hard in all its advocacy efforts to ensure that future Government reforms and programs are responsive to the unique challenges faced by GPs in supporting rural and remote communities. RACGP Rural aims to provide strong policy leadership in the areas that matter most to rural members, ensuring a strong rural voice to secure a sustainable rural health system for the future.

RACGP Rural's strength lies in its membership and it is through close consultation with the profession that RACGP are uniquely placed to provide valuable input to future health initiatives. To overcome long-standing rural disparities, rural health reform must lead to increased support for GPs and their communities and work to address current barriers to recruitment and retention. Consolidated strategies that seek to address the entire range of essential requirements specific to rural and remote communities are required. A more responsive and better coordinated health system in the future will need to foster rural innovation, improve access to high quality health care, provide for better coordination and reduce duplication and gaps.

RACGP Rural was formed in 1992 when the RACGP recognised the need for a rural voice. Rural issues and concerns are represented on RACGP Council, faculty boards and committees. With over 19,000 members, approximately 8,500 of whom are registered general practitioners in rural and remote Australia, RACGP Rural supports and advocates for GPs working in our rural and remote communities.

Since 1993, the RACGP has offered specific supports for Registrars with an interest in rural and remote practice. The program became known as the Rural Training Stream (RTS), and participation in the RTS resulted in the conferral of a Graduate Diploma in Rural General Practice, accredited in 1996 as a formal tertiary award with the equivalent to an Office of Higher Education in each state and territory. The Graduate Diploma in Rural General Practice boasts impressive retention rates with 70 percent of graduates still practising in rural areas.

With the withdrawal of Commonwealth funding for the Graduate Diploma that accompanied the transfer of funding to GPET, the membership of the RACGP assumed responsibility for subsidising what was clearly a successful workforce solution.

The FRACGP examination process itself has also been developed to ensure its relevance to rural and remote general practice. It is based on questions and cases that are set with rural question stems tailored for rural candidates who would manage conditions themselves in country hospitals. Many of the questions are written by rural general practitioners located across Australia. The National Rural Faculty has itself funded and organised exam-writing programs with rural and remote general practice specifically in mind.

The RACGP Board of Examiners and Board of Censors have representatives who are current or former rural general practitioners. There is a dedicated Rural Censor on the Board, who is also a member of the Board of the RACGP's National Rural Faculty. The standards setting procedures of all

segments of the FRACGP exam include Fellows who are rural general practitioners to ensure rural issues are well flagged and answers rewarded. Rural-based Fellows are also heavily involved in the marking of examination segments, both for the traditional examination and practice-based assessment (PBA). In terms of the clinical examination of the traditional exam, approximately 25 percent of examiners are rurally based.

In November 2003 the AMC announced the accreditation of the RACGP standards and processes for education and training leading to the Fellowship of the RACGP and of the RACGP Quality Assurance and Continuing Professional Development Program. In its report, the AMC acknowledged the role of the RACGP's National Rural Faculty in servicing the advocacy and educational needs of rural and remote general practitioners. It particularly commended the Advanced Rural Skills Training and the Graduate Diploma in Rural General Practice, and expressed the view that it would contribute to recruitment and retention in rural and remote general practice and enhance general practice care especially in rural Australia.

The RACGP Board of Examiners and Board of Censors have representatives who are rural general practitioners. There is a dedicated Rural Censor, who is also a member of the Board of the RACGP Rural. The RACGP Fellowship examination process has been redeveloped to ensure its relevance to rural and remote general practice – and in fact, many of the questions are now written by rural general practitioners.

The RACGP Rural has itself funded and organised exam-writing programs with rural and remote general practice specifically in mind. Rural GPs are heavily involved in the marking of examination segments - in terms of the clinical examination; approximately 25% of examiners are rural.

Research in the early 90s had showed that many GPs entering rural practice lacked confidence in managing the breadth of presentations, the procedural work, the emergency care and the involvement in Aboriginal Heath. Since 1996 the RACGP has offered the four-year Graduate Diploma in Rural General Practice as an additional award to the FRACGP.

In 2006 the historic 10th year of the Graduate Diploma in Rural General Practice, the RACGP offered the Fellowship in Advanced Rural General Practice building on the strengths of our Grad Dip Rural. Our Grad Dip Rural had real academic credibility, re-accredited formally as a tertiary qualification in 2001 and 2006 under the Australian Higher Education Framework.

The Grad Dip Rural and the FARGP complement GP training, to help candidates to become competent and confident to work and stay in unsupervised rural and remote practice. This confidence is endorsed by its impressive retention rates with 70% of graduates still practicing in rural areas and 66% still procedural more than 90% have training in more than one area of advanced practice.

The award includes advanced rural skills posts with curriculum approved by the Joint Consultative Committees. By far the most popular are anaesthetics and obstetrics, closely followed by emergency medicine. Without doubt the FARGP the most successful training award in Australia but soon it will be even better

RACGP Rural vision

Rural and remote communities across Australia have equitable access to high quality primary care.

Mission statement
RACGP Rural supports and advocates for general practitioners working in rural and remote Australia. RACGP Rural is committed to addressing rural disadvantage focusing our efforts toward strategies which lead to more equitable access to healthcare.

Integral to this key aim is the capacity of general practice and we strive to ensure our members are well placed and have access to appropriate training and professional development to bring about lasting change in rural communities through addressing health need.

Aim
Ensure a sustainable, well-supported rural general practice workforce to competently and confidently address the needs of rural and remote communities.

RACGP Governance

The current board members of the RACGP include:

- Dr Harry Nespolon (President)
- Ms Christine Nixon (Chair)
- Assoc Prof Ayman Shenouda (Vice President and Chair RACGP Rural)
- Assoc Prof Charlotte Hespe (NSW)
- Dr Tess van Duuren (Acting Censor-in-Chief)
- Dr Zakaria Baig (SA – NT)
- Dr Krystyna de Lange (Registrar)
- Dr Cameron Loy (Vic)
- Assoc Prof Peter O'Mara (A&TSIH)
- Assoc Prof Jennifer Presser (Tas)
- Dr Lara Roeske (Specific Interests)
- Dr Sean Stevens (WA)
- Dr Bruce Willet (Qld)
- Mr Martin Walsh (Co-opted, Chair FARM)

RACGP's Governance structures can be found at the following link:
https://www.racgp.org.au/the-racgp/council/council-members

The *RACGP Strategic Plan* (2018-2022) can be found at the following link:
https://www.racgp.org.au/the-racgp/about-us/vision-and-strategy/vision-statement-and-strategic-overview

The *RACGP Reconciliation Action Plan* can be found at the following link:
https://www.racgp.org.au/the-racgp/about-us/reconciliation-action-plan

RACGP Current number of Fellows/Members

Training and membership statistics 2017-18

Membership

Fellows:	22,471
Doctors in training	4,693
Other	8,221

Students	5,493
Total:	**40,878**

Aboriginal and Torres Strait Islander Fellows:	65
Aboriginal and Torres Strait Islander Registrars:	55
Members working in rural	8**,500.**

RACGP Annual Report

The *RACGP 2018-19 Statutory and Annual Reports* can be retrieved at the following link:
https://www.racgp.org.au/the-racgp/about-us/annual-reports

Appendix 1.3

Applicants' Declaration of Interests

The Australian Government is providing a funding grant for the Rural Generalist Medicine Specialist Recognition. This grant opportunity is to support the two GP Colleges to prepare an application to the MBA for recognition of Rural Generalist Medicine as a specialised field within the Specialty of General Practice. Grant funding will contribute to costs associated with this process.

The applicants to the best of their knowledge have no conflicting interests with respect to this application.

Appendix 2.1

Definitions of Rural Generalist Medicine

Collingrove Agreement Definition

"A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in hospital and community settings as part of a rural healthcare team."

(National Rural Generalist Taskforce Report, 2018)

Cairns Consensus International Statement on Rural Generalist Medicine Definition

"We define Rural Generalist Medicine as the provision of a broad scope of medical care by a doctor in the rural context that encompasses the following:

- *Comprehensive primary care for individuals, families and communities*
- *Hospital in-patient care and/or related secondary medical care in the institutional, home or ambulatory setting*
- *Emergency care*
- *Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues*
- *A population health approach that is relevant to the community*
- *Working as part of a multi-professional and multi-disciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs."*[1]

(World Summit on Rural Generalist Medicine, Cairns, 2014).

The full Cairns Consensus International Statement on Rural Generalist Medicine can be found at the following link:

http://www.acrrm.org.au/docs/default-source/documents/about-the-college/cairns-consensus-statement-final-3-nov-2014.pdf

Queensland Health definition:

A Rural Generalist refers to a rural doctor credentialed to serve in:

- Hospital-based and community-based primary medical practice, and
- Hospital-based secondary medical practice:
  - in at least one specialist medical discipline (e.g. obstetrics, anaesthetics, and surgery) AND

[1] Murray R (lead author) (2014) *Cairns Consensus Statement on Rural Generalist Medicine. http://www.acrrm.org.au/docs/default-source/documents/about-the-college/cairns-consensus-statement-final-3-nov-2014.pdf*

- Without supervision of a specialist medical practitioners in the relevant disciplines
- And possibly hospital- and community-based public health practice – particularly in remote and Indigenous communities.

Queensland Health Industrial Award

13.7 Advanced credentialed practice - recognised disciplines
(a) The chief executive has recognised the following disciplines as meeting the requirements for advanced credentialed practice for the purposes of clauses 13.2(a)(iv) and 13.2(a)(v):
(i) rural generalist medicine
(ii) clinical forensic medicine
(iii) generalist emergency medicine
(iv) addiction medicine
(v) sexual health medicine

(b) Disciplines which are assessed for recognition in addition to those listed in clause 13.7(a) will have effect from the date of the decision to recognise them by the chief executive. [2]

Northern Territory Health definition:

"*Rural Generalist Classifications*

Rural Generalist Trainee

A Rural Generalist Trainee (RGT) is a Medical Officer who has been accepted into the Rural Generalist Training Scheme (or equivalent), who is undertaking or has committed to undertake a training program for admission as a fellow of the ACRRM or the RACGP and has committed to undertaking advanced skill training.

Rural Generalist

A Rural Generalist (RG) is a Medical Officer employed or regularly performing duties in a rural or remote hospital or community setting who has advanced skills across a range of areas in rural and remote medicine. The Medical Officer will usually have been admitted as a Fellow of the RACGP or ACRRM (or equivalent).

Senior Rural Generalist

A Senior Rural Generalist (SRG) is a Medical Officer employed or regularly performing duties in a rural or remote hospital or community setting who has advanced skills and experience across a range of areas in rural and remote medicine. The Medical Officer will usually have been admitted as a Fellow of the RACGP or ACRRM (or equivalent), with advanced skills in areas of medicine as determined appropriate by the CEO from time to time.

Note: The reference to 'or equivalent' in clauses 15.44 and 15.45 includes a vocationally registered (VR) General Practitioner."[3]

[2] *Medical Officers (Queensland Health) Award – State 2015 2018 State Wage Case Reprint http://www.qirc.qld.gov.au*
[3] Medical Officers Northern Territory Public Sector 2018 - 2021 Enterprise Agreement. Page. 18. https://ocpe.nt.gov.au/nt-public-sector-employment/Information-about-ntps-employment/rates-of-pay/rural-medical-officers

Appendix 4.1

RACGP Fellowship Programs

Responsible organisation: The Royal Australian College of General Practitioners
Qualification: Fellowship of RACGP (FRACGP) and Fellowship of Advanced Rural General Practice (FARGP)
Length of program: 3 years (1 additional year for completion of FARGP)

Program structure, teaching and learning methods and locations:

The RACGP Fellowship Pathway:

- Australian General Practice Training (AGPT) Program
- Practice Experience Program (PEP)
- Remote Vocational Training Scheme (RVTS)

The AGPT program has two training pathways: Rural Pathway and the General Pathway.

I. Rural Pathway

The Rural Pathway encompasses a large percentage of Australia reaching from towns on the fringe of capital cities, to regional coastal areas and remote outback locations. This pathway offers a range of benefits and opportunities commensurate with the work of rural general practice, for example:

- access to specialist training such as mental health, addiction medicine, paediatrics, anaesthetics, surgery and obstetrics;
- opportunity to develop and consolidate an extended scope of practice working more closely with local communities;
- hospital and community-based primary care;
- contributing to addressing the health needs of communities with decreased access to health care;
- working alongside retrieval medicine teams;
- access to mentors and professional relationships which may not be possible in metropolitan areas;
- increased earning capacity—possible access to financial incentives not available in metropolitan locations; and
- being immersed into local communities and lifestyle benefits of country living.

Doctors who apply for the Rural Pathway can enrol with either of the colleges or both.

Doctors applying for the Rural Pathway are expected to live and work in the community.

II. General Pathway

The General Pathway is for doctors who choose to train primarily in inner and outer metropolitan locations. There are a range of benefits and opportunities commensurate with training on the General Pathway, for example:

- access to specialist training such as mental health, addiction medicine, paediatrics, anaesthetics, surgery and obstetrics; and
- access to mentors and professional relationships.

RACGP Training Program

The RACGP Curriculum can be found at the following link:
https://www.racgp.org.au/education/registrars/fellowship-pathways/curriculum/2016-curriculum

The Standards for General Practice training can be found at the following link:
https://www.racgp.org.au/education/registrars/fellowship-pathways/standards-for-general-practice

The RACGP's Vocational Training Pathway is a three-year vocational training program for medical practitioners wishing to pursue a career as a specialist GP. Details of the FRACGP Training Program can be found at the following link:
https://www.racgp.org.au/FSDEDEV/media/documents/Education/Students/A%20career%20in%20general%20practice/Pathway-to-Fellowship.pdf

The RACGP Fellowship (FRACGP) training program has three components:
- supervision and the practice environment
- education and training/teaching
- assessment.

Clinical training requirements

Successful completion of three years full-time training or equivalent part-time training consisting of:

- 12 months Hospital Training Time in accredited hospitals with rotations in:
  - general medicine
  - general surgery
  - paediatrics
  - emergency medicine, and
  - a range of other rotations.

- A minimum of 18 months general practice experience in RACGP accredited general practice training posts (under the guidance of a RACGP accredited supervisor)
- Six months of extended skills training

Education requirements

Successful completion of education activities:

i. A Cardiopulmonary Resuscitation (CPR) course completed within the 12 months prior to commencing General Practice Term 1 (GPT1) that meets the requirements detailed in RACGP's Cardiopulmonary Resuscitation and Advanced Life Support Courses Guidance Document.

ii. A Cardiopulmonary Resuscitation (CPR) course completed within the 12 months prior to applying for Fellowship that meets the requirements detailed in RACGP's Cardiopulmonary Resuscitation and Advanced Life Support Courses Guidance Document

iii. Training in the early management of trauma and advanced life support (ALS) completed within the four years prior to apply for Fellowship that meets the requirements in RACGP's Cardiopulmonary Resuscitation and Advanced Life Support Courses Guidance Document.

iv. RACGP's Aboriginal and Torres Strait Islander Health unit in the Curriculum to Australian General Practice.

v. A minimum of 18 months general practice experience in RACGP accredited general practice training posts under the guidance of a RACGP accredited supervisor.

vi. Six months of extended skills training approved by the vocational training provider in accordance with the RACGP Standards for General Practice Training.

Assessment requirements

Successful completion of these assessments:
Pass RACGP's:

- Applied Knowledge Test (AKT)
- Key Feature Problem (KFP) and
- Objective Structured Clinical Exam (OSCE)

within their period of candidature in the AGPT program or RVTS. Candidates must pass the AKT and KFP as a prerequisite to undertaking the OSCE.

The Fellowship in Advanced Rural General Practice (FARGP)

The Fellowship in Advanced Rural General Practice (FARGP) has pathways designed for both general practice registrars and experienced practising GPs. The FARGP aims to develop advanced rural skills and broaden options for safe, accessible and comprehensive care for Australia's rural, remote and very remote communities. The FARGP cannot be undertaken as a stand-alone qualification.

The Fellowship in Advanced Rural General Practice (FARGP) has three components:

- supervision and the practice environment
- education and training/teaching
- assessment.

Clinical training requirements

- 12 months in a rural general practice setting (MMM3-7)
- 12 months of Advanced Rural Skills Training (ARST) in an accredited procedural or non-procedural training post

Education requirements

- Completion of the FARGP learning plan and reflection activity
- Completion of the FARGP emergency medicine module which includes a series of case studies, skills audits and satisfactory completion of two advanced emergency skills course.

Assessment requirements

- Completion of a 6-month 'working in rural general practice' community-focused project.

The RACGP Practice Experience Program (PEP)

The RACGP's Practice Experience Program (PEP) is a self-directed education program designed to support non-VR doctors on their pathway to RACGP Fellowship. The PEP helps non-VR doctors prepare for the RACGP Fellowship exams and to deliver quality primary care to their patients. The PEP has a strong emphasis on self-directed learning with practical and relevant educational activities. Because the PEP participants are working in practice, the learning units are largely practice-based and have the dual benefit of enabling doctors to apply new knowledge and skills into their practice. The PEP is an RACGP initiative that is delivered in partnership with RTOs across Australia. The PEP will replace all other programs on the pathway to Fellowship with RACGP, other than the AGPT program and the RVTS.

The PEP is an individualised learning program based on the current knowledge, skills, experience and competence of each participant. Because of the focus on the individual rather than on a structured program designed for a particular group of registrars (as in the AGPT), the PEP participants are not part of a time-based cohort of peers and are unlikely to be undertaking the same learning program as any other individual in the PEP. The PEP is a program based in general practice, which means that before entering the program doctors must either be employed as a GP or have an offer of employment as a GP.

The RACGP Quality Improvement and Continuing Professional Development (QI&CPD) Program

The RACGP QI&CPD Program supports general practitioners to provide the best possible care for patients and their communities. The QI&CPD Program recognises the need for ongoing education to improve the quality of everyday clinical practice by promoting the development and maintenance of general practice skills and lifelong learning. The requirements for the 2017–19 triennium was updated on 14 September 2018.

I. Continuing professional development and lifelong learning for Australian GPs

Continuing professional development (CPD) for medical practitioners includes a range of activities to meet individual learning that is relevant to their scope of practice, in order to maintain, develop, update and enhance knowledge, skills and performance to ensure that they deliver appropriate and safe care. As adult learners, Australian GPs take responsibility for:

- undertaking personal learning to support their CPD
- identifying CPD needs throughout lifelong learning
- planning how those identified CPD needs should be addressed
- continuously reflecting on their individual professional standards, scope of practice and competencies
- shaping learning assessments according to individual professional needs and the needs of the communities which they serve.

In addition, a GP's CPD needs to promote quality systems-based approaches in the workplace and the teams in which they work. GPs are also responsible for maintaining evidence that they are undertaking CPD.

II. QI&CPD Program objectives

The QI&CPD Program has been developed for the Australian general practice setting to:

- provide GPs with opportunities to improve patient safety and quality outcomes

- support continuous quality improvement within the general practice setting
- enable GPs to fulfil their individual and vocational CPD requirements.

The RACGP supports a 'Healthy Profession. Healthy Australia' through the delivery and ongoing enhancement of its QI&CPD Program. The RACGP QI&CPD Program assists Australian GPs to maintain and improve the quality of care they provide to patients, promotes care of the highest possible standard to the community and documents their learning achievements for their own records and to meet the needs of regulatory and accrediting bodies.

III. Educational underpinnings of the QI&CPD Program

The RACGP QI&CPD Program recognises that CPD activities are more likely to result in improved personal and patient outcomes if the learning:

- is self-directed
- is driven by the learner's identified needs
- is integrated into an individual's learning program
- encourages active participation
- considers the GP's prior knowledge, skills, behaviours and attitudes
- involves reflection and evaluation of what has been learnt.

Accredited activities within the QI&CPD Program are based on adult learning principles that integrate the GPs' prior experience, promote high clinical, scientific and ethical standards, and extend knowledge and skills that impact positively on the behaviour of GPs in relation to improved quality of patient care. RACGP QI&CPD ensures that provider-led accredited activities are of a high quality and meet the needs of Australian GPs through the adherence to QI&CPD activity standards.

These activity standards provide the framework for consistency and quality in the planning, development, delivery and evaluation of QI&CPD accredited activities.

All participants are required to undertake a range of different activities from across the domains and the RACGP's Curriculum for Australian General Practice 2016 to address their individual learning needs.

IV. QI&CPD Program requirements for the 2017–19 triennium

A part of the RACGP's commitment to continually evaluate and improve the QI&CPD Program, the 2017–19 triennium will include an increased focus on reflective learning practices. A minimum of 130 QI&CPD points is required for the triennium, which must include:

- two Category 1 activities, one of which must be a quality improvement (QI) activity
- a cardiopulmonary resuscitation (CPR) course.

Table 4.2 Number of RACGP CPD program participants for the last three years:

Figures as at:	Total non-members in CPD	Total members in CPD	Total participants in CPD
1-Dec-17	6378	21433	**27811**
1-Dec-18	6205	22599	**28804**
1-Sep-19	6031	24136	**30167**

The detailed requirements for the 2017-2019 QI & CPD Program including lists of accepted activities can be accessed from the following link:
https://www.racgp.org.au/FSDEDEV/media/documents/Education/Professional%20development/QI-CPD/QICPD-Handbook-2017-19-triennium.pdf

Appendix 4.2

ACRRM Fellowship Programs

Responsible organisation: Australian College of Rural and Remote Medicine
Qualification: Fellowship of ACRRM
Length of program: 4 years (5 years for completion with AST RG surgery)

Program structure, teaching and learning methods and locations:

Registrars may enrol to ACRRM Fellowship training via three alternative streams:

- Independent Pathway
- Australian General Practice Training (AGPT)
- Remote Vocational Training Scheme (RVTS)

All ACRRM registrars are selected via a consistent selection process, are trained to the ACRRM curriculum and ACRRM training standards, and undertake the same assessments - managed and delivered by the College. Training is delivered directly by the College or in partnership with College accredited training organisations (for trainees with sponsored positions on AGPT or RVTS).

The Fellowship training program has two essential parts:

- Core Generalist Training (36 months)

  This training occurs in accredited training posts in a range of rural health contexts including: general practice clinics, Aboriginal Community Controlled Health Services (ACCHSs) and other Aboriginal Medical Services, hospitals and emergency departments and retrieval services. Training must be in locations classified MM2-7 unless specific skills training is required in an MM1 location. Training must commence with 12 months hospital training (on the IP and RVTS pathways, exemptions may be considered). Training must include at a minimum completion of:
  - Six months training in primary care
  - Six months training in hospital and emergency care, and
  - 12 months training in locations classified MM4-7

- Advanced Specialised Training
  This involves 12 months[1] training in one of 12 disciplines. Assessment is either a Structured Assessment using Multiple Patient Scenarios (StAMPS), a viva-styled assessment which considers the clinical context and its access and resources status; or, a thesis-styled project assessment.
  - Aboriginal and Torres Strait Islander peoples' health (project)
  - Academic Practice (project)
  - Adult Internal Medicine (StAMPS)
  - Anaesthetics (Joint Consultative Committee - Anaesthetics (JCCA) requirements including viva styled assessment)
  - Emergency Medicine (StAMPS)
  - Mental Health (StAMPS)

[1] 24 months for AST in RG surgery

- Obstetrics and Gynaecology (Consultative Committee Diploma of Obstetrics and Gynaecology[2] requirements including viva-styled assessment)
- Palliative Care (commencing 2020 -StAMPS)
- Paediatrics (StAMPS)
- Population Health (project)
- Remote Medicine (project)
- Surgery (StAMPS)

All training streams have structured out-of-practice and in-practice education programs mapped to the curriculum. Registrars are supported by accredited supervisors, medical educators and training staff. In addition to the training requirements listed above, to achieve Fellowship, registrars must demonstrate:

- Successful completion of the education program
- Four ACRRM online learning courses
- Rural Emergency Skills Training (REST) and one further tier 1 emergency skills course, or two tier 2 courses
- Successful completion of assessment requirements:
    - Mini-Clinical Examinations (MiniCEX)
    - Multiple Source Feedback (MSF)
    - Multiple Choice Question (MCQ) assessment
    - Primary curriculum StAMPS
    - Procedural Skills Logbook
- Advanced Specialised Training (AST) time, clinical experience, education, formative and summative assessments requirements as detailed in the individual AST Handbooks.

Independent Pathway

Registrars may enrol to Fellowship training through the Independent Pathway. This pathway is self-funded although registrars may now be eligible for limited support through the Commonwealth Government's new Non-VR Fellowship Support Program. Registrars undertake training in ACRRM accredited training posts in hospitals and private clinics and a range of other workplaces. They undertake a full multi-model structured teaching program provided by the College including week-long F2F training workshops and regular Medical Educator facilitated online discussions. As with all ACRRM registrars they undertake assessment managed and delivered by the College.

Table 4.3 Number of trainees entering the ACRRM training program 2015-2019[3]

	2015	2016	2017	2018	2019
New registrar enrolments	186	172	152	146	240

ACRRM Training Program

The ACRRM Curriculum can be found at the following link:
https://www.acrrm.org.au/training-towards-fellowship/curriculum-and-requirements

The Standards for training providers contributing to ACRRM Fellowship training can be found at the following link:

[2] In association with the Diploma of Royal Australian and New Zealand College of Obstetrics and Gynaecology
[3] Enrolment figures, as per Board Reports as at January in each respective year.

https://www.acrrm.org.au/training-towards-fellowship/training-your-registrars/training-organisations/standards-for-training-organisations

The Standards for accredited supervisors and teaching posts for ACRRM Fellowship training can be found at the following link:
https://www.acrrm.org.au/training-towards-fellowship/training-your-registrars/supervisors-and-teaching-posts

An overview of ACRRM Fellowship training can be found at the following link:
https://www.acrrm.org.au/training-towards-fellowship/overview-of-fellowship-training

The ACRRM Fellowship Training Handbook can be found at the following link:
http://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/handbook-fellowship-training.pdf?sfvrsn=12

The ACRRM Fellowship Assessment Handbook can be found at the following link:
https://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/handbook-fellowship-assessment.pdf?sfvrsn=42ba86eb_30

ACRRM Professional Development Program (PDP)

The ACRRM Professional Development Program (PDP) framework operates over trienniums. The program has been revised for the 2020-22 triennium. This has occurred as part of ongoing quality improvement and in compliance with the Medical Board of Australia's (MBA) new Professional Performance Framework (PPF) requirements.

For the new triennium - to meet compliance, participants are required to achieve a minimum of 150 hours per triennium made up of the following:

- 25% of PDP to be from educational activities
- 25% to be from performance review
- 25% to be from outcome measurement
- Remaining 25% can be any of the above

Certification of continuous professional development activities is conducted and reported across three consecutive years, or triennium. All Fellows must meet the ACRRM's PDP requirements each triennium to maintain their standards and certification and retain their Fellowship. An official statement and certificate of compliance is issued to eligible members after the end of triennium.

Advanced Life Support
ACRRM Fellows must complete Advanced Life Support (ALS) training. Program participants who hold Fellowship with an alternative accredited College must complete mandatory Basic Life Support Skills training

1. *Educational activities*
   Required hours could be achieved through accredited activities in one of following:
   - Conferences, workshops, seminars etc.
   - Skills/simulator/practical training
   - Teaching practice accreditation
   - Educational visit
   - Clinical forum discussions (coordination/moderation)
   - Educational program development

- Formal research project
- Planned learning project
- Presentation to non-medical group (health education)
- Distance-based education modules
- Scientific presentation
- Self-directed learning
- Supervision of registrars
- Teaching programs – presenting/facilitating/instructing
- University courses
- Other educational activity

2. *Performance review*
   Required could be achieved through accredited activities in one of following:
   - Multi-source feedback
   - Patient feedback
   - Peer Review
   - Case studies
   - Publications
   - Practice accreditation
   - Clinical teaching visit
   - Formal workplace performance appraisal
   - Assessment of skills/simulator/practical training
   - Clinical attachment
   - Locum improvement tool
   - Teaching programs – presenting/facilitating/instructing
   - Peer observation of teaching audit
   - Other performance review activity

3. *Outcome measurement*
   Required could be achieved through accredited activities in one of following:
   - Clinical audit
   - Practice accreditation
   - Review of medical records
   - Morbidity and mortality meetings
   - Significant event analysis
   - Publications
   - Practice analytics
   - Other outcome measurement activity

The activities listed above are common examples but there is scope to include other relevant activities in each category

The program also provides a service to enable members to meet their professional reporting requirements to third parties particularly in advanced specialised skills areas. This includes reporting for Maintenance of Professional Standards (MOPS) purposes in:

- Anaesthetics
- Obstetrics
- Radiology
- Medical acupuncture

- Mental health

PDP participants can also elect to have their activities in the following disciplines noted for clinical privileging purposes:

- Anaesthetics
- Obstetrics
- Surgery
- Emergency Medicine

Table 4.4 Number of ACRRM PDP program participants 2017-2019

Figures as at:	Total participants in PDP*
1 Dec 2017	2377
1 Dec 2018	2680
1 Sept 2019	2874

**PDP registration numbers fluctuate throughout the year point in time figures are given below.*

The detailed requirements for the ACRRM PDP can be accessed from the following link: https://www.acrrm.org.au/pdp-handbook-17-19/Default.htm

APPENDIX 5.1

National Rural Health Commissioner Consultations on behalf of the National Rural Generalist Taskforce

National Organisations

- Rural Workforce Agency Network – CEOs Meeting
- Regional Training Organisations Network – CEO Meeting
- Australian Society of Anaesthetists – Prof David Scott
- The Australian and New Zealand College of Anaesthetists – Dr Rod Mitchell, President
- AMA Council of Rural Doctors – Council Meeting
- AMA Council of Doctors in Training - Council Meeting
- Pharmaceutical Society of Australia - Mr Shane Jackson, National President
- Rural Doctors Association of Australia - Council Meeting
- CRANAplus, Mr Christopher Cliffe, Chief Executive Officer,
- Australian College of Rural and Remote Medicine – Council Meeting
- AMA, Presidents Michael Gannon and Dr Tony Bartone and Dr Warwick Hough, Director - General Practice & Workplace Policy
- Indigenous Allied Health Australia - Ms Donna Murray, CEO
- Australian Indigenous Doctors Association - Dr Kali Haywood, President. Mr Craig Dukes, Chief Executive Officer
- Australian Rural Health Education Network - Dr Lesley Fitzpatrick, CEO
- Services for Australian Rural and Remote Allied Health - Mr Jeff House, Chief Executive Officer,
- AHPARR – Ms Nicole O'Reilly, Convenor
- Allied Health Professions Australia –Ms Lin Oke EO,
- Australian Medical Students Association - Ms Alex Farrell, President
- National Rural Health Alliance - Mr Mark Diamond, Chief Executive Officer, Ms Tanya Lehmann, Chair
- Medical Board of Australia, Dr Joanna Flynn, Chair
- Medical Deans ANZ - Helen Craig, CEO; Professor Richard Murray, President
- Royal Flying Doctors Service - Board of Directors Meeting
- AMSA Rural Health - Ms Nicole Batten Co-Chair; Co-Chair Ms Gaby Bolton; Vice Chair Ms Candice Day
- Australian Dental Association - Ms Eithne Irving, Deputy Chief Executive Officer
- Remote Vocational Training Scheme - Dr Pat Giddings and Dr Tom Doolan
- Federation of Rural Australian Medical Educators – National Executive Meeting
- Rural Doctors Association of Australia Specialists Group - Meeting
- The Royal Australasian College of Surgeons - Council Meeting
- Council of Presidents of Medical Colleges – Council Meeting
- Rural Health Stakeholder Roundtable – Meetings
- The Royal Australian College of General Practitioners – Council Meeting
- Australian Council of Deans of Health Sciences – Council Meeting
- Royal Australasian College of Surgeons – Mr John Batten and Council Meeting
- Royal Australia and New Zealand College of Obstetricians and Gynaecologists - Rural Council Forum
- RDAA Junior Doctors Forum – Forum Meeting
- Australian Medical Council – Council Meeting

- Health Professions Accreditation Council's Forum – Forum Meeting
- Australian Hearing Services – Ms Sarah Vaughan, Board Director
- Australian College of Emergency Medicine - Dr Simon Judkins, President and CEO Dr Peter White
- Primary Health Care Institute – Mr Mark Priddle and Dr Shirley Fung
- Stroke Foundation – Ms Sharon McGown, Chief Executive Officer
- GP Supervisors Association – Dr Steve Holmes, President
- GP Registrars Association – Dr Andrew Gosbell, CEO
- AMA Federal Council – Council Meeting
- Royal Australia and New Zealand College of Ophthalmology – Dr Cathy Green, Dean of Education, and Policy team

Federal Parliament

- *Senator the Hon Bridget McKenzie, Minister for Regional Services, Minister for Sport, Minister for Local Government and Decentralisation*
- *The Hon Greg Hunt MP, Minister for Health*
- *The Hon Dr David Gillespie, former Assistant Minister for Health*
- *The Hon Dan Tehan, Minister for Education*
- Standing Committee on Community Affairs – Inquiry into the accessibility and quality of mental health services in rural and remote Australia

Australian Government

- Commonwealth Department of Health
- Ms Glenys Beauchamp PSM, Secretary
- Professor Brendan Murphy, Chief Medical Officer
- Mr David Hallinan, First Assistant Secretary, Health Workforce Division
- Ms Chris Jeacle, Assistant Secretary, Rural Access Branch
- Ms Fay Holden, Assistant Secretary, Health Training Branch
- Ms Maria Jolly, First Assistant Secretary, Indigenous Health Division
- Mr Chris Bedford, Assistant Secretary, Primary Health Networks Branch
- Mr Mark Cormack, Previous CEO, Health Workforce Australia
- A/Professor Andrew Singer, Principal Medical Advisor, Health Workforce Division
- A/Professor Susan Wearne, Senior Medical Advisor, Health Workforce Division
- National Mental Health Commission - Ms Maureen Lewis, Deputy Chief Executive Officer, and Ms Lucinda Brogden, Commissioner
- Dr Lucas De Toca, Principal Medical Advisor, Office of Health Protection
- Dr Chris Carslile, Assistant Secretary*, Office of Health Protection*

Australian Capital Territory

- The Hon Meegan Fitzharris, ACT Minister for Health and Wellbeing, Higher Education, Medical and Health Research, Transport and Vocational Education and Skills
- Aspen Medical - Mr Andrew Parnell, Government and Strategic Relationship Director,
- National Health Co-op - Mr Blake Wilson General Manager; Adrian Watts CEO

Northern Territory

- The Hon Natasha Fyles, Attorney-General and Minister for Justice; Minister for Health
- Mr Stephen Pincus Chief Executive Officer Northern Territory General Practice Education (NTGPE)
- Northern Territory Medical Program – Prof John Wakerman, Associate Dean
- FCD Health – Ms *Robyn Cahill, CEO*

Western Australia

- Office of the Minister for Health, Neil Fergus, Chief of Staff and Julie Armstrong, Senior Policy Advisor
- WA Department of Health - Dr DJ Russell-Weisz – Director General, Dr David Oldham, Director of Postgraduate Medical Education
- WA Country Health Service - Mr Jeff Moffet, CEO, Dr Tony Robins, EDMS
- WA Primary Health Alliance – Ms Linda Richardson, General Manager
- WAGPET - Prof Janice Bell. CEO
- Rural Clinical School WA - Prof David Atkinson, Director
- Rural Health West - Ms Kelli Porter, General Manager Workforce
- Healthfix Consulting - Mr Kim Snowball, Director
- Curtin Medical School - Professor William Hart, Dean of Medicine
- WA Country Health Services - Dr David Gaskell, DMS Kimberley Region
- Broome Health Campus - Dr Sue Phillips, Senior Medical Officer
- Kimberley Aboriginal Medical Service Executive – CEO
- Nindilingarri Cultural Health Service – Ms Maureen Carter, CEO and staff, Fitzroy Crossing
- Fitzroy Crossing Hospital and Renal Dialysis Unit - staff
- Broome Aboriginal Medical Service – Dr David Atkinson and staff
- Broome Regional Hospital Junior Doctors - Meeting
- Rural Clinical School Western Australia – Broome Staff and Students, Meeting

Queensland

- Department of Health - Ms Kathleen Forrester, Deputy Director General Strategy, Policy and Planning Division
- Darling Downs HHS, Queensland Country Practice – Dr Hwee Sin Chong, Executive Director, Dr Dilip Duphelia, Director Medical and Clinical Services
- Dr Denis Lennox, Previous Director, Rural & Remote Medical Support
- Longreach Family Medical Practice – Dr John Douyere and staff
- Longreach Hospital, Dr Clare Walker and staff – Meeting and Multi-Disciplinary Ward Round
- Central West Health Service Dr David Rimmer, DMS and other Executive members
- Central West PHN, Ms Sandy Gillies, Manager and other staff
- Centre for Rural and Remote Health, James Cook University – RG trainees, Longreach
- St George Hospital – Dr Adam Coltzou, DMS, GP staff, junior doctors and students
- Darling Downs HHS – Dr Peter Gillies, CEO
- Stanthorpe Hospital – Dr Dan Manahan, DMS, Dr Dan Halliday, ACRRM Board Member, Vickie Batterham, A/DON and staff
- Stanthorpe *Medical Practitioners – GPs, Junior Doctors and Hospital Staff - Meeting*
- Warwick Hospital - Dr Blair Koppen, Medical Superintendent, Anita Bolton DON and RG trainees
- Condamine Medical Centre – Dr Lynton Hudson and Dr Brendon Evans
- Goondiwindi Hospital – Dr Sue Masel DMS Lorraine McMurtrie DON and staff
- Goondiwindi Medical Centre – Dr Matt Masel, staff, Registrars and Students, Doctors Meeting
- Dr Col Owen, Past President RDAA and RACGP, Inglewood
- University of Queensland Regional Training Hub, Dr Ewen McPhee, Director, Rockhampton
- Centre for Rural and Remote Health, James Cook University – Professor Sabina Knight, Director, Mt Isa
- Dr Tony Brown, Executive Director Medical Services, Thursday Island
- Institute *of Health Biomedical Innovation - Professor Julie Hepworth*

New South Wales

- The Hon Brad Hazzard, Minister for Health
- Dr Nigel Lyons, Deputy Secretary, Strategy and Resources, NSW Health
- Dr Linda McPherson, Medical Advisor Workforce and Planning, NSW Health
- University of Sydney - Professor Arthur D Conigrave, Dean, Faculty of Medicine,
- The Hon Dr David Gillespie MP
- NSW Rural Doctors Network Executive
- Western NSW Local Health District – Mr Scott McLaughlin and Executive
- Senator for NSW, The Hon John Williams
- National Party Room Meeting, NSW Government, Sydney
- Kevin Anderson, MP, Member for Tamworth, Tamworth
- Glenrock Country Practice, Wagga Wagga, Dr Ayman Shenouda, and Ms Tania Cotterill
- Royal Far West, Ms Lindsay Cane, Chief Executive Officer
- UNSW Rural Clinical School, Wagga Wagga – student, junior doctor and consultant meeting
- UND Rural Clinical School, Wagga Wagga – Professor Joe McGirr, Director and staff
- Dr Cheryl McIntyre, Inverell Medical Centre
- Inverell Town Rural Doctors - Meeting
- Professor Rod McClure, Dean, Faculty of Medicine, University of New England
- Molong Health Service and District Hospital
- University of Sydney Rural Clinical School, Dubbo – Student Meeting
- University of Western Sydney Rural Program leaders, Orange
- Parkes District Hospital – Staff and junior doctors meeting
- University of Newcastle Rural Clinical School, Tamworth – Prof Jenny May, Director
- GP Synergy – Dr John Oldfield, CEO
- Prof David Lyle, Broken Hill UDRH
- NSW Ministerial Advisory Committee for Rural Health, Queanbeyan

South Australia

- The Hon Mr Stephen Wade MP, Minister for Health and Wellbeing
- Department of Health and Wellbeing - Christopher McGowan, Chief Executive
- Country Health SA – Ms Maree Geraghty, CEO and Dr Hendrika Meyer, Executive Director Medical Services
- Rural Doctors Workforce Agency - Ms Lyn Poole, Chief Executive Officer,
- Flinders Rural Health SA - Professor Jennene Greenhill, Director
- University of Adelaide - Professor Ian Symonds, Dean of Medicine
- University of Adelaide – Professor Lucie Walters, Director Adelaide Rural Clinical School
- Flinders University - Professor Lambert Schuwirth, Strategic Professor in Medical Education,
- Flinders University - Professor Jonathan Craig, Vice President and Executive Dean
- Mr Rowan Ramsey MP, Federal Member for Grey
- Mr Tony Zappia MP, Federal Member for Makin
- Dr Peter Clements, Rural Generalist Educator, Adelaide
- Dr John Williams, Rural Generalist, Port Lincoln
- Dr Ben Abbot, Rural Generalist Surgeon, Jamestown
- GPEx, Ms Chris Cook, CEO

Victoria

- The Hon Jill Hennessy, Minister for Health
- Professor Euan Wallace, CEO Safer Care Victoria, Melbourne
- Mr Dean Raven, Director, and Ms Tarah Tsakonas, Senior Policy Advisor, Victorian Government Department of Health and Human Services Workforce, Melbourne

- Monash Health - Ms Rachel Yates, Principle Advisor, Innovation and Improvement
- Professor Donald Campbell, RACP
- Monash University Rural Clinical School – Professor Robyn Langham and staff, Bendigo
- Bendigo Hospital – junior doctor and student meeting, Bendigo
- Bendigo Health – Mr Peter Faulkner CEO, Bendigo
- Rural Workforce Agency Victoria, Ms Megan Cahill, CEO, Melbourne
- Western Victoria Health Accord – Meeting in Portland
- Glenelg Shire Workforce Group, Meeting in Portland
- Rural and Regional CEO Forum, Melbourne
- Prof John Humphreys, Monash University, Bendigo
- Murray to Mountains Intern Program – Mr Shane Boyer, Shepparton
- Rural Health Forum, La Trobe University and Murray PHN, Mildura
- RFDS Rural Health Sustainability Project, Mildura
- Attend Anywhere Video Consulting Programs – Mr Chris Ryan, Director, Melbourne
- Gippsland PHN, Sale
- Western Victoria PHN, Ballarat
- Echuca Regional Health, Nick Bush CEO

Tasmania

- The Hon. Michael Ferguson MP, Minister for Health, Launceston
- Department of Health - Dr Allison Turnock, Medical Director GP and Primary Care, Hobart
- HR+ Rural Workforce Agency – Mr Peter Barns CEO, Launceston
- Dr Bastian Seidel, Rural GP, President RACGP
- North West Health Service, Executive Director of Medical Services, Dr Rob Pegram
- Professor Richard Hays, Rural Medical Generalist, Hobart
- Dr Brian Bowring and Dr Tim Mooney, Rural Generalists, Georgetown

Invited Presentations on the National Rural Generalist Pathway

- NSW Rural Doctors Network Annual Conference 2017, Sydney, NSW
- Rural Medicine Australia 2017, Melbourne, Vic
- RACGP Annual Convention 2017, Sydney, NSW
- Rural Doctors Workforce Agency Annual Conference, Adelaide, SA
- WHO Global Health Workforce Summit, Plenary Presentation, Dublin, Ireland
- WONCA World Rural Health Conference, Plenary Presentation, New Delhi, India
- 6th Rural and Remote Health Scientific Symposium, Canberra, ACT
- Tasmania Rural Health Conference, Launceston, Tas
- Victorian Rural and Regional Public Health Service CEO Forum, Melbourne, Vic
- Hunter New England Professional Development Program for Doctors, Pt Stevens, NSW
- Murray to Mountains Rural Intern Training Program Annual Dinner, Shepparton, Vic
- "Are You Remotely Interested?" Conference; Realising Remote Possibilities, Centre for Rural and Remote Health, Mount Isa, Qld
- National Regional Training Hubs Forum, Canberra, ACT
- Australian Primary Health Care Research Conference, Melbourne, Vic
- Medical Oncology Group of Australia Annual Scientific Meeting, Adelaide, SA
- Griffith Rural Medicine Retreat, Griffith, NSW
- Rural Doctors' Association of South Australia Annual Conference, Adelaide, SA
- Western NSW Primary Health Workforce Planning Forum, Dubbo, NSW
- National Rural Health Student Network Council Meeting, Adelaide, SA
- Victorian Health Accord Clinical Council Conference, Melbourne, Vic
- Flinders University Regional Training Hub Launch, Mt Gambier, SA

- 10th Anniversary of the Joint Medical Program, Armidale, NSW
- National Rural Training Hubs Conference, Sydney, NSW
- Seventh Rural Health and Research Conference, Tamworth, NSW
- Central Queensland HHS Clinical Senate, Rockhampton, Qld
- Medical Deans ANZ Annual Mid-Year Meeting, Canberra, ACT
- GP Training Advisory Council, Melbourne, Vic
- RACGP Annual Convention 2018, Gold Coast, Qld
- Rural Medicine Australia 2018, Darwin, NT
- NSW Local Health Districts and Regional Training Hubs Meeting, Sydney, NSW
- Australian Medical Council AGM 2018, Launceston, Tas
- Royal Australasian College of Physicians (SA), Annual Scientific Meeting 2018, Adelaide, SA
- Prevocational Medical Education Forum 2018, Melbourne, Vic

Appendix 5.2

National Rural Generalist Taskforce, Working Groups and Expert Reference Groups membership

National Rural Generalist Taskforce members.

- Emeritus Prof. Paul Worley - Chair
- Dr Kaye Atkinson
- Dr Adam Coltzau
- Ms Marita Cowie
- Mr Jeff Moffet
- A/Professor Ayman Shenouda
- A/ Professor Ruth Stewart
- Dr Yousuf H. Ahmad
- Professor David Atkinson
- Professor Amanda Barnard
- Dr Mike Beckoff
- Mr George Beltchev
- A/ Professor David Campbell
- Dr Hwee Sin Chong
- Dr Dawn Casey
- Dr Melanie Considine
- Ms Candice Day
- Mr Mark Diamond
- Dr Rose Ellis
- Mr David Hallinan
- Dr Kali Hayward
- Dr Sandra Hirowatari
- Dr Tessa Kennedy
- Dr Martin Laverty
- Dr Belinda O'Sullivan
- Ms Carolyn Reimann
- Dr Mark Rowe
- Dr Kari Sims
- Professor Ian Symonds
- Dr Allison Turnock
- Dr Kristopher Rallah-Bake

Postgraduate Standards, Curriculum and Assessment Frameworks Working Group Members:

- A/Professor David Campbell – Co-Chair
- Dr Mark Rowe – Co-Chair
- Dr Claire Arundell
- Ms Gaby Bolton
- Dr John Douyere
- Dr Teena Downton
- Dr Catherine Engelke
- Professor Liz Farmer
- Dr Pat Giddings

- Dr Emma Kennedy
- Dr Steven Lambert
- Dr Olivia O'Donoghue
- Ms Carolyn Reimann
- Professor Tarun Sen Gupta
- Dr Kari Sims
- Professor Ian Symonds
- Dr Kenan Wanguhu
- Emeritus Professor Paul Worley

Support, Incentives and Remuneration Working Group Members:

- Dr Adam Coltzau - Chair
- Dr Allison Turnock
- Mr Peter Barns
- Dr Dawn Casey
- Dr Hwee Sin Chong
- Dr Emma Cunningham
- Ms Ashley Brown
- Ms Candice Day
- Dr Phil Gribble
- Dr Kali Hayward
- Dr Sam Heard
- Dr Sandra Hirowatari
- Mr Warwick Hough
- Ms Tanya Lehmann
- Dr Michael Clements
- Dr Peter Rischbieth
- Dr Tony Robins
- Ms Praveen Sharma
- Dr Carolyn Siddel
- Emeritus Professor Paul Worley
- Ms Peta Rutherford – Content Manager

Evaluation Working Group Members:

- Dr Belinda O'Sullivan - Chair
- Professor David Atkinson
- Ms Megan Cahill
- Professor Dean Carson
- Mr Nick Crowle
- Professor Richard Hays
- Professor Jennifer May, AM
- Ms Maureen McCarty
- Dr Matthew McGrail
- Dr Deborah Russell
- Professor Roger Strasser
- Ms Michelle Taitz
- Professor John Wakerman
- Professor Lucie Walters
- Emeritus Professor Paul Worley

Recognition Working Group Members:

- Dr Mike Beckoff – Co-Chair
- Dr Melanie Considine - Co-Chair
- Dr Yousuf Ahmad
- A/Professor Kathleen Atkinson
- Dr Ian Cameron
- Dr Hwee Sin Chong
- Mr Amran Dhillon
- Dr Benjamin Dodds
- Ms Georgina Macdonald
- Dr Peter Maguire
- Dr Ewan McPhee
- Dr Olivia O'Donoghue
- A/ Professor Shannon Springer
- Mr David Trench
- Dr Jane Greacen
- Emeritus Professor Paul Worley

Rural Local Health Network Expert Reference Group Members:

- Emeritus Professor Paul Worley - Chair
- Dr Frank Evans
- Ms Lisa Davies Jones
- Mr Steve Rodwell
- Mr Scott McLachlan
- Mr Shane Boyer
- Mr Andrew Freeman
- Ms Chris Giles
- Mr Stewart Dowrick
- Ms Jill Ludford
- Dr Nicki Murdock
- Dr Danielle Allan
- Ms Linda Patat
- Dr John Elcock
- Mr Wayne Jones
- Dr Chun Yee Tan
- Mr Michael Di Rienzo
- Dr Dale Seierup
- Dr Shannon Nott
- Dr Ka Chun Tse
- Dr David Rimmer
- Ms Jo Whitehead
- Dr Hendrika Meyer
- Ms Maree Geraghty

Rural PHN Expert Reference Group Members:

- Emeritus Professor Paul Worley - Chair
- Dr Tamsin Cockayne
- Ms Pattie Hudson
- Ms Melissa Neal
- Dr Leanne Beagley

- Mr John Gregg
- Ms Suzanne Mann
- Mr Nik Todorovski

Student and Junior Doctor Expert Reference Group Members:

- Dr Kari Sims – Chair
- Ms Carolyn Reiman – Deputy Chair
- Dr Claire Arundell
- Ms Ashley Brown
- Ms Gaby Bolton
- Ms Candice Day
- Dr Amran Dhillion
- Dr Benjamin Dodds
- Dr Tessa Kennedy
- Ms Georgie Macdonald
- Ms Davina Oates
- Dr Carolyn Siddel
- Ms Georgina Taylor
- Mr David Trench

Vertical Integration Expert Reference Group Members:

- Professor Amanda Barnard - Chair
- A/Professor. Katrina Anderson
- Professor. Janice Bell
- Mr Shane Boyer
- Ms Christine Cook
- Dr Steve Flecknoe-Brown
- Professor Jennene Greenhilll
- Dr Steve Holmes
- Dr Bek Ledingham
- Professor Jenny May
- Dr Laurie McArthur
- Professor Richard Murray
- Dr Sue Page
- Mr Steven Pincus
- Dr Simon Quilty
- Dr Richard Tarala
- Dr Phillip Truskett
- Professor Deb Wilson

Aboriginal and Torres Strait Islander Rural Health Expert Reference Group Members:

- Emeritus Professor Paul Worley – Chair
- Mr Karl Briscoe
- Dr Tammy Kimpton
- Ms Janine Mohammed
- Ms Donna Murray

Rural Consumer Expert Reference Group Members:

- Mr Mark Diamond - Chair
- Dr Martin Laverty – Deputy Chair

- Mr George Beltchev
- Ms Katherine Burchfield
- Dr Dawn Casey
- Ms Dorothy Coombe
- Dr Chris Moorhouse
- Ms Lynne Strathie
- Ms Sally Sullivan
- Ms Leanne Wells

Jurisdictional Forum Members:

- Emeritus Professor Paul Worley - Chair
- A/Professor Kathleen Atkinson
- Dr Hwee Sin Chong
- Dr Dilip Dhupelia
- Dr John Douyere
- Dr Rose Ellis
- Ms Maree Geraghty
- Dr Hugh Heggie
- Dr Claire Langdon
- Dr Linda MacPherson
- Dr Hendrika Meyer
- Mr Jeff Moffet
- Dr David Oldham
- Ms Tarah Tsakonas
- Dr Allison Turnock
- Ms Lorraine Wright

Appendix 5.3

Advanced, additional skills overlapping with other specialties or fields of specialty practice

Advanced/ additional skill	Overlap with specialty or field of specialty practice	Required knowledge, skills and competencies	Differentiation from existing specialties	Link to curriculum statements.
Aboriginal and Torres Strait Islander Health	There is no current specific overlap with another medical specialty or field of speciality practice though other medical specialties cover Aboriginal and Torres Strait Islander Health in their curricula and training programs. Registrars are encouraged to consider working towards related academic qualifications in Aboriginal and Torres Strait Islander Health including completion of Graduate Certificate, Graduate Diploma, or Masters level qualifications in public health, or a related area.	RG Clinical training in Aboriginal and Torres Strait Islander Health requires a minimum 12 months full time or equivalent part time training and will be undertaken as an AST or ARST in an Aboriginal Community Controlled Health Service (ACCHS) in rural or remote Australia. The aim of this ARST / AST curriculum is to outline the knowledge and skills that an RG requires to work appropriately and effectively with Aboriginal and Torres Strait Islander peoples. The focus of this curriculum is how the RG works with Aboriginal and Torres Strait Islander peoples within the context of their culture, family and community. This AST / ARST training post can be an Aboriginal Community Controlled Health Service (ACCHS), or another health service where patients are predominantly Aboriginal and Torres Strait Islander peoples. The training post will be under the supervision of a RG who holds either fellowship of a GP College and is experienced in Aboriginal and Torres Strait Islander health, plus a cultural educator and/or mentor that is known, respected and accepted by the community and the specific health service. The cultural educator and/or mentor is an important link between the registrar and Aboriginal and Torres Strait Islander patients and their communities. Essential knowledge required.	Aboriginal and Torres Strait Islander Health is covered in RACP Advanced Training in Public health Medicine. https://www.racp.edu.au/docs/default-source/default-document-library/public-health-medicine-advanced-training-curriculum.pdf?sfvrsn=77252c1a_4	RACGP Curriculum statement: https://www.racgp.org.au/FSDEDEV/media/documents/Education/FARGP/Advanced-Rural-Skills-Training-(ARST)-Curriculum-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf ACRRM Curriculum statement: https://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/curriculum-advanced-specialised-training-aboriginal-and-torres-strait-islander-health.pdf?sfvrsn=145d86eb_4

		Recognises the social, cultural, historical, economic and political framework that has influenced the current health status of Aboriginal and Torres Strait Islander people, including: • The known characteristics of the pre-colonial health status of Aboriginal and Torres Strait Islander people • Major current mortality and morbidity patterns of Aboriginal and Torres Strait Islander people compared to the Australian population as a whole, particularly in relation to: fertility rate, life expectancy, maternal mortality, infant mortality, age specific mortality and morbidity • Major regional differences in mortality and morbidity patterns • Common age and sex specific causes of morbidity, mortality, clinic presentation and hospital admission for local Aboriginal and Torres Strait Islander people, linking them with the associated socio- economic, cultural and environmental factors. Knows an overview of colonisation in Australia including: • the term 'Terra Nullius' and its significance • cultural revitalisation • the background underlying colonisation in Australia • the process of colonisation • the resistance of Aboriginal and Torres Strait Islander people to colonisation. Knows an overview of the history of Australian government regulation in relation to Aboriginal and Torres Strait Islander people including: • segregation and protection policies, 'smoothing the dying pillow' to 'training for citizenship'		

		• assimilation, removal of children, the 'stolen' generation • contemporary policies, community empowerment, self-determination, the growth of Indigenous organisations • land rights • reconciliation Recognises the contemporary socio-cultural characteristics of Indigenous communities including: • family organisation, extended family • patterns of reciprocity and decision making • social distance from non-Aboriginal and Torres Strait Islander people • folklore and identity Defines the term 'cultural safety' and the application of culturally safe principles to health service delivery, including: • the importance of, and connection between, cultural safety, recognition of cultural diversity among Aboriginal and Torres Strait Islander peoples and self-determination • racism and the impact of racism on the health and the delivery of health care to Aboriginal and Torres Strait Islander peoples • strategies to maintain culturally safe practice • the concept of community held by Aboriginal and Torres Strait Islander people and appropriate protocols for consultation. Identifies the issues involved in communicating cross-culturally, including: • the different communication styles of Aboriginal and Torres Strait Islander people • communication cues from Aboriginal and Torres Strait Islander people particularly in relation to:		

		gender issues in the patient/doctor relationship, body space and touching, questions about initiation marks, limitations on questions about sexual organs, lore and about other people • the barriers to effective communication between doctors, other staff and community members including: socio-economic background, cultural issues, language, health beliefs, lore, authority figures, anticipation of approval from whites, gender • the concept of culture shock Knows the living picture of the population and distribution characteristics of Aboriginal and Torres Strait Islander people, including: • the population of Aboriginal and Torres Strait Islander people relative to the whole population, pre- and post-colonisation • major features of the distribution of Aboriginal and Torres Strait Islander people, nationally, in each state, rural–urban distribution, in his/her own region, town, community • demography of the Indigenous population in terms of age and gender • the broad diversity of backgrounds and lifeways of Aboriginal and Torres Strait Islander people Describes current social and economic inequities experienced by Aboriginal and Torres Strait Islander people and the link between socio-economic factors and health status, including: • employment status, education status, economic status, housing status, access and standard of environmental infrastructure • barriers to accessing primary, secondary and tertiary health services		

		• the social and economic determinants of health and mechanisms by which these act Identifies the elements, concepts and activities of Primary Health Care, including: • the shared characteristics of the primary health care model and the concept of health held by Aboriginal and Torres Strait Islander people • the principles of primary health care to his/her clinical practice • how preventive health care, including health promotion and environmental health issues can be an integral part of clinical practice relevant to the health of Aboriginal and Torres Strait Islander people. Describes barriers to health care and services in the local community, including: • access to services • alienation by culturally inappropriate or even hostile health services • overt or structural racial discrimination • health impact of dispossession • administrative issues, such as: entitlement cards, transport policies • cultural and emotional importance of connection to land and community • limited verbal understanding and literacy in English. Knows the evolution, philosophy and characteristics of health service delivery for Aboriginal and Torres Strait Islander people, including: • the types, quality and effectiveness of western-style health services provided prior to the Aboriginal community-controlled health services movement		

		• social and health conditions that underpin the evolution of community-controlled health services • the philosophy of community controlled health services • 'self-determination' as it is exercised in the context, operation and activity of community-controlled health services • community-controlled organisations in their local area and the services they provide • the relationship between government health agencies and community-controlled health services, nationally, regionally and locally • concepts of social justice, equity of health outcomes, and health rights in relation to Indigenous health care provision • the integral role of intersectoral and interprofessional collaboration and the function of Indigenous and Torres Strait Islander health workers in facilitating effective care of the individual and the community Knows links between early childhood development and the early origins of chronic disease, including: • providing appropriate advice and management for conditions that affect normal childhood development and education, such as otitis media, urinary tract infections, intestinal conditions, skin conditions and upper respiratory infections • providing nutritional advice appropriate to the child's age, food supply, family income and social situation • providing regular antenatal care, including intervention and follow up for common conditions of pregnancy such as urinary tract infections, hypertension, anaemia and poor weight gain		

		• showing an understanding of the importance that remote Aboriginal and Torres Strait Islander mothers may place on delivering their babies on their homelands • identifying and following up children at risk • participating in childhood immunisation programs. Describes the epidemiology of rural and remote Aboriginal and Torres Strait Islander communities, including: • patterns and prevalence of disease • public health issues, infectious diseases and their spread. Knows public health issues relevant to rural, remote and Aboriginal and Torres Strait Islander communities, including: • infrastructure, public health surveillance and procedures • disease control initiatives, environmental health issues • water, sewerage systems, other waste disposal, water testing, disease control arrangements, dogs and other environmental factors • power supply and generator maintenance. Understands the roles of Aboriginal and Torres Strait Islander employees and health workers in the ACCHS or other employer organisations. Aware of own strengths, values and vulnerabilities in maintaining a personal and professional balance in a cross cultural, rural and remote context. This includes: o knowing and respecting cultural and professional boundaries o caring for patients who might also be friends, family or colleagues		

		o being critically self-reflective, with a demonstrated capacity to learn from mistakes through reflection and feedback o undertaking critical incident debriefing as required o identifying personal support mechanisms o recognising personal and emotional limitations o developing and using a plan to take appropriate steps to ensure self-preservation, including taking regular time out.		
Adult and internal medicine	There is overlap with RACP training in Adult Internal Medicine which is a minimum of a six-year training program to become a Physician. This program includes a broad exposure to a comprehensive range of discipline areas that can be further developed during a subsequent Advanced Training program. Learning occurs primarily in the workplace, supported and supervised by consultants and peers. RACP program: https://www.racp.edu.au/trainees/basic-training/adult-internal-medicine	The RG / rural GP is usually the first line service provider for any health problems which may arise. RGs in small rural towns have limited access to tertiary hospitals, so often need to be able to manage a patient throughout the primary and secondary stages of medical care, while at the same time being aware of their own limitations. They are often confronted with challenging health problems in relatively isolated areas without immediate specialist backup. The health status of people in rural communities is below the national average as measured by most indicators of mortality and morbidity. Preventable medical conditions, particularly cardiovascular disease and cancer constitute two of the major causes of death in Australia. A large part of the usual daily workload of the RG / rural GP is in the area of adult internal medicine It is envisaged that with better training in Adult Internal Medicine, RG / rural GPs will be more competent and confident in this area and better able to cope with working in isolation. In many rural and remote areas there are large populations of Aboriginal children and whose health needs are greater than those of the wider community. RGs and rural GPs frequently advise	An AST / ARST is designed to augment core training by providing opportunities to develop more specialised and/or a broader range of knowledge and skills to meet the needs of rural communities. During additional skills training, a balance is struck between the training needs of the individual and the service needs of the community in consultation with the registrar's supervisor and training adviser. Prior to undertaking an ARST / AST the registrar will have had previous experience in hospital settings and community practice under supervision. As they advance through the training program, candidates benefit from feedback, formative assessment, and encouragement to become self-directed in their approach to learning.	RACGP Curriculum statement: https://www.racgp.org.au/FSDEDEV/media/documents/Education/FARGP/Adult-internal-medicine-ARST-curriculum-statement.pdf ACRRM curriculum statement: https://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/curriculum-ast-adult-internal-medicine.pdf?sfvrsn=1c5d86eb_2

		on public health and community health issues, and require additional knowledge in these areas, and the principles of social justice. The advanced rural skills Curriculum Statement in Adult Internal Medicine has been developed in response to the identified training needs of existing or potential RGs and the needs of rural communities for RGs with advanced skills. The development of knowledge and skills in Adult Internal Medicine is seen as an essential element of the core general practice training program. In addition, rural GPs can improve their ability to serve their rural communities by undertaking relevant advanced skills training as reflected in this Adult Internal Medicine Curriculum Statement. The learning objectives reflect the context of the working in a rural environment whether it be as a rural doctor working in a large rural town with tertiary support or in a one-doctor community in a geographically isolated area. The objectives identify the competencies which all GPs require to deal effectively with Adult Internal Medicine in rural general practice. Essential knowledge required □ Knows aetiology, pathogenesis, incidence, prevalence and where relevant trigger factors or causes of common or important medical conditions and infections □ Recalls signs and symptoms of common or important medical conditions and infections □ Understands appropriate initial pharmacological and non-pharmacological treatment of common or important medical conditions and infections, and can access up to date and evidence-based	At the completion of rural pathway training, registrars will have appropriate experience in the core curriculum areas of acute medical and traumatic conditions, obstetrics, medicine, mental health, aboriginal health, and child and adolescent health which link to advanced rural skills training. This experience may be obtained in an integrated manner in rural hospitals and practices or as hospital terms in these disciplines. Candidates may choose to specialise in certain procedural disciplines, such as emergency medicine, anaesthetics, surgery, obstetrics, or in the non-procedural disciplines of adult internal medicine, child and adolescent health, mental health, and aboriginal health. The training is designed to meet the professional accreditation standards of the RACP and RACGP. The training also reflects the scope of clinical practice required for credentialing and privileging to enable doctors to work as visiting medical officers in State Government rural health services. The ARST curriculum statement in Adult Internal	

		treatment recommendations from online resources □ Selects, locates and follows national evidence based and consensus guidelines for common medical conditions □ Understands the indications, contra-indications and techniques for a range of diagnostic investigations and the ability to arrange and interpret their results. These include but are not limited to: o medical imaging studies – X-ray, CT, MRI, Ultrasound and Nuclear medicine o blood tests o coronary angiography o echocardiography o exercise testing o Holter monitoring o endoscopy, including colonoscopy and ERCP. o bronchoscopy o polysomnography □ Knows appropriate use of a wide range of drugs, including but not limited to drugs used for: o anticoagulation o thrombolytic therapy o inotropic therapy o disease modifying anti-rheumatic drugs (DMARDs) o insulin therapy o chemotherapy o advanced palliative care Essential skills required □ Rebreathing mask □ CPAP/BIPAP □ Spirometry and peak flow measurement □ Nebulisation therapy	Medicine has been developed in response to the identified training needs of existing or potential rural general practitioners and the needs of rural communities for GPs with advanced skills. The curriculum statement assumes that through previous experience and training, candidates have already developed diagnostic skills for the management of acute and traumatic conditions. Consequently, the content of the curriculum focuses on the more complicated management of conditions in the rural context. The way in which the Adult Internal Medicine ARSP extends the breadth and depth of the core curriculum is described in detail in the full curriculum statement. Training for the AST / ARST year in adult internal medicine may be undertaken across one or more posts. An appropriate post or combination of posts must be prospectively accredited. Such posts must have the caseload and teaching capacity to provide appropriate experience and training in a sufficient range of general and sub-specialty AIM	

		□ Supplemental oxygen delivery devices □ Oxygen concentrators □ Pleural tap/drainage □ Orogastric tube insertion □ Nasogastric tube insertion □ Intercostal catheter □ Thrombolytic therapy □ Lumbar puncture □ Arterial blood sampling □ Ascitic tap □ Pericardiocentesis □ Urtheral catherisation on a male □ Suprapubic catheterisation □ Oxygen saturation monitoring □ Defibrillation □ Synchronised DC cardioversion □ Mechanical ventilators □ Reduction tension pneumothorax □ Adult sedation Desirable skills It is recommended that registrars develop skills relevant to the needs of the community, for example □ Endoscopy and colonoscopy (fulfilling the requirements of the Conjoint Committee of the Gastroenterological Society of Australia (GESA)) □ Ultrasound □ Echocardiography □ Haemo and peritoneal dialysis □ Bone marrow biopsy	conditions to meet the requirements of this curriculum. To achieve the curriculum outcomes, it may be necessary for a registrar to split his/her training between more than one post. It may also be necessary to undertake one or more short-term secondments to learn specific skills. Appropriate posts would have the following features: □ inpatient care facilities □ outpatient and community-based care □ registrar employed as Principal House Officer or equivalent □ on-call or after-hours services □ at least one resident general physician full-time or Visiting Medical Officer □ meets RACP requirements for basic training in general medicine □ ideally in a rural or regional location. Adult internal medicine is a very broad discipline, with approximately 20 sub-specialty areas. It is not possible for any registrar to gain extensive experience in more than a few of these areas during an AST year. Some posts will provide greater depth in a particular sub-	

			specialty, while others will provide greater breadth of experience across different sub-specialties. It is desirable to spend at least part of this training year in a 'general medicine' specialty post. Similarly, hospital-based posts will give greater experience in acute AIM presentations whereas outpatient or community facilities will give greater experience in the ongoing management of complex and chronic disease. It is highly desirable for registrars to gain experience in both of these areas. The following are examples of posts that would be valuable to include and as a component of training: Acute Medicine Units, Renal Units, Diabetic Clinics, Respiratory Clinics, Palliative Care and Geriatric. A teaching post accredited for RACP for basic / advanced physician training will generally be suitable but must also gain accreditation for AST AIM training. Institutions with established educational links to other institutions and involvement with undergraduate teaching and other vocational	

			training would be highly desirable.	
Anaesthetics	There is specific overlap with the medical specialty of anaesthetics delivered by the Australian and New Zealand College of Anaesthetists (ANZCA). The Joint Consultative Committee on Anaesthesia (JCCA) is a tripartite committee with representatives from ANZCA, RACGP and ACRRM. This training aims to broaden the skills and capacity beyond the standard scope of general practice training to meet the community needs of the diverse Australian geography and population distribution. The JCCA has a CPD program previously known as the Maintenance of Professional Standards (MOPS) program. It enables general practitioners providing anaesthesia services in rural general practice to maintain their skills and knowledge in anaesthesia. Many hospitals insist on participation as a requirement for ongoing credentialing.	The JCCA supervises and examines RG registrars from the RACGP and ACRRM who are completing a 12-month Advanced Rural Skills Training (ARST) post or Advanced Specialised Training (AST) post in anaesthesia. The JCCA is in part based on servicing large areas of Australia where there will always be a requirement for GPs to be administering anaesthesia (mainly small rural towns and provincial cities). The learning outcomes for Australian rural practice varies from working in a large regional town or small city with some tertiary support to a single doctor community which may be geographically isolated in extreme conditions. Some of these objectives are not exclusive to RG anaesthesia practice but are universal to any medical practice. The JCCA registrar will be able to: **Communication skills and the patient-doctor relationship** **Applied professional knowledge and skills** » develop the clinical skills required to competently manage safe anaesthesia practice in a rural RG setting » use and maintain a range of equipment required for general anaesthesia and monitoring » induce and maintain unconsciousness and provide intra-operative analgesia » administer and reverse muscle relaxation safely » administer local, topical and regional anaesthesia » provide post-anaesthesia care » manage acute pain and chronic cancer and non-cancer pain	The Scope of Practice for GPs providing anaesthesia service will always be dependent upon the knowledge, skills and capabilities of the individual practitioner and subject to local infrastructure and jurisdictional credentialing. In the context of rural and remote medicine, GPs providing anaesthesia service are called upon to provide a range of services to meet the individual needs of their communities. As a general guideline, an RG providing anaesthesia services should only be considering patients who are in the ASA 1 (normal healthy patient) and ASA 2 (mild systemic disease) categories. In some situations, following appropriate assessment, patients in the ASA 3 (patients with severe systemic disease) category may be considered. Patients in the ASA 4, ASA 5 and ASA 6 categories should only be considered by a specialist anaesthetist. The purpose of the grading system is simply to assess the degree of a patient's 'physical status' prior to selecting the anaesthetic or prior to performing surgery. Describing	https://www.racgp.org.au/FSDEDEV/media/documents/Education/FARGP/JCCA-Curriculum-for-General-Practitioner-Anaesthesia-5th-Edition-2018.pdf

		» effectively manage patients of all ages suffering from cardiac or respiratory arrest » stabilise, support and organise safe transportation for the critically ill patient » demonstrate an ability to predict pre-operative, intra-operative and post-operative anaesthesia risks, consulting with a specialist anaesthetist and referring when necessary. **Professional and ethical role** » demonstrate an understanding of the particular need and difficulties in maintaining confidentiality in small communities » develop skills in balancing the caseload and demands of working in isolation in a rural practice with social and personal responsibilities » develop a commitment to continuing self-directed learning and professional development sufficient to provide quality anaesthesia care » demonstrate awareness of current ANZCA standards for anaesthesia practice (College Professional Documents) and act in ways consistent with these standards **Organisational and legal dimensions** » outline legal responsibilities regarding notification of disease, birth, death and autopsy, and related documents.	patients' preoperative physical status is used for recordkeeping, for communicating between colleagues, and to create a uniform system for statistical analysisThe JCCA Curriculum for General Practitioner Anaesthesia Fifth Edition 2017 replaces the JCCA Curriculum Statement in Anaesthesia (CSA) for Advanced Rural Skills Training (ARST) post or Advanced Specialised Training (AST) Fourth Edition 2010. The curriculum is the academic basis for training of general practitioners who wish to provide anaesthesia services. A doctor undertaking this training is hereinafter referred to as a JCCA registrar. As from 1 January 2018 the JCCA's statement of completion of training has a currency of three years, dependent on successful completion of the JCCA CPD Standard.	
Advanced Emergency Medicine	By its nature, the practice of emergency medicine has considerable overlap with a number of other specialist disciplines, particularly anaesthetics, surgery, orthopaedics, internal medicine and paediatrics. Acute aspects of most	The ARST / AST in Advanced Emergency Medicine will build upon the emergency medicine learning outcomes of the Curriculum for Australian general practice 2016. Completion of a minimum 12 months AST is an essential component of training towards RG Fellowship. Advanced Emergency Medicine (AEM) is a key priority area due to the relative isolation in which rural or remote doctor's practise and,	The Advanced Emergency Medicine curriculum is designed to provide RG registrars with the skills, knowledge and confidence to provide quality emergency medicine in rural and remote communities. Undertaking ARST enables registrars to develop and extend their expertise in a	RACGP Curriculum statement: https://www.racgp.org.au/FSDEDEV/media/documents/Education/FARGP/Advanced-Rural-Skills-Training-–-Curriculum-for-Emergency-Medicine.pdf

	disciplines have relevance to the practice of emergency medicine. The FACEM Training Program is a five-year training program. It can be undertaken on a full-time or part-time basis. The training program includes structured training and education, work-place based assessments, research requirements and examinations. The RG program is a 12-motn program.	therefore, the need to manage a wide range of emergency situations with a high degree of autonomy. RG registrars are expected to be able to: • Initially stabilise Australian Triage Category 1 and 2 patients with the support of an experienced colleague (which may be through distance technology) pending definitive emergency medical care, and • Competently provide definitive emergency medical care for most Australian Triage Category 3, 4 and 5 patients and determine when required. This AEM curriculum builds on the emergency medicine component of the ACRRM and RACGP training programs. It focuses on the additional knowledge and skills required for advanced practice in emergency medicine. RGs are required to be able to: • Competently provide definitive emergency medical care including emergency medicine procedural interventions for individual patients across all presentations including Australian Triage Category 1 and 2. RG emergency medical practitioners may be involved in patient care activities ranging from the pre-hospital environment to emergency department assessment and stabilisation, as well as ongoing management that may include safe transfer to the next level of medical care. Characteristics of rural and remote settings and their impact on emergency medicine that need to be considered include the differences when compared with metropolitan settings in: • Prevailing social attitudes to health, illness and health care	particular area and/or expand their generalist skill set, and enhance their capability to provide secondary-level care to their community. The provision of emergency medicine in rural and remote areas of Australia is often undertaken by GPs due to the limited staff and resources available and the logistical and geographical difficulties of evacuating the seriously ill. The completion of an ARST in emergency medicine will provide RG registrars with the skills and confidence to manage emergency situations in the relative isolation in which they may operate. It also ensures that communities have access to appropriate skills and services through their GP. The minimum period of time required for AST / ARST in AEM is 12 months full-time or equivalent part-time. RG candidates are required to successfully complete three emergency courses covering the following types of emergencies: trauma, adults and paediatrics. The following courses are approved as suitable for AST Emergency Training: • Trauma	ACRRM Curriculum statement: https://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/curriculum-advanced-specialised-training-emergency-medicine.pdf?sfvrsn=385d86eb_2

		• Incidence and prevalence of emergency medical conditions • Aboriginal and Torres Strait Islander Peoples Health • Access to physical resources including investigations, medications and treatments • Access to specialist services • Selection criteria, protocols, principles, limitations and interpretation of results of the tests listed in skills section • Features of congenital and acquired conditions that may predispose patients to emergency presentations or complicate emergency management including; congenital heart disease, congenital maxillofacial and other anatomical abnormalities, acquired anatomical abnormalities • Diagnostic features and initial management of uncommon conditions which may have potentially serious consequences • Risk factors for secondary injuries in emergency patients, discuss strategies for reducing these risks, and outline appropriate management for secondary injuries if these occur: renal failure, cardiac failure, adult respiratory distress syndrome (ARDS), disorders of coagulation, cerebral hypoxia, multi-system failure, sepsis and neurovascular compromise. • Anaesthetics and analgesic decision-making and delivery. This includes the factors involved in making difficult anaesthetics decisions – neonates, young children, elderly, shock, obesity, co-morbidities and burns • Clinical and medico-legal requirements for management of physical and/or sexual assault cases, including:	o Early Management of Severe Trauma (EMST), or o Emergency Trauma Management Course (ETM) • Adult: o Rural Emergency Skills Training (REST), or o Adult Life Support Australian Resuscitation Council Level 2 (ALS2), or o Emergency Life Support (ELS), or o Advanced and Complex Medical Emergencies (ACME), or o Effective Management of Anaesthetics Crises (EMAC) • Paediatrics: o Advanced Paediatrics Life Support (APLS) course, or o Advanced Paediatric Emergency Medicine course (APEM).	

		o sexual assault examination and specimen collection o recognition of non-accidental injury patterns in children and domestic partners o understanding the coronial investigation process o writing medico-legal reports o giving evidence in court, and / or o treatment of minors and persons in custody • Principles of triage and their application to emergency situations. • Knowledge of the Australasian Triage Score and its application to the clinical setting • Potential complications (including possible treatment failure) of the emergency procedures and definitive therapies • Signs and symptoms of these complications and outline appropriate rescue plans. This includes: o post-procedural complications – thromboembolism, vascular insufficiency, infection, wound breakdown, perforation/obstruction, mechanical failure, pneumothorax, spinal headache, renal failure o complications of therapeutics – allergy/anaphylaxis, toxicity, drug interactions, GI bleeding, dystonic reactions, neuroleptic malignant syndrome, transfusion reactions, over-hydration, over-anticoagulation o complications of dialysis. Epidemiologic characteristics, prevention and control measures for infectious disease outbreaks, including: o immunisation and post-exposure prophylaxis o community epidemics o nosocomial outbreaks		

		o tropical and exotic infections o sexually transmitted infections. Principles for disaster prevention, preparedness, response and recovery in rural and remote communities • Principles of injury prevention in rural and remote contexts and demonstrate the ability to implement an injury prevention program • Epidemiologic characteristics and prevention and control measures for infectious disease outbreaks in small isolated communities • Ethical issues around end of life presentations (either medical, surgical, oncological, geriatric based or trauma).		
Mental health	Psychiatry. President of the Royal Australian & New Zealand College of Psychiatrists (RANZCP), Professor Malcolm Hopwood provided a letter expressing the colleges' support for the Mental Health curriculum, in recognition that the program: □ Has been developed with the benefit of collaborative engagement with our college. □ Is designed to develop competencies that will enable high quality healthcare provision including skills that will enable the participating doctors especially in rural and remote areas to work	The purpose of the Mental Health curriculum is to assist in delivery of mental health services in rural and remote communities by fostering advanced mental health training among rural and remote RG registrars. The curriculum defines the advanced skills that will enable RGs to offer enhanced mental health services to their communities, and provide an advisory resource in mental health to other GPs. This curriculum targets RGs who are undertaking an AST / ARST training year in mental health. It recognises that mental health skills are fundamental to all types of rural and remote general practice. Therefore, training in mental health is relevant to RGs wishing to work in any rural or remote setting. Training requirements: Clinical training in mental health requires a minimum 12 months full time or equivalent part time training.	Mental health is a priority area for rural and remote GPs due to: □ the high incidence of mental health conditions in rural and remote areas □ the high morbidity and mortality associated with mental health conditions □ the different case-mix of mental health conditions in rural and remote areas □ the specific challenges of mental health care delivery in rural and remote settings. The famous WHO-sponsored international study "Mental Illness in General Practice" found that Mental health presentations are very common in general practice, with up to 30% of all GP presentations involving an	ACRRM Curriculum statement: https://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/curriculum-advanced-specialised-training-mental-health.pdf?sfvrsn=205d86eb_8 RACGP Curriculum statement: https://www.racgp.org.au/FSDEDEV/media/documents/Education/FARGP/Advanced-Rural-Skills-Training-–-Curriculum-for-Mental-Health.pdf

	effectively with psychiatrists to deliver mental healthcare. Is designed to develop the best practice skill set for meeting the needs of the communities in which the registrars are expected to serve. It is recognised that in rural and remote areas these doctors practise in relative geographical isolation from psychiatrists and a wide range of psychiatric speciality services and resources. In these contexts, best practice may involve acquiring a range of skills and competencies not typically required in general practice in major cities. Is designed to ensure that the health service needs of priority groups such as rural and remotely based people and especially Aboriginal and Torres Strait Islander people living in these areas are acceptably met.	RGs undertaking an AST / ARST in mental health are required to satisfactorily complete the following course: an GPMHSC approved Level 2 Mental Health Skills course and Essential knowledge required Knows an overview of the history of development of psychiatry and theories of personality Understands national mental health priorities and their application to rural/remote medical practice Knows the social, cultural, ethical, geographical, and environmental characteristics of rural/remote communities that have an impact on the presentation and management of mental health problems Basic understanding of the aetiology and pathogenesis of mental health disorders, including: depression (major and adjustment disorder), anxiety disorders (generalised anxiety disorder, acute stress disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder), sleep disorders, personality disorders, psycho-geriatrics (dementia, depression, delirium), psychoses (bipolar, unipolar, schizophrenia, toxic and organic brain disorders), substance misuse Understands the national and state legislation that relates to mental health Defines the nature, natural history, incidence and prevalence of mental health disorders across the lifespan and current psychiatric diagnostic classification systems Understands and has knowledge of multi-axial diagnostic systems and dual diagnosis conditions,	underlying or co-morbid mental health condition. This seminal study of mental illness in primary care concluded that “contrary to the widely held belief that mental disorders seen in general practice are of minor significance, they are a major public health problem and cause a great burden on individuals, their families, health care services and society”. Subsequent major studies internationally and in Australia have confirmed and extended these findings particularly in respect of the extent of the morbidity and disability involved. Mental Health morbidity is high in rural and remote areas and the patterns may vary from urban practice. Aspects of mental health care delivery in rural and remote regions also differ, or differ in emphasis, from that in urban areas. These include: distance to specialist treatment and the consequent variation of treatment algorithms shared care concepts – local mental health teams and mental health nurses used a lot more – teamwork very important dynamics of small communities – confidentiality, trust and stigma	

		including physical co-morbidities, patients with persistent pain, and co-morbid substance use Understands Recovery concepts and ideas: o Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about the person having control over and input into their own life; o Recovery does not necessarily mean 'clinical recovery' (usually defined in terms of symptoms and cure) - it does mean 'social recovery' – building a life beyond illness without necessarily achieving the elimination of the symptoms of illness; o Recovery is often described as a journey, with its inevitable ups and downs, and people often describe themselves as being in Recovery rather than Recovered. Understands of the role of opioid substance treatment and its role with respect to illicit drugs, over the counter codeine containing medications and prescription narcotic misuse and abuse Understands and has knowledge of behavioural addictions for example gambling, internet and gaming Understands and identifies the various forms of help-seeking behaviour including abnormal illness behaviour and manipulative behaviour Describes a range of psychotherapeutic techniques appropriate for use in general practice Understands the major drug classes of pharmacotherapeutics for the treatment of mental health disorders Understands the principles of safe and effective pharmacotherapy, including: o patient education o patient adherence strategies and monitoring; o requirements for informed consent.	fluctuating demographics in rural/remote settings professional isolation. This curriculum has been developed with these factors in mind.	

		▯ Knows principles of management for complex pharmacotherapeutic scenarios, including: o serious adverse effects – acute and long-term o poly-pharmacy o treatment resistance o prescribing for children and adolescents o prescribing for pregnant and breastfeeding women. ▯ Sophisticated understanding of the range of counselling and psychosocial therapies available and high-level skills in selection of appropriate counselling and psychosocial therapeutic techniques and application of some of the following techniques: o patient education o supportive psychotherapy / expressive supportive continuum; o bereavement counselling; o general counselling o structured problem solving o motivational interviewing; o cognitive behaviour therapy (CBT); o inter-personal therapy (IPT); o family therapy and marriage counselling. ▯ Recognises the relevance of developmental stage on mental health ▯ Understands the importance of family issues/dysfunction and the broader social context ▯ Knows appropriate strategies and techniques for teaching mental health approaches to junior doctors and other health professionals ▯ Understands the nature and management of mental health issues in rural/remote areas. For example: o suicide in farmers o indigenous mental health o drug/alcohol issues o fly-in fly-out workers. Essential skills required: ▯ Communicate with patients in a respectful, empathic and empowering manner ▯ Use effective active/empathic listening		

		▯ Interpret non-verbal language ▯ Conduct a mental health status examination ▯ Assess suicide risk It is strongly recommended that candidates undertake an academic program in mental health or addiction medicine to support the acquisition of appropriate theoretical knowledge. The requirements for the ARST curriculum must be completed in 12 months (full-time equivalent) in an accredited training post, in accordance with the vocational standards and requirements published by the RACGP. The ARST / AST post must be in an accredited mental health facility (usually attached to a hospital) in a metropolitan, regional or rural setting. The training post will be under the supervision of a rural GP supervisor/mentor, medical educator and a clinical psychiatrist who is a Fellow of the RANZCP. The clinical psychiatrist provides the candidate with a source of clinical expertise, advice and educational support. The rural GP supervisor/mentor is a source of advice on training in the broader context of rural general practice, as well as a professional role model and mentor.		
Obstetrics	RANZCOG, RACGP and ACRRM are committed to improving access to high quality health outcomes for women of Australia and New Zealand. With this commitment comes an acknowledgement that these services are delivered not only by specialists, but a range of medical practitioners that require the clinical	The Women's Health curricula have been developed by the Conjoint Committee for the Diploma of Obstetrics and Gynaecology (CCDOG). The curricula are presented as a progressive framework of knowledge and skill competencies, designed to guide and support the training of medical practitioners offering care in women's health in Australia in general practice and hospital settings. The RANZCOG Women's Health curricula and educational objectives are specified to provide	The intention of the RANZCOG's Women's Health curricula still remains to enable the training of RGs, GPs and career hospitalists providing women's healthcare services to be professionally responsive to evolving healthcare needs of women and infants in urban and rural settings. The objective of the curricula is to equip medical professionals	https://www.racgp.org.au/FSDEDEV/media/documents/Education/FARGP/Certificate-of-womens-health.pdf https://ranzcog.edu.au/training/certificate-diploma/handbook-curriculum

	expertise, academic abilities and professional qualities necessary to provide these services with confidence, particularly in locations without a tertiary hospital or where specialist assistance is remote. As such, the Certificate of Women's Health, Diploma of the RANZCOG (DRANZCOG) and the DRANZCOG Advanced are offered by the RANZCOG for medical practitioners practicing in all areas of Australia to equip them for practice to enable the delivery of high-quality health outcomes for women.	clear information of the knowledge and aspects of practice where competency is expected and assessed. Competency is achieved through an incremental process of learning and development, so the curricula indicate ways in which learning might be promoted within the learning domains of Clinical Expertise, Academic Abilities and Professional Qualities. Fellows, Diplomates and Certificants of the RANZCOG who supervise the training of women's health practitioners are crucial to this process, in guiding day-to-day learning and ensuring robust growth of the profession. DRANZCOG Advanced This is a hospital-based training program. It is intended for medical practitioners who have gained skills in obstetrics through the DRANZCOG and who wish to develop them to a level that will enable them to safely undertake complex deliveries and perform more advanced gynaecological procedures. The DRANZCOG Advanced is a re-certifiable qualification that involves participation in appropriate Continuing Professional Development. The Diploma Advanced subject areas include: o DRAV1 Advanced Obstetrics: caesarean delivery, management of obstetric complications o DRAV2 Advanced Gynaecology: basic pelvic laparotomy, hysteroscopy o DRAV3 Ultrasound: first trimester scanning, late pregnancy scanning. There is a clinical component involved that requires a trainee to be in an accredited hospital position with two designated RANZCOG-accredited Training Supervisors in order to undertake the DRANZCOG Advanced.	offering care in women's health with a comprehensive learning program appropriate to the healthcare needs of women in a country that comprises a diversity of cultural and indigenous populations. This learning program enhances and builds upon pre-existing knowledge and skills.	

		DRANZCOG Advanced Training and Assessment Requirements include: □ All requirements of the DRANZCOG or, if previously completed, ongoing recertification of the DRANZCOG □ Procedural requirements as listed in the DRANZCOG Advanced Logbook, including signoff by appropriate Assessors, the Training Supervisors and the State Reference Committee Chair □ Workplace-based Assessments (WBAs), as listed in the DRANZCOG Advanced Logbook □ Five (5) Case Syntheses on a range of obstetric conditions □ Complete the DRANZCOG Advanced Oral Examination.		
Palliative care	There is a cross over with the RACP Training Program in Palliative Care. Doctors training in Palliative Medicine practice a depth of specialty training in the management of patients with active, progressive and far-advanced disease, for whom the prognosis is limited and the focus of care is on their quality of life. Registrars train for at least 6 years under supervision and prepare for independent practice as a consultant. The WHO defines palliative care as: 'An approach that improves the quality of life of patients and their families	AST / ARST in palliative care requires a minimum 12 months full time or equivalent part time training. The training may be undertaken in two or more blocks. The specific knowledge, skills and attributes for Palliative Care for a Rural Generalists registrars undertaking AST / ARST are required to demonstrate the following knowledge, skills and attributes, Knowledge Core • Discuss the aims of Palliative Care • Identify patients at risk of dying in the next 12 months who may benefit from a Palliative Care approach • Identify features of a patient who is actively dying at the end-of-life • Know how to access specialist palliative care support for patients • Explain the definitions, physiology and concept of pain	Palliative Care is recognised as one of the additional areas of specialised medicine that a rural generalist may undertake as AST or ARST. Palliative care is an important specialty area for rural and remote general practitioners. As growth in older populations continues to rise the prevalence of death from diseases with a palliative phase will rise accordingly. The end-of-life care burden is increasing. The current specialist-based palliative care system does not have the capacity to manage all deaths; the responsibility of care must be borne by all healthcare	ACRRM Curriculum statement: https://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/ast-palliative-care-draft.pdf?sfvrsn=8f776cec_2 RACGP Curriculum statement: https://www.racgp.org.au/FSDEDEV/media/documents/Education/FARGP/Advanced-Rural-Skills-Training-–-Curriculum-for-Palliative-Care.pdf

	facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.'	• Discuss the legal and ethical issues surrounding requests for euthanasia, and how euthanasia differs from the 'doctrine of double effect' of palliative care • Apply the range of medico-legal and statutory responsibilities including: o certification of death o cremation regulations o liaison with coroner's office Knowledge Advanced • Describe the range of terminal illnesses where a palliative approach is appropriate, including malignancy, neurodegenerative disease, organ failure, frailty, dementia, HIV/AIDs • Identify Medicare benefit schedule items to sustainably practise equitable palliative care • Discuss indicators of disease progression • Discuss implications of hepatic and renal impairment • Identify potential treatment interactions • Discuss dose adjustment principles for commonly used medications with: frail, elderly, children, altered metabolism, organ failure, end of life • Describe commonly used palliative care medications: routes of administration, absorption, excretion, metabolism, half-life, usual frequency of administration, toxicity and adverse effects and their management, use in syringe drivers, interactions with other medications, possibility of tolerance, dependence, addiction and discontinuation syndromes • Discuss the prevention and management of overdose • Compare pain types, including somatic, visceral, neuropathic and incident	practitioners, particularly those in primary care. This situation is exacerbated in rural and remote areas as most specialist based palliative care services are based in large urban areas. This curriculum defines the skills, knowledge and attributes required by a Rural Generalist undertaking an AST / ARST in Palliative Care. It also provides information on how these skills and knowledge are taught, learnt and assessed. A Rural Generalist Palliative Care Physician offers specialised palliative care services to their community, they: • manage palliative patients at home, in a hospital, a hospice or a residential care facility • provide an advisory resource in palliative care to other rural generalists • maximize the effectiveness of specialist outreach and telemedicine services in their communities • assist in training Rural Generalist Palliative Care Physicians • have knowledge of the pathophysiology, symptom management, psychosocial and spiritual issues related to life-	

		• Discuss pain syndromes including plexopathies, central sensitisation • Discuss definitions, physiology and concepts of pain and pain management • Explain principles of spinal analgesia and use of epidural and intrathecal catheters and infusion pumps • Describe common nerve blocks and neurosurgical procedures • Discuss emotional issues involved in pain management • Discuss Palliative Surgery/ Radiotherapy/ Chemotherapy • Describe the management of biochemical abnormalities in the terminally ill • Describe management of the emergencies that occur in the palliative care setting: severe pain/pain 'crisis', acute dyspnoea, airway obstruction, acute anxiety, acutely suicidal patient, cardiac tamponade, massive haemorrhage, superior vena caval obstruction, spinal cord/cauda equina compression, fractures, sepsis, seizures, brain herniation/coning, acute dystonia, substance overdose, opioid toxicity, acute withdrawal syndromes, Addisonian crisis, carer's crisis – unable to cope • Discuss Wills, Advanced Care Directives, Enduring Guardian, Power of Attorney • Identify the legal requirements for the certification of death, including burial, cremation and reporting of death to the Coroner • Identify the legal (and ethical) provision of terminal care at end of life, including the 'doctrine of double effect', the illegal status of euthanasia,	limiting illness and imminent death • understand the experience of disease from the perspective of the patient and the meaning and consequences of illness to the patient and their family • make appropriate clinical decisions to provide medical care that is structured around the patients' and families' needs.	

		and the status of voluntary assisted dying (legal status differs in different States/Territories) • Discuss the signs of approaching death • Identify the needs of patients and families in regards illness, death and bereavement. • Identify bereavement support organisations, within their community, the role of specialist, psychological services and indicators for their referral. • Detail therapeutic interventions in minimising psychological distress including counselling, behavioural therapy, group activities, relaxation/meditation, imagery/visualisation and creative therapies. Skills • Use appropriate tools to identify patients who may benefit from palliative care ('surprise question', indicators of decline, SPICT, GSF-PIG, RADPAC) • Anticipate and minimise potential problems caused by either the disease or treatments • Undertake a comprehensive pain assessment including assessment of types of pain: nociceptive, non-nociceptive, acute, chronic; and the impact of psychological factors on the pain experience • Manage pain in palliative care patients, appropriately utilising: o pharmacological options □ non-opioid analgesics □ opioids □ adjuvants □ NSAIDS □ antidepressants □ local anaesthetic agents □ corticosteroids		

		□ antispasmodics □ anticonvulsants □ antiarrhythmics □ anxiolytics o non-pharmocological options □ physical therapies (eg massage, heat and cold therapy, transcutaneous electrical nerve stimulation [TENS], physiotherapy) □ mind-based techniques (eg relaxation, meditation, mindfulness, psychologist) □ optimising environment (positioning, aromatherapy, music therapy, occupational therapy, diversional therapy) □ radiotherapy □ nerve-blocking procedures, epidural/spinal injections • Use opioid conversion guidelines when changing opioid drug therapy • Recognise and provide support for the psychosocial and spiritual needs of patients and their family • Assist patients with establishing Advanced Care Directives • Determine the cause of, and manage common problems experienced by palliative care patients: o gastrointestinal tract □ nausea and vomiting □ constipation □ bowel obstruction □ dry mouth o respiratory system □ cough □ dyspnoea □ death rattles o neurological symptoms		

		□ delirium/confusion □ seizures o psychological symptoms □ anxiety/panic attacks □ insomnia □ depression □ suicide risk □ terminal restlessness o skin and soft tissue symptoms □ deep vein thromboses □ pathological fractures □ wounds and pressure areas • Continue to be responsible for the patient after death and be an advocate for the family and friends during their time of grief • Integrate a supportive component into all aspects of providing palliative care • Communicate the benefits and burdens from investigations, interventions and nonintervention to patient and carers • Order and/or perform diagnostic tests where required to confirm disease progression, monitor medical care and/or exclude treatable conditions • Respect the need for maintenance of autonomy by giving the patient and family a central role in determining treatment • Formulate a management plan for symptom management in concert with the patient and/or carer, judiciously applying best evidence and the advice of expert colleagues • Anticipate and minimise potential problems caused by either the disease or treatments • Respond appropriately to any negative outcomes of terminal illness on patients and carers, including the loss of independence, role, appearance, sexuality and perceived self-worth		

		• Use validated assessment tools for symptoms and pain • Set realistic pain management goals in consultation with the patient and their family • Ensure safe and appropriate prescribing of pharmacological and non–pharmacological treatment options in the palliative care context • Respond to and explore emotional cues/concerns with patients and their families, including fear, anger, guilt, uncertainty, sadness and despair • Respect the patient's and carer's beliefs, needs and wishes regarding the end of life care • Maintain a plan of food and fluids relevant to patient condition and patient and family wishes • Manage stomas, tracheostomies, gastrostomies, nasogastric tubes, urinary and suprapubic catheters, implanted ports, PICC and central venous lines • Perform the following: o CPAP/BIPAP o Spirometry and peak flow measurement o Nebulisation therapy o Supplemental oxygen delivery devices o Oxygen concentrators • Recognise and respond early to the deteriorating patient to ensure patient and carer's end of life wishes may be accommodated • Interpret the complete clinical picture to estimate prognosis • Stabilise critically ill patients and provide primary and secondary care if consistent with Advanced Care Directives • Develop and apply strategies for self-care, to manage the challenges of dealing with death Attributes		

		• Compassion • Empathy • Commitment		
Paediatrics / Child health	Overlap with Paediatrics and Child Health training Program provided by RACP. The Basic Training in Paediatrics & Child Health Program is a minimum 6-year training program to become a Paediatrician. This program includes a broad exposure to a comprehensive range of discipline areas that can be further developed during a subsequent Advanced Training program. Learning occurs primarily in the workplace, supported and supervised by consultants and peers.	The AST / ARST Curricula sets out the advanced abilities, knowledge and skills required upon completion of training in paediatrics. AST / ARST in Paediatrics requires a minimum 12 months full time or equivalent part time training. The curriculum outlines delivery of paediatrics services in rural and remote communities by fostering advanced paediatrics training among rural and remote doctors. The curriculum defines the advanced skills that will enable GPs to offer enhanced paediatric health services to their communities, and provide an advisory resource in paediatrics to other GPs. Registrars undertaking an AST in paediatrics are required to satisfactorily complete the following courses: • Advanced Paediatric Life Support (APLS) course • Neonatal resuscitation course and • Child protection course It is strongly recommended that candidates undertake an academic program in child health or paediatrics to support the acquisition of appropriate theoretical knowledge. The curriculum defines the abilities, knowledge and skills for AST in Paediatrics. The domains are: 1. Provide medical care in the ambulatory and community setting 2. Provide care in the hospital setting 3. Respond to medical emergencies 4. Apply a population health approach 5. Address the health care needs of culturally diverse and disadvantaged groups	The RG is usually the first-line service provider for any health problems that may arise among the large population of children and young people in rural and remote areas of Australia. These health issues affect the whole family, thus requiring the RG to involve more than just the individual when providing care. Additionally, the more care that can be provided in the child's hometown by the rural GP, the more the burden upon families in terms of time, travel and expense can be reduced. In many rural and remote areas there are large populations of Aboriginal and Torres Strait Islander children. Rural GPs frequently advise on public health and community health issues, and require additional knowledge in these areas, as well as being familiar with the principles of social justice. It is envisaged that with additional training in child and adolescent health, rural GPs will be more competent and confident in this area and better able to cope with working in isolation.	ACRRM Curriculum statement: https://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/curriculum-advanced-specialised-training-paediatrics.pdf?sfvrsn=545d86eb_2 RACGP Curriculum statement: https://www.racgp.org.au/FSDEDEV/media/documents/Education/FARGP/Advanced-Rural-Skills-Training-–-Curriculum-for-Child-Health.pdf

		6. Practise medicine within an ethical, intellectual and professional framework 7. Practise medicine in the rural and remote context. The RACGP has a preference that registrars wishing to complete an ARST in child health should complete the Sydney Child Health Program (SCHP) awarded in conjunction with the Sydney Children's Hospitals Network and the University of Sydney, coupled with a suitable period of clinical placement in an approved training post. The SCHP enables the development of knowledge, confidence and skills in caring for children and young people. It is a one-year, part-time program requiring approximately seven to eight hours of study per week. Delivery is through 112 webcasts, updated annually, which form the core of the course content. To complete training, registrars must successfully pass academic requirements of the program, and provide evidence of six months' clinical paediatric experience in a hospital or community practice. Paediatric clinical experience can be gained at any time before, during or after undertaking the SCHP course. A 12 months' ARST in child health must be completed.	Many rural and remote areas in Australia experience long-term shortages of specialist paediatricians. In these areas the RG can usually obtain advice from a specialist paediatrician by telephone, or send test results by email for an opinion. However, these clinical interactions are more complex than standard referrals, and place additional requirements on the treating GP. The RG will often need to deliver a broader range of services, regardless of telephone advice or assistance. In particular, most practical skills, time-critical skills and chronic care skills are difficult or impossible for a distant specialist to deliver over the telephone. Therefore, advanced skills in paediatric diagnosis and management can be highly advantageous to rural or remote general practitioners and to their young patients. Children of families living in rural and remote areas experience the same spectrum of chronic and acute presentations as their urban counterparts. However, families living in rural and remote areas often have less support available compared to families living in larger urban centres. However,	

			these burdens can be reduced if appropriately skilled GPs in rural and remote areas are able to provide some of these advanced paediatric services in the child's home town. In some rural and remote communities, such as remote Aboriginal communities, GPs also need to understand the high burden of paediatric disease encountered in those communities. They need to be able to determine the patterns of disease and take a population health approach to disease prevention and management. Rural and remote communities need GPs who are confident to deal with the acute and non-acute childhood and adolescent presentations, as well as parental concerns.	
Population Health	There is a cross over with RACP Training Program in Public Health Medicine which covers depth of specialty training in the health and care of populations, including health promotion, prevention of disease and illness, assessment of a community's health needs, provision of health services to communities and	Essential knowledge required. The candidate will demonstrate an in-depth understanding of national public health priorities, targets and campaigns and discuss their relevance, impact and application to local rural and remote communities. In particular, this applies to the following national health priority areas: • arthritis and musculoskeletal conditions • asthma • cardiovascular health • cancer control • diabetes mellitus	The AST / ARST in population health is considered a priority for rural generalists for a number of reasons: • inequity of health outcomes in rural and remote communities • all rural or remote general practitioners have the opportunity and responsibility to address health inequalities through population health interventions, and	ACRRM Curriculum statement: https://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/curriculum-advanced-specialised-training-population-health.pdf?sfvrsn=5c5d86eb_10

	research. Registrars train under supervision and prepare for independent practice as a consultant for a minimum of 6 years. Population health has been defined as: "The prevention of illness, injury and disability, reduction in the burden of illness and rehabilitation of those with a chronic disease. This recognises the social, cultural and political determinants of health. This is achieved through the organised and systematic responses to improve, protect and restore the health of populations and individuals. This includes both opportunistic and planned interventions in the general practice setting."	• injury prevention and control • mental health • obesity, and • tobacco and alcohol control and harm minimisation. • Epidemiology: o study design to a research situation o ability to read and understand epidemiological publications critically o fundamental understanding of the principles of epidemiology, and o sound understanding of the pros and cons of the main study designs. • Barriers to health care and services for Indigenous and people in the community, such as: o difficulty accessing services o culturally inappropriate health services, policies and procedures o health impact of dispossession, and o administrative issues such as entitlement cards and transport policies. • Links between historic and social factors and the health of Indigenous populations including: o the psychological impact of colonisation, disempowerment, removal from family and country, institutionalisation, marginalisation and discrimination o health consequences of poverty, inadequate education, lack of economic opportunity, poor food access and childhood nutrition, poor housing availability and maintenance, and inadequate community infrastructure o the complex background and impact of issues such as substance misuse, domestic violence, child abuse and neglect, and o the importance and health impact of family	• rural and remote general practitioners are likely to be first responders in infectious disease outbreaks and other health promotion and prevention situations. The importance of population health in rural generalism is acknowledged by ACRRM in the structure of this AST curriculum. As a domain, population health intersects every aspect of rural and remote medical practice. However, it is also acknowledged as a specialty discipline in its own right, with specialist study and practice in this field being critical to the ongoing advancement of rural and remote health outcomes.	

		relationships, social support, access to transport, and a sense of control over one's life. • Specific and differing profile of over-represented conditions among Aboriginal and Torres Strait Islander people, and demonstrate an understanding of how population health strategies can be used to address these issues. • Characteristics of rural and remote settings and their impact on population health, including: o types of conditions likely to be encountered o impact of rural and remote attitudes and the historical events leading to these attitudes o impact of current and previous health professionals o distance o limited resource availability o rural/remote environmental factors o unique agricultural health and medical issues impacting upon workers and their families, and o unique mining health issues in rural and remote areas. • Understanding of your community and working with people from Culturally and Linguistically Diverse Communities. • Population health principles and practice relating to infection control in primary, secondary and tertiary care settings, including: o personal hygiene o protective equipment o management of sharps o sterilisation procedures, and o hazardous waste disposal. o Population health principles in crisis situations, such as: o climatic variation impacting upon rural industry and families		

		o natural disaster management o major trauma planning and response, and o pandemic or epidemic response		
Remote medicine	There is no specific cross-over with another specialty. The aim of this AST / ARST is to provide remote populations with appropriately trained, safe and competent rural generalists who have an interest in working in remote environments. Several definitions have been developed to describe 'remote health' and 'remote practice'. Wakerman offers the following working definition of 'remote health': "Remote health is an emerging discipline with distinct sociological, historical and practice characteristics. Its practice in Australia is characterised by geographical, professional and often, social isolation of practitioners, a strong multidisciplinary approach, overlapping and changing roles of team members, a relatively high degree of GP substitution and practitioners requiring public health and emergency and extended	There is a considerable gap between undergraduate education and the advanced and extended role of all health professionals in remote areas. Remote doctors require a broader and deeper range of knowledge and skills than their urban and rural counterparts. This is due to a combination of factors including poorer patient health status, poorer patient educational preparation, the diverse range of service providers and the need to use a multi-professional primary healthcare approach. Advanced skills are required in areas such as public health, infectious disease, environmental health, emergency, retrieval and disaster medicine and cultural awareness. he need for appropriate training was acknowledged by the Commonwealth Department of Health and Ageing in 1999, when funding was provided for the Pilot Remote Vocational Training Scheme (RVTS) – a joint initiative of the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners. The RVTS, as it is now known, continues to provide remotely located candidates throughout Australia with a supported vocational training program via distance education and remote supervision. This remote medicine curriculum has been developed with these factors in mind and the AST requires a minimum 12 months full time or equivalent part time training. Essential knowledge required Public health issues relevant to remote communities, including:	Remote populations include Indigenous Australians, multi-generation primary producers, mine workers, professional people (short and long-term), seasonal and tourism workers, and those who work on ships, oil rigs, islands and Antarctica. Remote populations account for approximately 2.3 per cent of the total Australian population. Aboriginal and Torres Strait Islander Australians make up approximately 16 percent of the remote population and 48 percent of the very remote population. Indigenous Australians have the worst health status in the world on some indicators: diabetes, renal disease, infectious diseases (especially gastroenteritis, otitis media and pneumonia in children) and circulatory diseases. Factors such as distance, isolation, lower incomes, poor educational opportunities, meagre housing, minority population status, and lack of services all exacerbate health inequality.	ACRRM Curriculum statement: https://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/curriculum-advanced-specialised-training-remote-medicine.pdf?sfvrsn=4d5d86eb_6

	clinical skills. These skills and remote health systems need to be suited to working in a cross-cultural context, serving small dispersed and often highly mobile populations, serving populations with relatively high health needs, a physical environment of climatic extremes, and communications environments of rapid technological change. The following key features differentiate remote medicine from urban or rural general practice: 1. Employment – Remote doctors are usually employed by government and nongovernment organisations rather than in a private practice. They usually share their workloads with other doctors from that organisation. They are often highly mobile and have a high community profile. 2. Isolation – Remote medical practice is isolated, with limited sophistication of medical care and access to peers. It often occurs in extreme conditions – geographically, climatically,	• infrastructure, public health surveillance and procedures • disease control initiatives, environmental health issues • water supply, sewerage systems, water testing • power supply and generator maintenance, and • triage and the mortuary • occupation and personal health and safety issues relevant to remote communities, including: o occupational medicine issues, and o personal safety issues and security Links between social factors and their effects on the health outcomes in a particular community. This includes: • the impact of poverty, nutrition, housing, education and employment opportunities, family relationships, social support, transport, and control over one's life, and • the Barker hypothesis and health outcomes in adulthood. Principles of ethical practice in a remote community, including: • respecting different cultural frameworks for determining ethical behaviour • understanding the ethical principles underlying the care of chronically ill patients in remote practice – informed consent, confidentiality, autonomy and issues associated with dying • respecting a patient's right to refuse, or vary treatment, and • understanding local issues that might impact upon the decision to treat a person locally or refer. Nature of remote communities, and of medical practice in these environments, including: • sociology of remote communities	The remainder of the populations living in remote communities share a number of common features. They tend to be predominantly male, usually consisting of young, fit, healthy, transient workers, who often take risks, work with machinery and present late when suffering from non-acute illness. Work-related accidents and serious infectious diseases can be common. One unique remote transient population is the group of 14,000 scientists, tourists and adventure seekers from eighteen nations who visit Antarctica each year by ship, yacht or aeroplane. The most common medical conditions are generally trauma (which can be serious and require evacuation) and insomnia (which is endemic during periods of 24-hour sunshine). Other remote populations include Australian Defence Forces (ADF) personnel and the populations served by them. They can include people who require treatment for trauma-related conditions caused by war, natural disaster, or terrorism, or need essentials such as food, water and shelter. While humanitarian assistance was traditionally secondary to the	

	professionally, personally, environmentally, politically and culturally. Doctors may also fly-in and fly-out for a particular episode of patient care. 3. Tele-health – Remote doctors are often required to provide their patients with diagnostic and management advice over the telephone, radio, satellite and internet networks or other electronic devices/means. 4. Increased clinical acumen – Remote doctors require a higher level of clinical acumen to diagnose and manage illness where there is often an absence of pathology, radiology and the other usual clinical diagnostic support and specialist services, so the ultimate responsibility lies with the remote doctor. 5. Extended practice – Remote medical practice extends across primary, secondary and tertiary levels of care and requires novel methods of practice, different treatment protocols, and innovative implementation approaches. Remote doctors can be required to undertake	• treating self, family, pets and those you know and work with • having a greater responsibility of care • using different protocols appropriately • management skills and professional networks, and • strategies for reducing professional and personal isolation and burnout. Protocols for establishing a donor panel to use in an emergency, including managing a walk-in blood bank to take blood by donation. • How to arrange for locum cover for planned leave and emergencies. Essential skills required Competent and independent performance of the procedural skills listed in the Primary Curriculum procedural skills logbook and those skills specific to individual remote community or type of health service.	ADF's military missions,9 the past decade has seen an increasing number of primarily humanitarian missions. Therefore, ADF doctors have been required to diagnose and treat a far wider range of medical conditions, especially in the areas of women's and children's health and tropical medicine. Remote areas are characterised by limited access to all services, including medical services. The medical services available in these populations are often provided by health professionals other than doctors. Therefore, a number of unique medical services have emerged, including: • tele-health • fly-in fly-out medical, emergency, evacuation and primary care services • Indigenous primary health care services for discrete, very remote Indigenous communities, usually provided by remote area nurses and Indigenous health workers (with medical support via the telephone) • Aboriginal Medical Services, which are community controlled and provide primary health care services to largely Indigenous populations	

	a range of advanced procedural practices which would usually be reserved for specialists in urban or rural contexts (e.g. obstetrics, surgery, pathology, dentistry). Doctors and nurses may also be required to perform tasks usually undertaken by other healthcare workers, such as paramedics, vets, government medical officers, nurse practitioners, ambulance officers and community aid workers. 6. Cross-cultural – Remote doctors often work with marginalised populations with poorer health status, different worldviews and different cultural understandings of health. 7. Multidisciplinary – Remote medicine is multidisciplinary, with each health professional performing more advanced and extended roles than those normally found in urban or rural practice: physician/medical assistant, nurse practitioner, Remote Area Nurses and Indigenous health / refugee worker. These health professionals must work in teams to be		• small communities with clinics and small hospitals with no full time Medical Officers on site • mining health services • bush nurses posts, and • primary care services provided by medical practitioners based in remote, predominantly non-indigenous communities on islands, ships, expeditions, or in the ADF.	

	effective, and their role boundaries are often blurred. 8. Public health and security – Remote medicine occurs in environments where it is critical to have a strong understanding of public health and an ability to use a population health approach. The doctor will often take on a leadership role in this regard. Also, it can be unavoidable in remote communities that the doctor will develop social relationships with patients, or may be required to provide medical care for friends, family, staff and colleagues. Added to this, staff turnover is usually very high. For these reasons, patient information/records security and patient confidentiality issues are paramount.			
Surgery	There is considerable overlaps with the RACS Training program which is a minimum of 6 years of training. RG registrars Candidates who choose to undertake an AST / ARST in surgery must	The ARST / AST Curriculum for RG Surgery requires that the candidate complete a minimum of 24 months' (full-time equivalent) supervised surgical training in an accredited training post. Accredited posts must be approved by RACS and RACGP / ACRRM. The 24-month training period will include: • a minimum 6-month general surgery rotation	College curricula sets national standards for training Rural Generalists with additional skills in surgery. It describes the surgical presentations that a candidate may be required to be involved with and the surgical	

	undertake a minimum of 24 months training in this area. Surgery has been selected as one of the priority areas due to limited availability of specialist surgeons in rural and remote locations. This training aims to improve access to surgical services in rural and remote communities through increased access to rural doctors with advanced training in surgery and endoscopy. This AST / ARST outlines the expected outcomes and assessment for candidates undertaking Advanced Specialised Training in Rural Generalist Surgery.	• a minimum 3-month orthopaedics rotation • a minimum of 3 months in another relevant surgical rotation or additional general surgery or orthopaedic rotations • direct supervision by a Fellow of the RACS throughout the training period • indirect supervision and support to be provided by a Medical Educator/GP Surgical Proceduralist approved by either College, or a GP Mentor/RG Surgical Proceduralist approved by either College. Essential knowledge Candidates undertaking AST / ARST in surgery are required to have the following knowledge: • Anatomy and physiology relevant to domains of surgical practice in the curriculum. • Selection criteria, protocols, principles and limitations of the diagnostic procedures tests and interpret their results. • Knowledge of basic principles for: o emergency ultrasound o procedural sedation o endoscopy o surgical technique o laparoscopy o laparotomy • Potential surgical complications including possible failure of the surgical procedures listed in this curriculum, describe the signs and symptoms of these complications and outline appropriate rescue plans. • Management plans and algorithms for common potential variations for common procedures eg when an ovarian pathology or bowel cancer is	skills a RG who has completed an AST / ARST in Surgery can perform under minimal or distant supervision from, or consultation with, regional specialist surgeons. An RG with additional surgical skills will generally be employed in a senior medical officer role in a rural hospital, working with the support of specialist surgeons either on or off-site. An RG with additional surgical skills plays an important role in facilitating and co-ordinating care of the surgical patient in a rural context. The RG with additional skills generally provides surgical care for low to medium complexity surgical cases. If more complex surgical work is required to be performed, the RG will perform the surgery in consultation with a specialist surgeon or refer on. An RG with additional surgical skills also works as part of an on-site team with other skilled medical, nursing and allied health practitioners delivering anaesthetics, emergency medicine, and obstetrics & gynaecology services. In addition, RGs with advanced surgical skills provide an advisory resource in surgery to other RGs and optimise the effectiveness	

		found for a case that was thought to be appendicitis. Essential skills An RGF who has attained an AST / ARST in Surgery is expected to advance their surgical skills beyond those described in the College Curriculum. At the completion of the AST / ARST the RG is expected to be able to manage the following presentations and provide the essential surgical skills and under minimal or distant supervision and/or liaison with regional specialist surgeons. Basic skills • emergency ultrasound • procedural sedation • gastroscopy & colonoscopy - required to fulfill requirements of the Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) • surgical technique • laparoscopy • laparotomy • surgical audit • risk assessment Management of abdominal presentations • Abdominal wall mass or pain: hernia repair. • Acute right and left lower quadrant pain: appendicitis, adnexal/ovarian disease, diverticular disease, constipation. Damage control techniques The principles of damage control techniques are to control haemorrhage, prevention of contamination and protection from further injury, for example in the following presentations • intra-abdominal haemorrhage • appendicitis	and purpose of specialist outreach and telemedicine services in their communities. Additional skills allow RGs to extend their expertise in a particular area and enhance their capacity to provide secondary-level care to their community. RGs practice additional skills in response to community need, and therefore the skills are determined by context. An RG in surgery has undertaken additional advanced skills training to develop specialist surgical skills can perform a broad range of surgical procedures. These surgical services are provided within the RG's local community on a needs-based approach, through the local hospital operating theatre or other appropriate medical facility, without the need for referral. Services provided will include emergency and elective procedures within the skill set of the individual, and knowledge of treat or transfer principals. RGs providing surgical services make an important contribution to comprehensive care in communities, with the potential to reduce the need for patient	

		• open fracture • Gastrointestinal bleeding (upper and lower). • Gastrointestinal screening and surveillance (upper and lower). • Perianal presentations: hemorrhoids, infections, warts, pilonidal sinuses, anal fissures. Management of non-abdominal presentations • Integumentary lesions: skin, nail, subcutaneous lesions, ganglia, lipoma, digital amputation, burns cellulitis, skin flap and skin graft closure. • Wounds: dressings, excision and suture, drainage and debridement, drainage and packing. • Fertility: vasectomy • Genitourinary disease: acute testicular torsion, epididymitis, phimosis, circumcision, • Breast lump: triple assessment and referral. • Hand/limb: carpal tunnel release, hand trauma/infection, extensor tendon repair, compartment syndrome upper and lower limb. Additional skills It is suggested that an RG with advanced surgical skills considers also undertaking DRANZCOG advanced training during or after Fellowship training to be able to manage complications of pregnancy, including: • Complications of labour and delivery: operative vaginal delivery, cesarean section, perineal trauma, uterine inversion, postpartum haemorrhage, retained placenta, advanced labour and risk management, neonatal resuscitation. • First trimester pain and bleeding: uterine bleeding: dilation, curettage and hysteroscopy (pregnant and non-pregnant), ectopic pregnancy and • Tubal ligation Other additional skills for example vascular / trauma surgery procedures such as amputations	travel and the waiting times for surgery. In addition, patients can have their specialised care delivered by a medical practitioner with whom they have an established and trusted therapeutic relationship. The procedures that the RG in surgery can perform are determined by the individual practitioner's training, accreditations, and the local infrastructure and support services available to them. The end point of the RG surgical training program must be recognition of a described capability to deliver safe, unsupervised, high-quality surgical services.	

		may be obtained either during or following Fellowship training to address community needs. These additional skills may require special training or accreditation to perform. Before undertaking new procedures, the candidate must obtain specific approval and training by his/her supervisor. Important considerations when seeking to develop additional skills include: • Training requirements for envisaged elective and emergency work, including requirements for maintaining competencies relevant for potentially required emergency procedures. • Frequency of exposure in regular practice to various medical conditions and operations. • Where qualifications require specified volumes of cases for successful completion, the training facilities need to have a training plan that enables the training candidate to have sufficient clinical exposure to meet these training requirements. This may require discussions between the different supervisors / facilities as to how these case volumes can be achieved. • Capacities of the future envisaged district hospital facilities and workforce. • Medico-legal considerations for the candidate and the supervisor.		