RACGP

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

Submission to the Stage 2 Detailed Assessment

Joint application of the ACRRM and the RACGP for Recognition of Rural Generalist Medicine as a new field of specialist practice under the Health Practitioner Regulation National Law

December 2022

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Identifying information

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Verify proposal

The information presented is complete, and it represents an accurate response to the request for further information at Stage 2 assessment of the proposal.

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Signature

Paul Wappett, RACGP Chief Executive Officer
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Marita Cowie, ACRRM Chief Executive Officer
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Executive Summary

This is a combined application of the general practice colleges proposing that 'Rural Generalist' be recognised as a protected title, and Rural Generalist Medicine (RGM) be recognised 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 RGM 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.

The two colleges in collaboration with the National Rural Health Commissioner endorse the following definition (the 'Collingrove Agreement'):

"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."

1. RGM is a distinct and legitimate area of specialist practice

The specialist field describes a practice scope that can provide services across all the traditional medical disciplines and in this sense is grounded in medicine's established core disciplines. Its point of departure from other fields, is that it seeks to define workable, practitioner scopes which can maximise the safe, high-quality care that can be provided to people in rural or remote locations. Common to all rural/remote contexts are issues of distance from urban specialised services and resources, a local low-resource base, a small local healthcare team vulnerable to under-staffing, and a general environment of social disadvantage. The traditional disciplines are thus redefined through these parameters. A defining aspect of the field is the strong integration of practice across primary, secondary, and emergent care.

The specialist field is supported by a growing international body of research and medical curricula development to inform clinical standards. Australia is a recognised leader in advancing RGM and its work in the discipline is commonly cited in the literature as a model for adoption.[1,2,3]

2. RGM is capable of contributing to standards of medical practice

The specialist field in Australia is supported by the two general practice colleges, ACRRM and RACGP, with well-established AMC accredited Fellowship certification, training and continuing professional development (CPD), and organisational and clinical governance frameworks. The defining aspects of RGM have been part of both college's curricula over the past three decades to varying degrees. A Commonwealth Government commissioned external curriculum review confirmed that both colleges have provided the framework to support a national specialist field. The Colleges have established joint arrangements with other specialty colleges to support training and practice of its practitioners in areas of overlapping scope.

The general practice colleges' activities in the specialist field, are supported at all stages of the training and career journey through the university sector, and the Commonwealth and jurisdictional governments. Key supporting mechanisms include the jurisdictional Rural Generalist Training Programs, the Rural Clinical Schools, and the John Flynn Rural Doctors Program. The National Rural Generalist Pathway Strategic Council is providing a key role in identifying opportunities to improve the support for training and practice through health systems at the jurisdictional and the national level. It comprises a broad stakeholder group with representation from the colleges, jurisdictional health services, the Commonwealth Department of Health and

Aged Care (DOHAC), peak organisations for Aboriginal and Torres Strait Islander people's health and other key stakeholders.

3. *RGM Recognition will address service delivery and quality of care*

The key issue this proposal seeks to address is the persisting inequity of access to comprehensive, quality healthcare for people living in rural and remote areas including the significant number of Aboriginal and Torres Strait Islander peoples in these areas.

Australians living in rural and remote communities continue to record significantly lower health status by nearly all key indicators than those living in major cities, with the higher rates of chronic disease, hospitalisations, and mortality increasing with remoteness.[4] At the same time, they experience significantly poorer access to medical care, which is manifest in their lower utilisation of all healthcare services and substantially lower utilisation of services provided by non-GP specialists.[5]

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

RGM enables people in rural and remote places to have the best possible access to high-quality medical care, by providing an economic workforce solution of locally-based general practice doctors trained to provide a broad scope of services to a defined and assessed professional standard including to work in general practice clinics, hospitals and emergency departments, and to enable collaborative team-care solutions.

Rural Generalists are primary medical care providers with advanced/additional skills that enable them to work in secondary and tertiary arenas in collaborative networks with other health professionals and 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 Rural Generalist workforce of around 4,000 practitioners is established and providing vital services across rural and remote Australia. This workforce's growth and sustainability however continues to be impeded by a range of structural barriers, including to appropriate resource planning and recruitment, job portability, clinical governance, and credentialing, supported training, and promotion of careers and job opportunities.

Recognition of the specialist field will formalise and nationalise the status of these doctors' skilled practice scope. This will provide the necessary system visibility, and transparency and consistency of standards in the recruitment, training, employment, and practice of this workforce.

Protected title and recognition will:

- provide future and aspiring rural doctors with a nationally recognised professional endpoint, associated with a clear training pathway, job identity and job portability
- assist rural communities and health services to recruit suitable doctors and build service models leveraging the Rural Generalist scope
- facilitate structured quality and safety, credentialing and titling frameworks for best-practice Rural Generalist-led care articulated to nationally accredited training
- drive academic effort toward defining best-practice Rural Generalist models of care

A strong Rural Generalist workforce can provide a sustainable solution to critical healthcare needs. Recognition of RGM as a field of specialty practice is a necessary step toward enabling its growth and sustainability. This will directly remove specific structural barriers. More broadly it will enable health services, training systems, and rural communities to work toward a thriving national network of these doctors and to leveraging their unique skillset in the best interests of quality care for the people in rural and remote Australia.

1. The field of practice is distinct and a legitimate area of specialist practice

This requires that the applicant:

- describe the major medical concepts that underpin the proposed specialty, with reference to the published literature
- describe the current role of the proposed specialty within the Australian health care system (including its relationship to other medical and healthcare providers)

1.A The specialty or field of practice is based on substantiated concepts in medical science and health care delivery

The field of RGM has emerged to describe a scope of practice that occurs extensively in rural and remote areas in Australia and across the world. It is estimated, based on the two general practice colleges' membership data, that around 4,000 rural doctors[i] are providing services in accordance with this model of practice in Australia. There is considerable evidence of the prevalence of this scope of practice elsewhere including from Canada [6], New Zealand[7], the United States[8,9], Africa[10,11] and Asia[12].

For example, a recent US study found that in 67% of rural hospitals, family physicians were providing obstetric care and in 26% of these, they were the only providers of obstetric care. [13] Another study found that of family physicians who perform caesarean sections, more than half were doing so in rural communities and 38.6% were providing caesarean sections in counties that had no resident obstetrician/gynaecologists.[14] Another study estimated that in the US, there were some 7,600 family physicians working full time in rural "frontier" emergency departments and many more working part-time.[15] In Canada, 49% of rural family physicians provide services in emergency departments as opposed to 13% of urban family physicians, 34% of rural family physicians provide services in nursing homes as opposed to 13% of urban family physicians, 31% of rural family physicians provide services in community health centres as opposed to 12% of urban family physicians [16]

RGM is not new. While over the past century, the technological and regulatory context in which it is practiced has changed considerably, rural areas have always been characterised by doctors that adopt this distinctive approach to medical care.

RGM has emerged as a defined specialist field relatively recently. This has occurred by necessity to describe and direct the model of care so it can continue and can reflect best practice within the changing healthcare context. In so doing, it can be quality-assured, promoted, and imparted into health systems and to future generations of doctors.

RGM represents a systematic approach to defining a skillset for doctors that can facilitate the best possible access to the fullest possible scope of safe, high-quality care for people in contexts of isolation from the concentration of resources of major cities. The field has its foundations in describing a well-established pattern of practice. Particularly, over the past three decades however, an evidence-based lens has been brought to all aspects of its operation to ensure its feasibility, quality, safety, and efficacy and its continuing alignment with evolving community need and context.

Accordingly, a body of scholarship has emerged:

[i] Noting that this workforce is not currently captured through national data systems, this is a conservative indicator estimate based on annual enrolment patterns in the Rural Procedural Grants Program (RPGP). Eligible RPGP participants have general practice Fellowship, are rurally-based and will undertake training to maintain active credentialled work in one of four key areas of advanced rural generalist practice (Obstetrics, Emergency Medicine, Anaesthetics, and Emergency Mental Health).

- to define the curricula and syllabuses to enable transfer of the necessary skillset and to quality-assure its attainment
- to capture and share the cumulative knowledge and expertise of its practitioners to inform continuous quality improvements in its practice
- to bring evidence-based rigour, and drive ongoing exploration into how the skill set and scope can be improved toward better health outcomes for rural and remote communities
- to enable advocacy within health systems to ensure the model of practice is enabled and appropriately supported

Common themes underpinning the Specialist Field

The specialist field and the scope of practice it describes reflects the exigencies of recurring themes in medicine and healthcare which are pervasive across international, cultural, and economic boundaries.

To varying degrees, rural and remote communities everywhere in the world are characterised by the following:

- Physical distance from major centres where the fullest possible scope of specialised medical technologies, practitioners and resources are concentrated.
- Relatively low-resource local healthcare settings with small healthcare teams to meet the breadth of local needs
- Relative healthcare underservicing and pervasive workforce shortages (globally, such shortages are almost twice as high in rural areas)[17]
- Relative socio-economic disadvantage[18]
- Relative lack of influence in national systems - this reflects remoteness from major cities where government, universities, and healthcare decision-making bodies are centred.[19]

From these distinctions, comes a convergence of healthcare issues warranting a distinctive approach to medical care. In 2004, Smith and Hays published an article exploring the status of Rural and Remote Medicine as a speciality[20]. Since that time, from the concepts detailed in this publication, the specialist field of RGM has emerged, and the terminology of RGM has been incorporated into training and employment systems. Smith and Hays publication provides an instructive framework to describe the distinctions which define this RGM field (see Table 1.1). These key distinctions are outlined below with adjustments to provide the most current statistics and context.

Table 1.1 Summary of distinctions of rural medicine context and content

Context	**Differences for Rural Doctors**
Rural and remote locations	• Geographically and socially isolated • Fewer resources • Less access to referred specialist care • Limited personal and professional support, therefore, greater reliance on other members of healthcare team • Chronic workforce shortages and small teams (‘*always one doctor away from a crisis’*)[21] • Need to be more resourceful, independent • Living in a small community – self-care, anonymity, confidentiality, and family issues • Highly accountable to the community
After hours care	• 52% of rural doctors provide afterhours care, compared with 20% of metropolitan doctors[22]

	• Negligible deputising services • Perform secondary care services after hours – anaesthetics, surgery, emergency care, or inpatient hospital care
Hospital care	• Often medical superintendent at the local hospital with rights of private practice • Most have a mixture of ambulatory and inpatient roles - outpatient consultations, palliative care, paediatrics, emergency care and obstetrics • On-call work
Content	**Differences for Rural People**
Emergency care	• 3-4 times more likely to die in road accidents[23], • Twice as likely to be hospitalised, and twice as likely to die, from injury[24] • Less backup – require resourcefulness • Rural doctors need extended emergency skills to manage these incidents, to stabilise, manage, and transport a critically ill patient in difficult geographical areas • Rural doctors need personal support, confidential debriefing
Extended clinical skills	• More anaesthetics, • More obstetrics, • More surgery, performed by rural family doctors than metropolitan counterparts[25,26] • Increases with greater rurality • Rural doctors require higher levels of diagnostic, therapeutic and clinical management skills
Aboriginal and Torres Strait Islander peoples' health	• 62% of Australia's Indigenous peoples live in rural and remote areas • Percentage of population who are Indigenous increases with remoteness, (1% in major cities, to 32% in remote)[27] • Indigenous health status is far worse than other Australians [28] • Rural doctors need advanced skills in cross cultural communication and an understanding of Aboriginal history, culture, health, and community-controlled health systems
Public Health	• Rural and remote people have worse health status than their metropolitan counterparts and higher rates of lifestyle related illness[29] • Rural doctors have an increased need for population health, health education and prevention information inc. managing community natural disaster response, pandemics etc.

RGM recognises these distinctions and defines the set of skills and attributes to support a scope of practice which can maximise the safe, quality medical services that people are able to receive in these circumstances. The skillset reflects a core body of knowledge, but also recognises that adaptability and a community responsive skillset is itself a fundamental aspect of the Rural Generalist's training and scope.

The practice of this distinctive scope of General Practice in rural and remote areas occurs extensively by virtue of need but until recent decades, largely without clear and consistent recognition by the regulatory and funding systems as they have emerged. This lack of recognition has become increasingly problematic as regulatory frameworks and structures have become more pervasive.

The practice of RGM is unique in the combination of abilities and aptitudes that are required of a doctor for a distinctly broad scope of practice in a rural or remote clinical context.

The field is grounded in the scientific foundations, principles and concepts of care that are generic to medicine. The content of the field is primarily comprised of a nuanced combination of a broad range of evidence-based traditional disciplinary areas of medicine most notably including:

- Primary care/ continuous care
- Emergency medicine, surgery, anaesthetics, and retrieval medicine
- Obstetric care/ emergency obstetric care
- Hospital in-patient care
- Public health, population health and preventative medicine
- Aboriginal and Torres Strait Islander peoples' healthcare

The fundamental concepts of these various areas of medicine, often presuppose an urban context in which they can be provided by a range of individuals specialised in their respective medical and allied health areas, with access to related specialised resources and support. In RGM however, these content areas occur in a health service context in which some or all the services may be provided by a single doctor, or small team of doctors within a small healthcare team supported by minimal locally available resources. Even, where specialised aspects of care are provided episodically (through digital technologies or outreach visits), the local doctor has elevated responsibility to link these in, to patients' continuous care including responding to their medical emergencies.

Thus, the intersection of the established disciplinary areas with the clinical context of relative isolation from the urban clinical resource-base, presents unique clinical scenarios and associated healthcare issues and appropriate management responses. The essential defining concepts of the disciplinary field are the questions of what, how, and how much medical care, an individual doctor working in a small healthcare team can feasibly and safely deliver to their community. Some of the key cross-cutting concepts underpinning this context-sensitive approach, include the following:

> ***Community-responsive care:*** RGM is defined in its entirety by the exigencies of social accountability and community-responsive care. As such, it incorporates the concepts of Community Oriented Primary Care (COPC) which blends traditional primary care and public health, with what Smith and associates have described (in the context of General Internists) as Community Responsive Medicine. This is a medical approach in which, *"the Curriculum is defined by the elements and skills necessary to improve the health status of the target community"* and *"the curriculum is balanced between the ambulatory and the tertiary settings."*[30] A key theme reflected in the specialist standards, curricula and training experience is the emphasis on 'community-engagement' which has been recognised by the WHO as an important element of best practice rural healthcare.[31] RGM is unique in that it takes this approach to describe a scope that spans, the primary, secondary and tertiary care context in whichever combination can best meet community needs. This is consistent with what the WHO has described as *integrated care* and has promoted as an important approach to medical models which can improve service delivery.[32] The discipline is further distinguished in that within this community responsive, integrated care model, clinical decision making occurs in environments in which availability of staff and resources cannot be assumed to be available.

Generalism: This in essence is the capacity to provide broad scope practice to manage the breadth of healthcare issues of patients in the doctors' community. The generalist approach goes beyond broadness of scope of services, to what Woods and associates have described as the core activities of the generalist approach of being able to deal with complexity, novelty, and ambiguity.[33] A Rural Generalist should be prepared to manage undifferentiated patient presentations whether they occur in a GP clinic, an aged care home, a hospital, or in a first responder scenario. While it is not expected that they would be able to provide every medical service, they should be able to make an assessment of the situation and exercise clinical judgement to determine an appropriate medical response including emergency responses.

Complex clinical decision making within safe scope of practice: Rural Generalists operate in an environment in which they cannot feasibly meet all their communities' healthcare needs yet not providing these services may well lead to rural and remote people foregoing access to needed care. Thus, understanding their limitations and how to provide the best service within them is a core feature of practice. This is, especially important in emergency situations where patient transport may not be the safest option. Even for non-emergent care, there are disproportionately high and potentially prohibitive time and financial costs to patient referrals to consultant specialists for care and this needs to be taken into consideration in every clinical decision. The College of Family Physicians of Canada (CFPC) have described the concept of 'specificity' as a core disciplinary competency of all family practice.[34] They describe this as a set of skills associated with a physician not doing things in a routine fashion but being selective in their approach: *adapting it to the situation and patient. This physician sets priorities and focuses on the most important, knowing when to say something and when not to, gathering the most useful information without losing time on less contributory data, or doing something extra when it will be helpful.* In a similar vein, Han and associates have examined the work of emergency physician and specialty internists and described clinical decision making as a discipline which operates largely as: *a "hidden curriculum" of medical care and training*.[35] Cooper and associates have described this as working in the 'corridor or uncertainty" and view this as essential general practice.[36]

While these concepts are important to all medical disciplines and especially general practice, they are explicit and core competencies in RGM, and uniquely involve multiple levels of complexity spanning primary, secondary and tertiary systems and incorporating complex considerations around the availability and accessibility of support staff, resources, transport, and the associated costs and time implications. For example, Robinson and Kornelsen in a review of Rural Generalists and other rural surgical and obstetric maternity care providers in rural British Columbia, found five essential components to rural clinical obstetric decision-making which should be reflected in related clinical standards: (1) clinical factors, (2) physician factors, (3) patient factors, (4) consensus between providers and (5) the availability of local resources.[37] McConnell and Pashen took a similar approach and developed a Rural Generalist risk management framework model to guide Rural Generalist quality and safety standards.[38]

At a practical level maintaining a safe scope of practice involves practitioners not just attaining the competencies associated with this scope but also maintaining them and managing the administrative requirements of credentialling and ongoing performance review to certify this. Thus, there is an important role for the specialist field in drawing on the cumulative experience of the field, to develop evidence-based clinical guides for feasible and attainable individual scopes associated with the common typologies of care models. This also enables the development of viable, streamlined processes associated with attaining and maintaining it.

Adaptability and flexibility as a skill and a practice approach: In rural and remote clinical contexts, communities are more likely to experience barriers to accessing needed healthcare services. Rural doctors are more empowered to directly influence care within their community and tend to be more accountable to their community for addressing their healthcare needs. Rural Generalist doctors need to have an approach to practice of using flexibility and resourcefulness to help patients to get the care they need including acquiring

new or more advanced skills. Safe scopes need to be negotiated with other medical and allied health craft groups. Extended and evolving service in one or more areas of focused cognitive and/or procedural practice may be required to sustain needed health services locally among a network of colleagues. Scholarship in the field has extended beyond practical considerations to exploration of the phenomenological aspects of working under conditions of uncertainty in the Rural Generalist context.[39] Konkin and associates identified the following key themes of Rural Generalists experiences: *Standing up to serve anybody and everybody in the community; Accepting uncertainty and persistently seeking to prepare; Deliberately understanding and marshalling resources in the context; Humbly seeking to know one's own limits; Clearing the cognitive hurdle when something needs to be done for your patient; Collegial support to stand up again.* [40]

Team based care: Consideration of issues of working within healthcare delivery systems involving team-based care is an increasingly important care area of health systems scholarship, [41] and incorporated to some degree in most speciality disciplines, (e.g., Oncology[42]). These approaches however are core to the RGM approach. Team based care may relate to the in situ multidisciplinary team, teams of Rural Generalists within the local area, or it may involve the local Rural Generalist working with distal consultant specialists via outreach visits, or telehealth.[43]

Sustainable Health Systems: Considering the most effective models of care involving rural generalist trained doctors to optimise delivery of services to people in rural and remote communities is an essential element of RGM. It has been recognised by the WHO in their recommendations for retention of rural health workforces, that a focus on 'sustainable health systems' is key to delivering a strong rural workforce. [44] Chronic workforce shortages, and smallness of local healthcare teams and resources are a pervasive aspect of rural and remote practice. Even where local resources are strong as Worley has identified, rural and remote communities are only ever, *one resignation away from a workforce crisis*.[45] As such, strategies for recruitment, retention and ongoing workforce support are all core considerations for RGM. There is considerable diversity across rural and remote communities, making it important to localise systems of care for each context, but equally important to identity a range of best-practice models of care that can be appropriately applied in different community typologies. These systems of care can inform health policy and resourcing decisions.

1.B The specialty or field of practice is a legitimate and distinctive field of medicine with specialist knowledge and skills that are separate from other existing specialties or fields of practice. This might include, for example, the extent to which the field of practice has:

1.B.1 An established and distinct body of knowledge

This requires that the applicant provide evidence that the proposed specialty is underpinned by a comprehensive and developing body of research. This can be demonstrated through documenting:

- well-funded research programs specific to the proposed specialty in Australia and overseas
- the existence of peer-reviewed scholarly journals specific to the discipline and/or discipline specific research published in high profile generalist scholarly journals (e.g., Nature, Science, NEJM, JAMA etc)
- a growing evidence-base to inform and guide clinical practice (including, for example, systematic or other EBM reviews in the Cochrane Library).

Please provide evidence that demonstrates:

- the record of the applicant body or bodies and their membership in the ongoing development of the evidence base of the clinical discipline.

The practice of RGM is unique in the combination of abilities and aptitude that is required of a doctor for a distinctly broad scope of practice in a rural or remote context. RGM reflects a scope of practice that is well established and widely practiced across rural and remote Australia and in many rural and remote areas globally.

In Australia, the model of care is supported by substantive frameworks to direct and promote scholarship to explore, measure and describe its best practice. These researchers regularly collaborate and engage with their colleague Rural Generalist researchers across the globe who are supported to varying degrees by their own national research infrastructure.

The terminology of RGM is becoming increasingly prevalent in the international literature and in educational and professional training frameworks. Similarly, the conceptual model of Rural Generalism is widely discussed and being increasingly incorporated into formal systems.

Colleges' role in supporting RGM research

Nearly all RGM research emanating from Australia involves members of one or both of the general practice colleges. The colleges both undertake research and endeavour to support and promote a research effort across their membership. Most of the members' research activities are done in conjunction with external organisations as outlined below, but some is also done directly through their respective colleges. In addition to publication, senior members of the two Colleges regularly attend and present at international forums on the specialist field. Some key international forums have included:

- World Organisation of Family Doctors (WONCA) Rural – World Rural Health Conference, held annually by the WONCA Rural (WONCA Working Party for Rural Practice)
- Ottawa Conferences for Health training programs' Assessment and Evaluation
- Rural Generalist Summits held in 2013, 2015, 2017 in conjunction with the WONCA Rural conferences

Within the field of RGM some key efforts by the Colleges are detailed below.

ACRRM:

ACRRM is dedicated to RGM and has a research committee to drive scholarship in this field. The Committee includes in its membership international Rural Generalist researchers and representatives of the Rural Clinical Schools. The College has a dedicated Quality and Safety Council as one of its three peak Councils to determine appropriate quality and safety standards and clinical guides associated with its Fellow's Rural Generalist practice. It has a series of clinical reference sub-groups to provide expert clinical advice in key areas of Rural Generalist practice. The College also has a Digital Health Committee.

Some key research related to the field undertaken directly by the College includes:

- Walters et al. Selection Outcomes that Count: Seven Years on from developing selection criteria to develop a Rural Generalist Workforce. Presentation to the Ottawa Conference, August 2022.
- Position Paper: ACRRM Fellowship - Articulating the RGM Standard (2022)
- Position Paper: Defining Safe and quality procedural and advanced care (2022)
- Rural and Remote Access to Primary Health Care (2020)
- FACRRM Assessment – a review of the first 12 years (2020)
- Rural and Remote General Practice in Scotland (2019)
- Position Paper: RGM (2018)
- Rural Procedural Grants Program: Briefing Paper (2016)
- The Rural Way: Implementation of a National Rural Generalist Pathway (2014)
- The expanding role of generalists in rural and remote health: A systematic review (2007)
- The Arts of risk management in rural and remote medicine (2007)

RACGP:

The RACGP has a number of expert committees including the RACGP Expert Committee – Research which was established to provide advice and policy direction on research related issues in general practice. The Rural Education Committee is dedicated to excellence and innovation in rural general practice training and education. They provide advice on education development and strategy including for the RACGP Rural Generalist Fellowship. The RACGP also has a dedicated Anaesthetics Working Group which considers common issues facing Rural Generalist Anaesthetists and promotes the development of advanced skills training. This working group sits separately to the Joint Consultative Committees which develop and govern some of the additional skills training.

RACGP Foundation provides grants and awards to GPs undertaking research in general practice. These awards have included research investigating the experience of rural GP interns, and also research into the rural general practice supervisors who underpin the capacity for rural general practice training. The RACGP has funded approximately 20 Education Research Grant projects in the past five years which have included a focus on rural training settings. The RACGP strongly supports research training for rural trainees, including through the Academic Post Program. The following Academic Post research projects with a rural focus (since 2018) include:

- Assessing the contraceptive choice and decision-making processes of adolescent and young women in rural and remote New South Wales (2023)
- Understanding rural general practitioners' perceptions of and facilitators and barriers to the management of metabolic syndrome in country areas of Western Australia (2023)
- How do rural general practitioners manage suspected melanoma? (2023)
- GP perspectives on what enables rural patients to have a good death (2022)
- Comparing the help-seeking behaviour in patients with breast cancer from rural and urban NSW: A qualitative study (2021)
- Smoking, men and mental illness – a social determinants of health approach in a regional setting (2020)
- Using a hand-held medical device for opportunistic screening for atrial fibrillation in rural general practice settings (2019)
- A study to evaluate the acceptability and usability of the NSW Health template 'Making an advance care directive' in general practice patients in rural NSW (2018)
- A snapshot of clinical learning opportunities in general practice placements recorded by undergraduate medical students at distributed sites across rural and metropolitan Victoria (2018)

The RACGP Research Strategy 2021-2024 aims to foster general practice research capacity which equips rural GPs to participate in and undertake research, improved training in research and critical thinking, and ultimately enhanced quality of healthcare in general practice throughout all of Australia. The 2022 RACGP curriculum and syllabus for Australian general practice has a unit on Research in General Practice

The RACGP provides a number of services to members undertaking general practice research, to support clinical practice and any level of research GPs may wish to engage in. These include:

- The RACGP Library has a unique and specialist collection of rural general practice related resources. Members can send requests for resources, information, journal articles and literature searches, and can also directly access full text journal titles, e-books and other resources via the website.
- The National Research and Evaluation Ethics Committee is a human research ethics committee with a focus on general practice research. Its responsibility is to ensure the ethical conduct of human subject research and provides a service to GP researchers in all parts of Australia who may not otherwise have access to an ethics committee.
- RACGP GP Research Project Noticeboard lists opportunities for GPs to participate in a variety of different research projects and promote their own studies.

- The Australian Journal of General Practice (*AJGP*) is a peer-reviewed journal which aims to provide relevant, evidence-based, clearly articulated information to Australian general practitioners (GPs) to assist them in providing the highest quality patient care, applicable to the varied geographic and social contexts in which GPs work and to all GP roles as clinician, researcher, educator, practice team member and opinion leader.
- The RACGP Annual Conference has both research and rural health sessions, providing the opportunity for Rural Generalists to present and learn about new research relevant to their practice.
- A Research webinar series is available for GPs nationally to access to upskill in aspects of research and evidence- based medicine.
- The RACGP provides representatives on various research advisory groups and committees. For example, the RACGP has an expert representative on the PARTNER rural clinical trials practice-based research network that has been funded through the MRFF. The network will recruit 90 rural GP practices across Australia to form a national network that helps improve access to clinical trials for rural patients. It's goal is also to build rural primary health care research capacity to improve the development and conduct of primary care-based clinical trials.

The RACGP also supports GP research led by other organisations in a variety of ways – writing letters of support, providing GP subject matter experts to be involved in the research, promoting the research to our GPs to engage in etc. In 2021 we supported the University of Melbourne's grant application for funding their "Strengthening Care for Rural Children" research project. This project is focused on supporting and upskilling rural GPs to deliver evidence-based child health management practices, increasing the quality of paediatric care delivered; reducing unnecessary referrals to hospital services; increasing GP's confidence in the management of paediatric conditions; and increasing family confidence in and preference for the GP to manage their child's health needs closer to home.

Some policy research related to the field undertaken directly by the College includes:

- Submission to the inquiry into the provision of general practitioner and related primary health services to our metropolitan, rural and regional Australians (2021)
- General practice research priority setting in Australia (2019)
- Position paper – Rural Generalism 2020 (2017)
- Position Paper - Integrated rural training hubs (2016)
- GP-led palliative care in rural Australia (2016)
- Position paper – Advanced skills in rural general practice (2014)
- Final report – New approaches to integrated rural training for medical practitioners (2014)
- Supporting the next generation to ensure a future rural general practice workforce (2014)

National programs supporting research in RGM

Rural Generalist Coordinating Units

The seven Rural Generalist Coordinating Units in each of the states and Territories (New South Wales and Australian Capital Territory are a single unit) are funded to undertake a range of tasks which extend to supporting research in the field. The Queensland Rural Generalist Program which has been established since 2009 and has dedicated funding to support research including a Senior Clinician Researcher appointment and a program of research grants in the discipline. It has built a considerable body of research in the field. Its publications in the past five years include:

- Martin P et al (2019) Rural competencies in emerging medical practitioners: Beyond clinical skills[46]
- Tennett et al. (2020) Access and outcomes of general practitioner obstetrician (Rural Generalist)-supported birthing units in Queensland[47]
- Bond and Chong (2020) Investing in Queensland's rural medical leaders: Lessons from the Queensland Rural Generalist Program[48]

- Kitchener et al (2021) Queensland Rural Generalist Pathway: why do trainees separate without achieving a Rural Generalist end point?[49]
- Kitchener. (2021) Local and regional workforce return on investment from sponsoring Rural Generalist-based training for medical students[50]

National General Practice Training Framework

The Australian General Practice Training (AGPT) program has been in place for over twenty years to support general practice training including training to Rural Generalist scope. Over that time, the program has sponsored research through the Regional Training Organisations network that it has funded. This has been undertaken by registrars as well as through the network staff. Going forward this funding will be directed to the general practice colleges directly. Funding to support research is also provided in association with the AGPT program to the General Practice Supervisors Association (GPSA). This work has included considerable scholarship in the field of RGM. Research has included:

- O'Sullivan et al. (2021). Supervision Roadmap: Rural Generalist training in Victoria.[51]
- O'Sullivan et al. (2022). Developing supervision capacity for training Rural Generalist doctors in small towns in Victoria.[52]

Rural Clinical Schools and Universities

The Rural Clinical Schools (RCS) network has been funded for over twenty years by the Commonwealth Government to support research in the broader area of rural medicine. The network currently comprises 89 RCSs attached to 18 university medical schools. It is further supported in this work through the Integrated Rural Training Hubs program. These networks have been a key driver of research in rural and remote medicine and specifically in the field the of RGM. Some key publications generated through this network in the past two years include:

- Padley et al. (2022) Contemporary Australian socio-cultural factors and their influence on medical student rural career intent.[53]
- Roxburgh et al (2022) Satisfaction with general practitioner obstetrician-led maternity care in rural Western Australia.[54]
- Wazir et al (2022) General practitioner obstetricians' models of care in rural Western Australia.[55]
- Woolley et al. (2021) "We learnt it, then we lived it": Influencing medical students' intentions toward rural practice and generalist careers via a socially-accountable curriculum.[56]
- Raftery et al. (2021) Factors associated with medical students' interest in remote and very remote practice in Australia: A national study.[57]
- O'Sullivan et al (2020) Understanding the field of rural health academic research: a national qualitative, interview-based study.[58]
- O'Sullivan et al (2020), A Realist Evaluation of Theory about Triggers for Doctors Choosing a Generalist or Specialist Medical Career [59]

Peer-reviewed Journals supporting research in RGM

There are a range of peer reviewed journals based both in Australia and overseas which provide a particular focus on issues of rural and remote health and medicine generally and include significant scholarship in RGM. These include:

- The Australian Journal of Rural Health which is administered in association with the National Rural Health Alliance of Australia and is peer-reviewed by an international editorial team. The team includes clinicians from a range of disciplines including several Rural Generalists and Fellows of RACGP and/or ACRRM, including Prof Roger Strasser FACRRM, FRACGP.

- The Rural and Remote Health Online (International) which is based in Australia and peer-reviewed by an international team of experts. This has a stronger focus on medicine. Its editor in chief is Rural Generalist and the commissioner of the National Rural Generalist Pathway

Taskforce Report, Prof Paul Worley. Its regional editorial team includes Rural Generalists from around the world.

Some other important journals contributing to RGM research include:

- Australian Journal of General Practice: journal of the RACGP
- African Journal of Primary Healthcare and Family Medicine: journal of the WONCA African Region.
- BMC Medical Education, Medicine (International)
- Canadian Journal of Rural Medicine: journal of the Society of Rural Physicians of Canada
- Canadian Family Physician: journal of the College of Family Physicians of Canada
- Human Resources for Health (WHO)
- Journal of the American Board of Family Medicine
- Journal of Family Medicine and Primary Care (India)
- Journal of Rural and Remote Health (United States): journal of the National Rural Health Alliance of the United States.
- Journal of Primary Healthcare (New Zealand): journal of the Royal New Zealand College of General Practitioners (RNZCGP)
- Lancet Regional Health (Western Pacific, United States)

1.B.2 A comprehensive and developing body of international and local research, literature, practice, and innovation

This requires that that the applicant provide evidence that the proposed specialty is well recognised in academic medicine. This can be demonstrated through documenting:

- senior academic appointments in medical schools in Australia and other countries held by members of the applicant body
- postgraduate courses offered in Australian and international universities
- coverage in medical school undergraduate and prevocational graduate programs.

Prevalence in international literature

The field of RGM can be shown to have a strong and rapidly growing footprint in the international literature particularly in the past five years.

A complicating factor in describing the body of research is that there is not an internationally consistent language to describe this specialist field of RGM, nor the discipline of general practice. “Rural Generalist” terminology is commonly and increasingly used in the medical literature. The literature review described below for example found 64 peer reviewed articles published in the past five years specifically using this terminology to describe these doctors and their practice. With over a third of these (24) documenting overseas experience and perspectives.

Where it is not used, the terminology of “family practice”, “family physicians”, “family doctors”, “primary care doctors” or “general practitioners” is often paired with references to an expanded scope for rural settings such as rural proceduralism, hospitalism, general practice with an associated advance skill, (e.g., GP obstetrics, GP surgery, GP anaesthetics etc.), and/or general practitioners with special interests. There is also considerable discussion in the international literature now related to rural generalism in the context of allied health and nursing. These concepts all overlap with the concept of RGM, but there are important distinctions to be made with each of these concepts, none of which fully describe the scope of RGM. This application proposes that national recognition of the specialist title and specialist field would assist in this regard and strengthen further shared learning among scholars in this field.

Schubert et al[60] carried out a comprehensive scoping review of the prevalence of RGM issues in the international literature in 2018. Their analysis reviewed literature from 1988 to 2017. To provide a continuous picture to the present, a review has been conducted from 2018 to Sep 2022, using similar design methods.[ii]

The summary outcomes of the 1988-2017 review are as follows:

Table 1.2: Geographic regions of included papers (published from 1988 to 2017)	
Region	Included
Asia pacific	4
Australia/New Zealand	46
North America	36
Africa	11
Europe	4
International (WHO)	1
Total	102

Table 1.3: Articles by report type (published from 1988 to 2017)	
Descriptive opinion piece	40
Quantitative data analysis	22
Qualitative study	12
Position paper	10
Literature review	8
Program description	8
Government report	7
Systemic review	2
Total	109

For the updated literature review similar search methods were used. These were intentionally consistent with the design parameters of the study by Schubert and colleagues and the authors are acknowledged for their personal assistance.

The following data collection methods were adopted.

Search terms and databases
Rural* AND Generalist* OR Generalism* (PubMed, Scopus, Web of Science, Ovid)
Other search methods
• Manual search of reference lists of identified articles • Google Scholar • Grey literature from existing resources known and identified from specific grey literature data searches (on Scopus and Web of Science).

The inclusion/exclusion criteria applied to the screening of the papers for this review

Criterion	Inclusion	Exclusion
Time period	May 2017-Sep 2022	Studies outside of these dates
Article type	Peer-reviewed literature Grey literature from Government or Medical Professional Organisations	Non-peer reviewed publications and online sites Grey literature not from Government or Professional Organisations
Study focus	Rural medical generalism; the scope of rural medical generalist, the RMG training pathway	Articles on Rural Generalists that did not meet the specific (Collingrove) definition

[ii] Special thanks to Nick Schubert, Prof Tarun Sen Gupta and Dr Rebeca Evans for their assistance and advice.

Criterion	Inclusion	Exclusion
	enablers and barriers to practice and recommendations for reform. Rural generalism definition as general practitioner/family practitioners/family physician in rural areas with reference to provision of primary and emergency care and one or more specialised practice The definition of RGM involves an inclusive use of the term 'rural' to reflect the context of the specific research setting	Disciplines outside of medicine (allied health, nursing, and health support roles) Rural specialist physicians including 'generalist specialists' other than in the context of their relationship to Rural Generalists Articles with a focus on a specific advanced skill (e.g. obstetrics) unless it was examined in the context of rural generalism. Disease specific research unless it was considered in the context of rural generalism.
Literature focus	Articles with specific reference to the development of rural medical generalism and/or rurally based general practitioners/family practitioners, primary health family practitioners or family physicians with specialised (procedural or non-procedural GP proceduralists)	Articles that discussed rural heath, rural medicine and/or rural GPs but without reference to rural medical generalist as defined by the Collingrove definition
Population and sample	Rurally-based medical generalist as rural GPs/primary medical care provider with specialised sills (including rural GP proceduralists	Other GPs and/or medical practitioners outside of the (Collingrove) definition of Rural Generalist

The updated literature review highlighted a continuity with the findings of Schubert et al and a strengthening of the body of literature developing around the essential concepts associated with RGM. With almost as many items published in the past five years (109) as were published in the preceding thirty years (108).

It demonstrated that Canada, Australia, and New Zealand and to a lesser extent Japan, Oceania, and South Africa, are the key international centres that have engaged with the terminology of Rural Generalism. In these countries, the developments in the literature have occurred in tandem with the development of curricula and training pathways dedicated to this field.

The United States and India are also notable contributors to the discussion of broad scope, context adaptive, rural general practice, albeit with less use of the Rural Generalist terminology. The World Health Organization (WHO) has also supported considerable scholarship in this area.

Schubert et al noted in their analysis, that most of the published research in the field had taken the form of descriptive opinion pieces and noted the need to build the research base. It is noteworthy thus, that the majority of literature found from the subsequent five years has taken the form of qualitative and quantitative studies.

While it is outside the scope of this application, it is noteworthy that there is also a growing body of research around the Rural Generalist model of care as it applies to other healthcare disciplines. This is important as it supports the development of well-defined and appropriately trained healthcare teams, within which the Rural Generalist scope of medical practice can be delivered. For example, a PubMed search over the past five years found, six articles in peer reviewed literature specifically naming and discussing Rural Generalist practice within their respective disciplines. [61,62,63,64,65,66]

Table 1.4: Geographic regions of included papers (published May 2017-Sep 2022)	
Region	Included
Asia pacific (Japan, Kyrgyzstan, India, Nepal, Oceania)	7
Australia	47
New Zealand	10
Canada	20
United States	10
Africa (South Africa)	5
Europe (Scotland)	1
International	8
Total	108

Table 1.5: Articles by report type (published May 2017-Sep 22)	
Descriptive opinion piece	14
Quantitative data analysis	26
Qualitative study	38
Position paper	10
Literature review	0
Program description	14
Government report	1
Systemic review	5
Total	108

Some of the key scholarly journals included in the review are:

Table 1.6 Key journals' frequency in included articles	
Journal	**Included**
Journal of Rural and Remote Health	13
Australian Journal of Rural Health	11
Journal of Primary Healthcare (New Zealand)	8
Canadian Family Physician	5
Canadian Journal of Rural Medicine	4
Journal of the American Board of Family Medicine	4
Medical Journal of Australia	4
Frontiers of Public Health (WHO)	3
Australian Journal of General Practice	2
Human Resources for Health (WHO)	2
Journal of Family Medicine and Primary Care (India)	2
Lancet Regional Health (Western Pacific, United States)	2
Journal of Rural Medicine (Japan)	2
African Journal of Primary Healthcare and Family Medicine	2
Frontiers of Public Health	2
New Zealand Medical Journal	2
Journal of Rural Health (United States)	1
British Medical Journal	1
Bulletin of the WHO	1
Journal of the American Medical Association	1

A full summary of the included papers in the literature review is provided.

Attachment 1.1 Summary of RGM Literature Review Included Papers

Key Appointments in Universities

In Australia, Canada, and New Zealand many key academic appointments have been made to doctors with Rural Generalist qualifications from RACGP and/or ACRRM. Others have attained

equivalent training through alternative credentials or certification. These doctors have been appointed to positions related to the specialist field, such as Professorships in Rural Health. Some leading Rural Generalist academics and their key current and previous positions in Universities are listed below.

Key Rural Generalist Appointments in Universities
Prof Bruce Chater OAM MS BS (Hons) Qld, FACRRM, DRANZCOG Adv, FRACGP FACNEM Head of Mayne Academy of Rural and Remote Medicine and Rural and Remote Medicine Clinical Unit, Chair, WONCA Rural (Working Party on Rural Practice) Prof Chater is a Rural Generalist based in Theodore, Queensland He is a former President of ACRRM and a foundation member of WONCA Rural. He was the founding convenor of the Rural Doctors Associations of Queensland and Australia as well as the National Rural Health Alliance.
Prof Ian Couper, BA, MBBCh, MFamMed, FCFP(SA) Managing Director, University of the Witwatersrand, Centre for Rural Health, and, Professor Rural Health, Stellenbosch University, and Director, Ukwanda Centre for Rural Health, South Africa A trained family physician, Prof Couper spent nine years practising in a remote rural hospital in northern KwaZuluNatal province, and then 16 years working in primary care and health service development in rural Northwest province. He held the first chair of Rural Health at the University of the Witwatersrand (Wits). He has chaired both the Rural Doctors Association of Southern Africa (RuDASA) and the WONCA Working Party on Rural Practice (WONCA Rural).
Prof Richard Hays, MBBS PhD MD FRACGP FACRRM FRCGP, DRACOG PFHEA FAoME FANZAHPE FAMEE Professor, Rural and Remote Health and Medicine, JCU Formerly Foundation Dean of Medicine, JCU, and Dean of Medicine, University of Tasmania Professor Hays was at the vanguard of international rural health research and is internationally published in medical education, medical assessment, and rural health. Prof Hays has worked extensively across rural and remote Australia.
Prof Richard Murray, FACRRM Dean, Medicine and Dentistry, James Cook University, and member of the board of Medical Deans Australia and New Zealand. Prof Murray's career focus has been in rural and remote medicine, Aboriginal health, public health, tropical medicine, medical and health professional education and the healthcare needs of underserved populations. He has a national and international profile in rural medical education and rural medicine and has held a range of national leadership positions.
Prof Jill Konkin, BA(Hons), MClSc, MD Professor, Department of Family Medicine Formerly, Associate Dean, Rural and Regional Health, Faculty of Medicine and Dentistry, University of Alberta and Formerly, Associate Dean, Admissions and Student Affairs, Northern Ontario School of Medicine. Prof Konkin is a Rural Generalist and has held key roles including as Chair of the Association of Faculties of Medicine Distributed Medical Education Network, and a member of the planning group for the International Consortium of Longitudinal Integrated Clerkships, and various representative roles on the Alberta College of Family Physicians.
Dr John McCarthy MD Assistant Dean, Rural Medical Programs, University of Washington Dr McCarthy leads the Rural/Underserved Opportunities Program (RUOP) of the University of Washington, one of the United States' largest medical schools, ranked as its top school for both rural medicine and family medicine. This incorporates, the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) Rural Integrated Training Experience (WRITE) with 31 family residency programs across those states, and the Targeted Rural Underserved Track (TRUST) programs. Dr. McCarthy has practiced in rural communities for many years.
Assoc Prof Lachlan McIver MBBS FACRRM MPHTM FAFPHM FACTM PhD Associate Professor at JCU and Medical Advisor, Infectious Diseases, Epidemic Response and Antimicrobial Resistance, Médecins Sans Frontières International Office Assoc Prof McIver is a Rural Generalist and public health physician, with over ten years of experience working in remote, Indigenous, and tropical communities around Australia, Africa, Asia, and the Pacific. He is an internationally published research and book author.

Key Rural Generalist Appointments in Universities
Dr Sarah Newbery MD Associate Dean, Physician Workforce Strategy Dr. Newbery is inaugural Associate Dean of Physician Workforce Strategy. In this role, she works with faculty, communities, and other partner organizations to support strategic initiatives to enhance the physician workforce for Northern Ontario. She has worked as a Rural Generalist family physician of over 25 years in the community of Marathon, she has held leadership roles in primary care, the hospital sector, and the Ontario College of Family Physicians.
Assoc Prof Gary Nixon, MB ChB FRNZCGP(Dist) FDRHMNZ PGCertCPU PGDipRPHP Associate Dean Rural, Division of Health Sciences and Head of Rural Section, Department of General Practice and Rural Health, University of Otago, New Zealand A/Prof Nixon is a practising Rural Generalist, based at Dunstan Hospital in Clyde for both his academic and clinical roles. He is developing a system of geographic classification for health to improve understanding of urban vs rural differences in outcomes and access in New Zealand. His other research interests include workforce development, rural cardiovascular disease management, rural hospitals and rural diagnostics including point-of-care ultrasound and laboratory testing.
Prof James Rourke, MD, CCFP(EM), MClinSc, FCFP, FRRMS, FCAHS, LLD Professor Emeritus, Memorial University of Newfoundland, Canada. Formerly, Dean of Medicine and Professor of Family Medicine at Memorial from 2004 to 2016. Prof Rourke has practiced as a Rural Generalist family physician for 25 years in Goderich, Ontario where he was the founding Director of the Southwestern Ontario Rural and Regional Medicine Program of the University of Western Ontario and Assistant Dean, Rural and Regional Medicine.
Prof Roger Strasser AM, MBBS, BMedSc, MCISc, FRACGP, FACRRM Professor of Rural Health (Te Huataki Waiora School of Health) Formerly, founding Dean and CEO of the Northern Ontario School of Medicine from 2002 to 2019. In 2020, Prof Strasser became Professor of Rural Health at the University of Waikato in New Zealand. Prior to 2002, he was Professor of Rural Health and Head of Monash University's School of Rural Health. From 1992 to 2004, he was Chair, World Organization of Family Doctors (WONCA) Rural Practice Working Party. He has many years' experience as a Rural Generalist and General Practitioner in rural Victoria and around the world.
Prof Sarah Strasser, OAM, FACRRM, FRACGP Dean (Te Huataki Waiora School of Health) Formerly, Head, Rural Clinical School, Faculty of Medicine and Biomedical Sciences, UQ Formerly, Associate Dean, Flinders University Medical Program – Northern Territory In addition to her research and academic roles, Prof Strasser has many years' experience working as a Rural Generalist and General Practitioner in rural Victoria, northern Canada and New Zealand.
Adjunct Prof Ruth Stewart, MBBS, PhD, FACRRM, DRANZCOG (adv) Adjunct Professor Rural Medicine, JCU Formerly, Director, Rural Clinical Training and Support, JCU Director of Rural Generalist Training, Queensland Rural Generalist Program Adjunct Prof Stewart worked for twenty-two years as a Rural Generalist obstetrician in Southwest Victoria and has lived and practiced in the Torres Strait and north and southwestern Queensland. She led the JCU Rural Clinical School program and was course director for the Masters of Rural and Remote Medicine postgraduate course at JCU. She is the National Rural Health Commissioner.
Prof Tarun Sen Gupta, MBBS, FRACGP, FACRRM Professor of Health Professional Education and Head of the Townsville Clinical School, JCU College of Medicine and Dentistry, North Queensland, Australia. Prof Sen Gupta was in rural practice in Richmond, north-west Queensland from 1987-1993, and has worked in leadership roles in rural medical education since 1993. He has worked as Rural Generalist Training Adviser for Queensland's Rural Generalist Pathway. He has held executive roles on the Rural Doctors Association of Queensland and the RDAA Research Foundation and is Chair of the ACRRM Assessment Committee.
Prof Lucie Walters, PhD, MBBS (UoA), DCH, FRANZCOG, FRACGP, FACRRM Director, Adelaide Rural Clinical School. Prof Walters was instrumental in developing Australia's reputation for longitudinal integrated clerkships and contributed to Flinders University, Otago University and University of Northern Ontario programs. She has worked as a Rural Generalist in Mount Gambier since 1993 with clinical scope

Key Rural Generalist Appointments in Universities
during this time covering: general practice, emergency medicine and inpatient care. She is a former President, Australian College of Rural and Remote Medicine.
Prof Paul Worley, FACRRM, FRACGP Emeritus Prof College of Medicine and Public Health, Flinders University Inaugural National Rural Health Commissioner Rural doctor and Dean of Medicine at Flinders University Prof Worley was the inaugural National Rural Health Commissioner. He is the Editor in Chief of the international online journal, Rural and Remote Medicine. He has been a leader in developing evidence based rural longitudinal clerkship programs in South Australia where he has lived and practice as a Rural Generalist for many years.
Prof Ian Wronski, AO MBBS, MPH, MScEpid, FACTM, FAPHM, FRACGP, FACRRM Emeritus Professor, Deputy Vice-Chancellor Northern Australian Medical and Health Workforce Development at Charles Darwin University Formerly, Deputy Vice Chancellor, Division of Tropical Health and Medicine, JCU, and Dean of Faculty of Medicine, Health, and Molecular Sciences Past President and Hon Life Member, ACRRM Prof Wronski was the inaugural Director of Health Services, Kimberley Aboriginal Medical Services Council and Medical Director of the Broome Regional Aboriginal Medical Service where he worked for many years as a Rural Generalist. He currently holds roles as chair of the Tropical Australian Academic Health Centre and Board member of the Asia Pacific Economic Cooperation (APEC) Life Sciences Innovation Forum.

Training Pathways, Programs and Curricula

Undergraduate Education in Australia

At the undergraduate level all AMC accredited, and compliant medical curricula should provide the essential foundations for the practitioners in the specialist field to progress to prevocational training. There are however key features of medical curricula that can maximally prepare graduates for a career as a Rural Generalist. These would include:

- Significant rural training experience and rural community immersion
- Curriculum content specifically addressing issues of rural health
- Foundational training in working in situations of relative self-reliance, clinical uncertainty, and unpredictability
- Strong Aboriginal and Torres Strait Islander health
- Strong generalist orientation
- Experience in primary care and particularly in general practice settings

Australian university have embraced these concepts to varying degrees and the Commonwealth funded Rural Clinical Schools network has strongly supported this work. Flagships such as James Cook University Medical School have dedicated rural selection and curricula as well as the potential to train completely in rural and remote settings. While other universities have identified innovative rural programs such as the Flinders University Integrated Training Pathway.

Postgraduate Training in Australia

At the prevocational level ideally preparation for Rural Generalist careers would include:

- Significant (if not all) training time in rural/remote locations
- Strong foundational skills in in-patient care, emergency, anaesthetics, obstetrics
- Significant time spent in community-based primary care clinics

The Commonwealth Government's John Flynn Rural Doctors Program has been established to facilitate rurally based generalist training in the first two prevocational years leading to

general registration. Ideally, this can link up to the various Rural Generalist programs established in all states and territories through the Rural Generalist Coordinating Units. These programs take various designs but all support prevocational training typically in advanced skill areas associated with Rural Generalist practice.

Some universities also offer postgraduate courses not directly linked to Fellowship qualification, but which support the professional skills development of Rural Generalist practitioners.

Rural Generalist Fellowship level training should be based in a rural or remote location and should include the broad skills associated with comprehensive general practice, emergency medicine, and the broad scope of extended and advanced skills. Ideally content and assessment should reflect the rural and remote context.

Some of the key training programs in Australia and internationally demonstrating these features are detailed below.

Table 1.7 Flagship Rural Generalist Training Curricula and Programs

Program	Description
Rural Clinical Schools, Australia	There are 18 University Medical Schools supporting 89 Rural Clinical Schools. The Rural Clinical Schools are funded by the Commonwealth Department of Health to facilitate rural immersion options in the medical programs of the participating medical schools. The schools aim to encourage students to become rural doctors. They have a specific aim to collaborate with key organisations to this end including ACRRM and the RACGP. The Federation of Rural Australian Medical Educators (FRAME) provides national coordination to the work of the network members including toward developing national policy and in growing a national pool of data on their operations.
Rurally oriented undergraduate medicine (MBBS) and Masters and Postgraduate Diploma of Rural and Remote Medicine, JCU, Australia	At the undergraduate level, the University offers a rural immersion pathway whereby students are placed in rural areas and live and study there for a year. They are attached to hospitals and local GP practices and travel to more remote locations. At the postgraduate level the Rural Health Department offers several courses to rural GPs and Rural Generalist doctors: • Postgraduate Diploma of Rural and Remote Medicine • Masters of Rural and Remote Medicine These are postgraduate programs for rural clinicians wishing to expand their capacity as educators and researchers in issues related to rural and remote medicine.

Table 1.7 Flagship Rural Generalist Training Curricula and Programs	
State/Territory led Rural Generalist Programs, Australia	All states and territories are funded by the Commonwealth Government to support postgraduate training in RGM. Their activities include facilitating prevocational training and supporting Fellowship training with the two general practice colleges. The programs include: • New South Wales Rural Generalist Program (includes ACT) • Northern Territory Rural Generalist Program • Queensland Rural Generalist Program • South Australian Rural Generalist Program • Tasmanian Rural Generalist Program • Victorian Rural Generalist Program • Western Australian Rural Generalist Program
Rural Generalist Pathway - Northern Ontario Medical School (NOMS), Canada	NOMS Rural Generalist Pathway provides training from undergraduate medicine through to Fellowship qualification based in rural areas of northern Ontario. Pathway participants undertake Rural Generalist specific content throughout their training. Pathway includes: • Undergraduate Medical Education program to medical degree (MD) (rurally oriented) • Residency Programs includes Family Medicine enhanced skills programs
Medical program and residency, Memorial University of Newfoundland, Canada[67]	Graduate-entry medical program to medical degree (MD). Includes: • Core clerkship in Rural Family Medicine: Students work with and learn from rural physicians in the 'cottage hospital' setting of small GP-run rural and remote hospitals. • Electives/selective: Family Medicine, rural and remote electives give senior students additional opportunities to practice advanced skills with greater independence under rural Family Medicine supervisors. • Vocational residency training accredited by the College of Family Physicians Canada (CFPC). This includes option for CFPC Priority Rural Topics (Adv skills)
Fellowship Curriculum, (inc. Rural and Remote Family Medicine), College of Family Physicians of Canada	Assessment Objectives for Certification in Family Medicine, including: Priority Topics and Key Features for Rural and Remote Family Medicine (See Appendix 1) Advanced Skills curricula: • Obstetric Surgical Skills • Advanced Family Practice Anaesthesia • Enhanced Surgical Skills • Palliative Care • Care of the Elderly • Addiction Medicine The Advanced Skills programs are delivered through medical schools including: • University of Toronto • University of Albertha • Northern Ontario Medical School

Table 1.7 Flagship Rural Generalist Training Curricula and Programs	
	• McMaster University • McGIll University • University of British Columbia
Rural Training Tracks, University of Washington School of Medicine (UWSOM) and WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) Collaboration, United States	Rural Training Tracks - UWSOM - is a post internship residency program designed to train doctors for rural areas with a full Rural Generalist scope including emergency obstetrics, public health, primary care, inpatient care, emergency care with a commitment to underserved communities Program includes: • Full spectrum family medicine including surgical obstetrics from well-trained family physicians • High volume of clinic and hospital procedures • Opportunities for Spanish language immersion program • Active community engagement, including school-based health centres, migrant camp outreach clinics • Robust behavioural health and addiction medicine program including colonoscopy/EGD for interested learners • Several options for full spectrum jobs in North Central Washington post-residency The WWAMI Rural Integrated Training Experience incorporates 31 rural family residency programs across those states.
Rural Pipeline Programs, United States	There are around 40 rural training pipeline medical schools in the United States offering broad scope Rural Generalist type curriculum options. Key programs include: • Physician Shortage Area Program (PSAP) of Jefferson Medical College, Thomas Jefferson University[68] • RMED Program of the University of Illinois College of Medicine (COM) at Rockford • Rural Medical Education (RMED) Program, State University of New York • Rural Health Leaders Pipeline at the University of Alabama • Rural Physician Associate Program (RPAP) of the University of Minnesota; the University of Minnesota Medical School, Duluth • Upper Peninsula Program of Michigan State University • University of Missouri School of Medicine Rural Track Pipeline Program (MU-RTPP)
Postgraduate Diploma in Rural Medicine, Stellenbosch University, Ukwanda Centre for Rural Health, South Africa[69]	Postgraduate Diploma in Rural Medicine The program prepares doctors to work in rural district hospitals in South Africa and elsewhere in Africa with the necessary knowledge, skills and approaches for practice in these contexts. Graduates have clinical skills to: • manage a range of patients at a rural district hospital with limited specialist support • be able to work with the local healthcare team and maintain effective healthcare delivery systems • understand appropriate public health interventions • participate in community-oriented primary healthcare. Four modules:

Table 1.7 Flagship Rural Generalist Training Curricula and Programs	
	• Clinical Skills for District Hospitals • Major Infectious Disease Challenges • Clinical Governance in District Health Services • Delivering Healthcare in Rural Communities
Medical Programs, University of Waitangi, University of Otago, New Zealand	Both these medical schools offer rurally-based and rurally-oriented undergraduate programs. The University of Otago operationally links through to training in the New Zealand Rural Generalist Program. Additionally, University of Otago offers: • PG Diploma in Rural and Provincial Hospital Practice • PG Certificate in Rural and Provincial Hospital Practice • Postgraduate Certificate in Clinician Performed Ultrasound • CME program specifically aimed at doctors working in Rural Generalist practice. Including, The Otago flagship, annual Rural Generalist CME Workshop is offered in conjunction with the Cook Islands Ministry of Health and the Division of Rural Hospital Medicine in the Cook Islands annually.
Rural Generalist Program Japan[70]	Rural Generalist postgraduate training program based on ACRRM curriculum, based in rural and remote islands of Japan, includes. Training comprises: • onsite domestic training in a rural or remote hospital for 12 months • webinars featuring online discussions and lectures by Rural Generalists, and, • elective training for up to 3 months (rural locations in Australia, Norway, Nepal, the US)
Rural Generalist Program, New Zealand[71]	The New Zealand Rural Generalist training model is distinct. It recognises and aligns with the Cairns Consensus definition of RGM. It offers a dual training approach in which rural doctors train for a 'rural hospitalist' qualification in parallel with a 'rural GP" qualification through the Royal New Zealand College of General Practitioners. They are then part of a single CPD program. The training program is delivered in partnership with University of Otago.

1.B.3 Formal recognition of the field of practice in the health systems of comparable countries

This requires that that the applicant describe the formal status of the proposed specialty in comparable international jurisdictions. Relevant examples include, but are not confined to, the United Kingdom and Ireland, the United States of America, Canada, and New Zealand.

The colleges are proud to acknowledge that Australia is a world-leader in promoting, facilitating, and researching this field of medicine. This partially reflects the confluence of the maturity of our institutions and the fact that the geography and demography of our country makes this field of medicine an especially valuable tool for meeting our national healthcare needs.

There is also a recognition that globally, primary care generally and especially primary-centred care in rural areas is by its nature poorly connected to, and poorly represented in the decision-making structures of health systems.[72] We are thus gratified to be in a country which has

continued over many decades to be at the forefront of these international developments for better health services so closely related to patterns of health disadvantage and inequity.

Formal recognition has however occurred to various degrees in other countries and is increasingly emerging in the health systems of other countries. This recognition takes diverse forms reflecting the diversity of systems and funding structures and the diversity of terminology used to describe similar practice models.

International

Some key international agreements and developments that formally recognise Rural and Remote Medicine include:

Cairns Consensus International Statement on RGM This was signed by 43 signatories representing 23 organisations from 12 different countries and five continents. The Statement was made following the Rural Generalist Summit of 2014. The Cairns Consensus is recognised by the Canadian Society of Rural Physicians, the New Zealand Rural Generalist Program, the South African Diploma of Rural Medicine, the Queensland Rural Generalist Program. The Cairns Consensus Statement is recognised in the WONCA Consensus Statements (see below).

Rural WONCA: The World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) is the peak international body representing family doctors/general practitioners. It has ten Working Parties dedicated to core areas of family practice on of which is the Rural Practice Working Party known as Rural WONCA.

Rural WONCA has been in operation for over thirty years. The group is led by doctors that describe themselves as Rural Generalists including its chair, Prof Bruce Chater who holds a FACRRM and FRACGP and has been a practicing general practitioner providing obstetric care and hospital management for many years. It includes rural doctor members from each of the world's regions (Africa, Australia/Pacific, Asia, Europe, North America, South America).

Recognising the importance of building the evidence base in this field Rural WONCA has established a dedicated resource website. It has produced its seminal Rural Medical Education Guidebook Volumes 1 and 2.

The group has a program of annual international conferences which have become critical opportunities for international engagement for practitioners of the specialist field, the World Rural Health Conferences that have been ongoing for three decades. The international Rural Generalist Summits have been held as adjunct events to these.

Rural WONCA develops a range of policy statements in accordance with overarching WONCA governance frameworks. Many of these have addressed the issue of RGM.

Some key statements in recent years have included:

Blueprint for Rural Health 2021
This identifies, producing *Rural Generalist family doctors* as a key strategy for improving rural health, particularly where these doctors are supported by health care teams with Rural Generalist scopes within their respective professions. It also highlights fit for purpose rural curricula citing the ACRRM Fellowship curriculum as a key tool to achieving this. The document references the Cairns Consensus Statement on RGM to define the discipline. The statement arose from the Conference Declaration of the 17th World Rural Health Conference in Bangladesh 2021.

Albuquerque Attestation on the Future of Rural Family Medicine in the United States 2019 [73]
This statement provides an instructive description of RGM and its goals. It identifies the need to ensure:

> *that rural communities have access to maternity, emergency, and primary care services across generations. All of these services can be provided by well-trained family doctors. Even in poorly resourced communities, a core group of family doctors can provide much of the care*

found in tertiary care hospitals, especially in conjunction with technologic and system advances. While telemedicine can serve as a tool for rural workforce effectiveness, it cannot replace the hands-on skills of the family doctor. Every community should have a plan for addressing obstetric, paediatric, and traumatic emergencies, though the details will vary significantly based on factors such as the distance to tertiary care, weather, and community capabilities.

Rural communities are heterogeneous, and their needs vary community to community. Therefore, it is necessary to study rural communities through a lens that allows differentiation of needs from one location to another due to local population needs, documented disparities, age of the population, and availability of technology and human resources. Factors important to consider are distances to nearest hospitals, transportation options, availability of community services, and the community's infrastructure including the quality of the roads and availability of communication, especially internet access.

The concept of rural generalism speaks to the need for community oriented primary care in rural areas to extend to critical services not as often required in less remote or higher resourced circumstances.

The statement arose from the Conference Declaration of the 16th World Rural Health Conference in Albuquerque 2019.

Island Medicine Statement 2019 [74]
This statement acknowledges the Cairns consensus statement on RGM and its identification that medical care for island communities is mostly provided by generalist clinicians. It recommends that Island Medicine be recognises as a form of RGM with its own unique set of challenges and rewards.

Delhi Declaration 2018: Alma Ata Revisited [75]
Recognises that rural health care needs generalist health practitioners and family doctors who are appropriately trained to have an extensive and comprehensive range of certified skills to meet the specific challenges that they will face in their everyday work.

Canada

Canada has a strong infrastructure around training and support doctors to become skilled family practitioners with the expanded scope and approach to care of the Rural Generalist. The terminology of Rural Generalism is being used increasingly across the medical and medical education sector.

The Northern Ontario Medical School (NOMS) has developed a Rural Generalist Training Pathway which provides a rurally-based training experience in the full scope of Rural Generalist practice, from medical school through to professional Fellowship with the College of Family Physicians and beyond to CPD options.

The College of Family Physicians of Canada (CFPC) has developed a curriculum standard for attainment of Fellowship level, professional recognition as a Family Physician, which identifies the specific competencies for rural practice and includes training in advanced skilled areas which has been designed for rural family physicians.

The Society of Rural Physicians of Canada (SRPC) has been established since 1992 and has over 3000 rural doctor members from all provinces and territories. It hosts professional education, research and networking conferences and events. It has been instrumental in advocacy for Canadian rural health policy for over thirty years. The Society's mission is:

"Championing rural generalist medical care through education, collaboration, advocacy, and research"

The Society produces a peer reviewed journal – Canadian Journal of Rural Medicine

The Canadian Rural Roadmap is a joint initiative of the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) launched in 2017. Its implementation is overseen by the Rural Roadmap Implementation Committee, which is broadly representative of key stakeholders including the College of Emergency Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, Indigenous Physicians of Canada, the Canadian Medical Association representatives of the nursing professions, local governments, and medical trainees and students.

- Canadian Rural Roadmap - Action Plan 2017[76]
- Canadian Rural Roadmap - Report Care 2021[77]
- Canadian Rural Roadmap – Latest update 2021

The terminology of RGM is used throughout the documents. The goals of the Rural Roadmap include goals related to networks of support for rural generalist practice and the need for an accredited Rural Generalist education pathway.

The medical professions and colleges of Canada have worked collaboratively to reach strategic consensus positions with relation to the practice of RGM to enable family doctors to work within their safe expanded scope of practice to meet rural healthcare needs. These include:

- Consensus statement on networks for rural anaesthesia, surgery, and anaesthetic care in Canada 2022[78]
- Joint position paper on rural surgery and operative delivery, 2015.[79]
- Joint position paper on training for rural family physicians in anaesthesia, 2001 [80]
- Joint position paper on training for rural family practitioners in advanced maternity skills and caesarean section, 1999.[81]
- Joint position paper on training for rural family practitioners in advanced maternity skills and caesarean section (1999).[82]

New Zealand

New Zealand has a strong and growing commitment to the rural generalist approach and recognises the common themes and definitions adopted by the international community of interest in this field.

The New Zealand Rural Generalist Program evolved from the discussions arising from the WONCA Rural - World Rural Health Conferences and with recognition and reference to the Cairns Consensus definition of RGM.[83] New Zealand's community of rural practitioners however have chosen to adopt a slightly different model of training and continuing professional development to support the specialist field. (Note: This joint-application does not seek to replicate this approach in Australia).

The New Zealand Rural Generalist Program is a four-year training program which trains doctors as rural hospitalists leading to the award of Fellow of Rural Hospital Medicine. It offers the opportunity to gain this qualification in parallel with Fellowship qualification as a general practitioner and most trainees to date have taken this option. The Rural Generalist Training Program information notes that 10% of New Zealanders depend on rural hospitals for their healthcare and that 50% of doctors in New Zealand's rural hospitals also work in general practice. Through this Program, the Division seeks to deliver the vocational scope for doctors working within rural hospitals and to create a career path which builds on general practitioner skills and require a broad body of generalist knowledge and specific skills.

The two Fellowship qualifications are awarded within the Royal New Zealand College of General Practitioners the former being awarded through the College's Division of Rural Hospitalist Medicine and both are recognised by the Medical Council of New Zealand.

These professional training programs are strongly linked to the University medical schools, who deliver many of the continuing professional development options for program Fellows including annual Rural Generalist Continuing Medical Education Workshops held in the Cook Islands in collaboration with the Cook Islands government.

Nixon and colleagues, have noted that the program design while different in some ways to the Australian and Canadian Fellowship programs on which it was modelled has had similar success in terms of rural workforce recruitment and retention for rural communities.[84,85 86]

United States

The United States has a strong network of medical schools offering rurally-oriented training pathways and curricula that extend into residency (postgraduate) training. For example, Ventura County Hospital, California, training program for family medicine residents includes, trauma and resuscitation training, a broad range of procedures including caesarean section, high-risk obstetric and critical care management, with an option to complete a further year of obstetric or surgical training.[87] There is considerable evidence linking these pathways to strong rural workforce outcomes.[88,89] Some of these are listed in Table 1.7 above.

The terminology of Rural Generalism has not been widely adopted in the United States. This is at least partially due to it not having the same connections to the terminology and traditions of the British College Fellowships system of Canada, Australia, and New Zealand.

There is however recognition of the significant workforce shortages they have with family physicians generally in rurally areas. There is also a strong recognition of the reliance of rural Americans on family physicians to provide critical hospital-based, obstetric, and emergency care.[90,91,92]

Deutchman and associated identify that of the 28 million rural women of reproductive age in the United States, around 7 million of them live in areas of limited access to maternity care. While only 6.7% of Family Physicians currently provide maternity care, they are the only delivering physicians in 27% of rural hospitals. Of the 1.6% of Family Physicians performing caesarean deliveries as a primary surgeon, 57.3% do so in a rural county and 38.6% do so in a county without an obstetrician. Cultivation of the next generation of Family Physicians providing maternity care is (therefore) essential to prevent further spread of existing maternity care deserts.[93] In another study, researchers found that most physicians performing both vaginal and abdominal deliveries in rural hospitals in 15 states were family physicians.[94]

The recognition of the importance of this rural generalist scope practice has led to a range of collaborative initiatives between the family physicians and other professional organisations:

- American Academy of Family Physicians and American College of Obstetricians and Gynaecologists Joint Statement on Cooperative Practice and Hospital Privileges
  This statement addresses issues as outlined in the AAFP Position Paper around the critical role of rural family physicians in providing obstetric care including caesarean section deliveries. These principles of facilitating extended scope rural family physicians, extend to topics covered by Position Papers including on Obstetric Ultrasound, ECGs, Colonoscopies, Radiology.

- AAFP - American College of Emergency Medicine (ACEM) joint statement on Emergency Care
  This statement addresses issues as raised by the AAFP in their recent Position Paper[95] related to the need to enable family physicians (particular in rural areas) to provide services in emergency departments. It included the following:

  > *"Family physicians are trained in the breadth of medical care, and as such, are qualified to provide emergency care in a variety of settings. In rural and remote settings, family physicians are particularly qualified to provide emergency care.*
  >
  > *Emergency department credentialing should be based on training, experience and current competence. Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit."*

Japan

Japan while small, its topography leads to relatively isolated communities including island communities which experience the same healthcare themes as other rural areas.

The Rural Generalist Program of Japan has been established in recent years as a product of the WONCA collaborations with strong support from Rural Generalists and their professional organisations in Australia (detailed at Table 1.7) Key challenges for Japanese Rural Generalist advocates have been in training a highly urbanised and subspecialised medical workforce in the skills necessary to provide family practice oriented care in low resource environments.

Japan also hosts a peer-reviewed publication: Journal of Rural Medicine.

2. The field of practice is capable of contributing to the standards of medical practice

2.A The specialist field of practice has structures and governance arrangements in place that demonstrate substantial institutional support for its practice including:

- **professional bodies that represent practitioners in the field of practice**
- **acceptance by government and non-government health service funders, and service delivery bodies.**

Describe the structures in Australia that develop, manage, and review practice statements, codes, and guidelines associated with practice in the area and for disseminating these to practitioners and to health services, jurisdictions, and medical and other professional bodies.

List the evidence that the proposed field of specialty practice is accepted by health service funders and health service delivery bodies, including:

- Arrangements for training
- Credentialling

Considering the acceptance already provided, what additional benefits will accrue to recognition of the specialty or field of specialty practice

The specialist field is represented by the two general practice colleges. Both colleges are well established institutions. They are accredited by the AMC to set Fellowship standards appropriate to general practice and to provide education and continuing professional development in alignment with their respective standards. The colleges also play a key role as supporters and advocates for their members and their provision of high-quality clinical practice. They are highly engaged in workforce and policy discussions at local, state, and national levels.

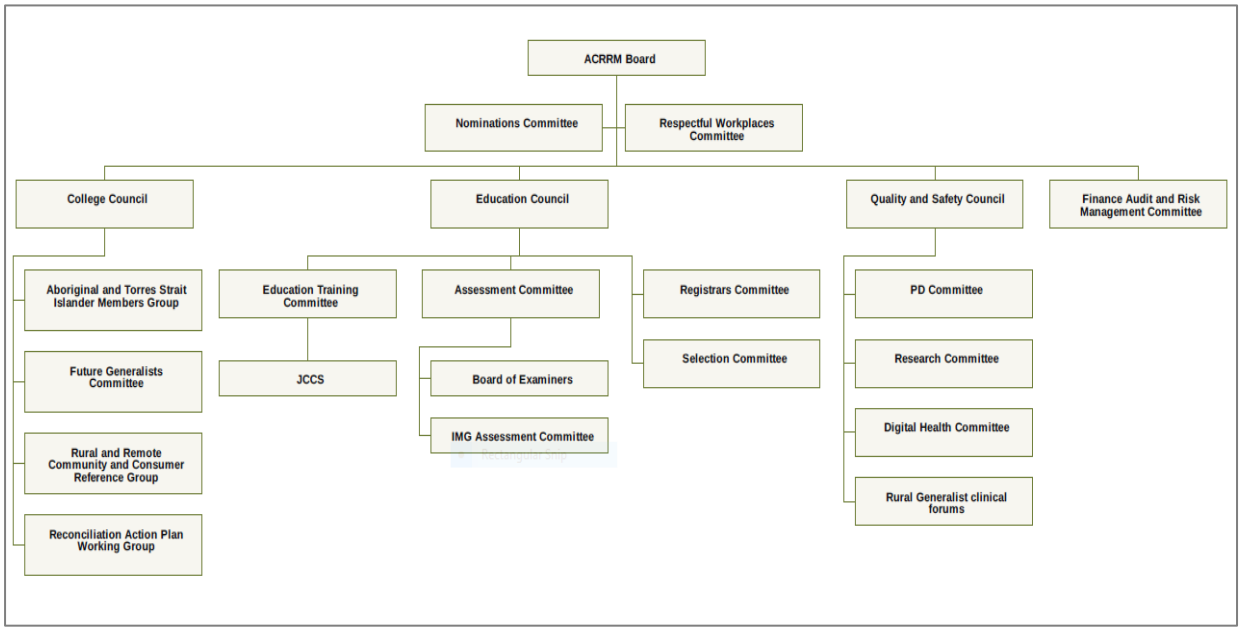
Colleges' Internal Governance

ACRRM:

ACRRM is oversighted by the College Board which holds ultimate authority for all corporate governance. There are three peak councils which report to the Board each with their own respective reporting committees and working parties. They are the College 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 as well as a Rural Community and Consumer Reference Group. It also has a series of reporting RGM clinical working groups which provide expert guidance in key focus areas of the Rural Generalist scope of practice such as Mental Health, Anaesthetics and Obstetrics.

Clinical Practice standards are considered as appropriate either through the relevant clinical working groups and other relevant committees such as the Digital Health Committee, the Research Committee and the Aboriginal and Torres Strait Islander Members Group and reported up to the Quality and Safety Council as the peak advisory body to the Board.

Figure 2.1 ACRRM Governance Committees



- *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 Annual Reports can be found at the following link: https://www.acrrm.org.au/about-the-college/annual-reports

Process for establishing standards

New ACRRM standards related to policies, clinical guides and curricula are established through the following process:

- A need to develop a new standard may be raised through staff, membership, or external bodies.
- The issue is tabled with the relevant Governance body/s for initial consideration. Relevant bodies might include for example, the related Rural Generalist Working Parties, Research Committee, Digital Communications Committee, Education Training Committee or Assessment Committee.
- The Committee determines if the standard should be developed and will seek endorsement from the appropriate Council. For Clinical Practice Standards this is the Quality and Safety Council, for education standards this is the Education Council, for broader national policy issues this is the College Council. All Councils include community representatives.
- It is a guiding principle of all College standards, guides, and educational materials that these are developed by Rural Generalists for Rural Generalists and as such involve expert input from our Fellows and their associates.
    - If endorsed the relevant Committee will identify an appropriate process for standard development. This includes the following:
        - Determination of appropriate body to lead development of the standard and appropriate College supporting staff and resources
        - Scoping of literature and evidence underpinning the standard, including health outcomes and implications

- Scoping of any current or comparable standards
- Consultation within the College and externally as appropriate to the standard
- Approval by the relevant Committee
- Approval by the relevant Council
- Approval by the Board
- Notification of the new standard through College communications channels
- Standards are accessible on the College Website
- Standards have an incorporated framework for review and evaluation

RACGP:

The RACGP is governed by the RACGP Board comprising President, Censor-in-Chief, the Chair of each state/territory faculty, Chair of RACGP Rural, Chair of RACGP Aboriginal and Torres Strait Islander Health, chair of RACGP Specific Interests, a General Practice Registrar Representative, and any additional members co-opted by the Board to the extent allowable under the RACGP Constitution.

The RACGP's mission is to improve the health and wellbeing of all people in Australia by supporting GPs, general practice registrars and medical students through its principal activities of education, training and research and by assessing doctors' skills and knowledge, supplying ongoing professional development activities, developing resources and guidelines, helping GPs with issues that affect their practice, and developing standards that general practices use to ensure high quality healthcare.

RACGP Rural is a National Faculty of the RACGP and 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 Board*
- *RACGP Annual Reports*
- *RACGP 2022-2025 Operating Plan*
- *RACGP Governance*

The RACGP has several expert committees which oversee and support the development of a plan for a program of work at the beginning of each triennium. This includes the RACGP Expert Committee on:

- Practice technology and management
- Funding and health system reform
- Quality care
- Standards for general practices
- Research

The RACGP education committees include the Council of Censors which is functioned to support, guide, and advise on the development, delivery, evaluation, and ongoing improvement of all elements of the Fellowship programs, and the Rural Education Committee which provides direction regarding educational and vocation training.

Standards Joint Consultative Forums

General Practice Fellowships by their nature set AMC accredited standards across the gamut of medical care including surgery, anaesthesia, and obstetrics and gynaecology and both Colleges include consultation with all relevant medical colleges in their curriculum and standards development. Fellowship to the RGM scope involves extending these standards to match more advanced service provision. This occurs to some degree across all fields, but particularly in areas of selected advanced level training.

Collaborative arrangements are in place to consult on standards particularly as they apply to the advanced skills programs in anaesthetics, obstetrics and gynaecology associated with the Fellowship of Advanced Rural General Practice (FARGP) and the Fellowship or ACRRM (FACRRM). The FARGP qualification is undertaken in addition to the Fellowship of RACGP (FRACGP).

The ACRRM Fellowship (FACRRM) program includes completion of one of a range of 12 Advanced Specialised Training (AST) programs. Similarly, RACGP's FARGP includes completion of 12 months Advanced Rural Skills Training (ARST) in an accredited procedural or non-procedural training post, in a choice of nine disciplines. On 1 July 2022, the RACGP launched the RACGP Rural Generalist Fellowship (FRACGP-RG) to replace the FARGP. The new Fellowship includes a more robust core-emergency medicine curriculum and revised ARST curricula.

Where formal arrangements do not exist a standardised approach is taken whereby standards which have clear overlap with another medical college are developed in consultation with that College. All curricula development and reviews involve an iterative process of consultation with other relevant Colleges.

Conjoint Committee for the Diploma of Obstetrics and Gynaecology

The Conjoint Committee for the Diploma of Obstetrics and Gynaecology (CCDOG) is a tripartite committee between the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the RACGP and ACRRM, It has been in place since 2009 when it was formerly constituted as the Joint Consultative Committee on Obstetrics (JCCO). The committee meets at least three times a year and includes representatives from RANZCOG, the RACGP and ACRRM.

The principal role for this committee is to set conjoint standards for the curriculum, assessment, and syllabus for the Diploma of RANZCOG (DRANZCOG) and the Diploma of RANZCOG Advanced (DRANZCOG Adv) which are aligned to the related Fellowship curricula and to oversee assessment in the Diploma program. The DRANZCOG Advanced qualification is the core requirement for completion of:

- the Advanced Specialised Training Obstetrics in the FACRRM
- the Advanced Rural Skills Training in the FARGP/FRACGP-RG

The Committee also provides a forum for more general discussion around standards for obstetrics training and continuous professional development for the general practice colleges.

Tripartite Committee of Rural Generalist Anaesthesia

In a similar model to CCDOG, the standards and assessments associated with the Anaesthetics AST and ARST have been designed in consultation with both GP colleges and the Australian and New Zealand College of Anaesthetics (ANZCA) through the Joint Consultative Committee (Anaesthetics). The Committee has recently agreed to collaboratively develop a formal Diploma of Rural Generalist Anaesthesia (DRGA). Associated with the new Diploma, the group has reconstituted to the Tripartite Committee of Rural Generalist Anaesthesia. Further details of the new arrangements are available on the website.

General Practice Mental Health Standards Collaboration (GPMHSC)

The General Practice Mental Health Standards Collaboration (GPMHSC) similarly, provides a forum to discuss joint approaches to standards and comprises representatives of ACRRM, RACGP, Royal Australian and New Zealand College of Psychiatrists (RANZCP), Mental Health Australia and the Australian Psychological Society. A key role of the Collaboration is to oversee the Mental Health Skills Training programs offered by the colleges which are associated with eligibility to provide mental health services with specified Mental Health MBS item numbers 2715 and 2717.

Joint Consultative Committee Emergency Medicine (EM)

This provides a forum to discuss joint approaches to training and assessment for advanced skills in Emergency Medicine. The Consultative Committee comprises representatives of ACRRM, Australian College of Emergency Medicine (ACEM) and RACGP.

Joint Consultative Committee on Medical Acupuncture

This provides a forum to oversee recognition of standards in medical acupuncture and the process of reporting maintenance of these standards for national registration purposes. The Committee comprises representatives of ACRRM, RACGP and the Australian Medical Acupuncture College.

External Recognition of Fellowship credentials

The Fellowship of ACRRM (subject to the College's ongoing accreditation) is recognised by the Medical Board of Australia as an acceptable specialist qualification for registration in the discipline of general practice. The FACRRM signifies attainment of the full scope of skills and assessment associated with the Rural Generalist scope of practice. The Fellowship of RACGP is recognised by the Medical Board of Australia as an acceptable specialist qualification for registration in the discipline of general practice. The Fellowship of Advanced Rural General Practice (FARGP) has been undertaken as a separate Fellowship attainable following award of FRACGP. The FRACGP-RG was launched on 1 July 2022 and will replace the FARGP. Whilst enrolments into the FARGP have closed, those currently enrolled can elect to complete it, or transition to the new FRACGP-RG.

Rural Generalist Standards incorporation into hospitals and health services

RGM is defined by its role in providing healthcare services to communities that are geographically and by extension institutionally separated from the locus of key decision-making bodies. It is symptomatic, that it's standards and standard bearers are not well represented in health care decision making bodies. This phenomenon is exacerbated by RGM being centred around primary care which operates predominantly outside hospital systems. There are significant consequences for practice in this field when appropriate standards are not set for its practitioners. This is thus a key motivation for this application.

In the absence of formal, nationally consistent recognition, some key formal mechanisms to incorporate the RGM standards into health systems have been achieved.

- At a granular level, standards are represented in the clinical governance structures of hundreds of rural and remote hospitals and health services through the representation of Rural Generalists on clinical governance committees and other associated forums. It is noted however that the representations are typically by doctors in their personal capacity. While this occurs often, opportunities for representation are ultimately arbitrary. There is no overarching expectation on health services to include doctors with expertise and knowledge of rural generalist practice and standards in decision making. This is seen as a key positive outcome that could arise from for specialist recognition.

- There are also many diverse avenues in which the standards are represented by the Colleges or by Rural Generalists in their capacity as College representatives. These include forums to determine state level planning and resourcing, or special projects and taskforces, clinical frameworks and credentialing standards, workforce development and training capacity. Some examples of the key committees both jurisdiction-wide regional, and local, which the Colleges are represented on in their capacity as arbiters of RGM standards are listed below.

Table 2.1 RGM representation on health and clinical forums	
Jurisdiction	**Examples of forums where RGM standards are represented**
Commonwealth	• NRGP Strategic Council • NRGP Jurisdictional Implementation Forum • GP Training Advisory Committee, DOHAC • Aboriginal and Torres Strait Islander GP Training Advisory Group, DOHAC • Australian National COVID-19 Clinical Evidence Taskforce • Strengthening Medicare Taskforce • National Medical Workforce Advisory Committee • GP Advisory Committee MBS and PSR compliance and MBS Taskforce Advisory Committees • PHNs boards and stakeholder committees • Rural Workforce Agencies – boards and stakeholder committees • Aged Care Clinical Standards Advisory Committee • Independent Hospitals Pricing Authority - Small Hospitals Working Group • GP-led Respiratory Clinics Reference Group • AIHW Primary Care Committee • ACSQHC committees including: - Primary Care Committee - Emergency Triage Education Kit (ETEK) Project Advisory Group - General Practice Accreditation Coordinating Committee - Primary and Community Health Care Standards Advisory Committee • Australian Tele-trial Advisory Committee and Consumer Advisory Group • Closing the Gap Steering Committee • National Pathology Accreditation Advisory Council Document review and liaison committee • Nurse Practitioner Reform Steering Committee
Other Medical Colleges and Professional Organisations	• Council of Presidents of Medical College (CPMC) and subcommittees and working parties • ANZC Perioperative Medicine Committee • Conjoint Committee of Pre-Hospital and Retrieval Medicine • Diploma of Psychiatry Steering Group • Better Access Psychiatrists, Psychologists and Mental health workers • ACEM National Project Steering Committee • NACCHO Partnership - National guide to preventive healthcare for Aboriginal and Torres Strait Islander people • General Practice Mental Health Standards Collaboration
New South Wales/ACT	• NSW RG Coordinating Committee (RG CU Governance Body) • NSW Medical Council (Colleges represented) • Rural Palliative Care Taskforce, NSW Health • Health Education and training Unit - Steering Committee – Murrumbidgee Local Health District – which manages the Rural Generalist - Single Employer Model Program • Statewide Referral Criteria Project, NSW Health • RDN - Natural Disaster and Emergency Response – GP and Primary Care Partnership Group • Health Genomics Workforce Committee, NSW Health
Northern Territory	• NT Health Workforce Stakeholder Group • NT RGP Reference Committee (RG CU Governance Body)
Queensland	• Rural and Remote Health and Hospital Services Medical and Dental Credentialing and Scope of Practice Clinical Practice

Table 2.1 RGM representation on health and clinical forums	
	Committee, Queensland Health, Office of Rural and Remote Health (ORRH) • Queensland Clinical Senate, Queensland Health • Queensland RG Reference Group and Strategic Oversight Group (RG CU Governance Body) • QRGP RG EM Advisory Group • Medical Specialist Colleges Virtual Forum, Queensland Health • Radiation Advisory Council, Queensland Health • Medical Condition Reporting Education and Awareness Working Party, Queensland Health • Qld Skin Cancer Prevention Collaborative • Health Workforce Queensland Primary Care Workforce Stakeholder Group • North Queensland Health Workforce Alliance
South Australia	• Committee of College Chairs, South Australia Health • South Australian Rural Generalist Program – Steering Committee (RG CU Governance Body)
Tasmania	• Rural Medical Generalist Coordinating Council (RG CU Governance Body) • Voluntary Assisted Dying Stakeholder Reference Group, Tasmanian Government
Victoria	• Committee of Chairs of Medical Colleges, Victoria • Grampians Region, Credentialing and Appeals Committee, East Grampians Health Service • VRGP Statewide Reference Committee (RG CU Governance Body) • VRGP Regional Network committees • Medical Workforce Planning Advisory Group, Victorian Dept of Health, and Human Services • VACCHO General Practice Working Group • RWAV Statewide Group
Western Australia	• WA RG Advisory Committee (RG CU Governance Body) • WA Medical and Dental Council • WA GP Stakeholder Committee • Rural Health West Reference Group • Working Group RG Single Employer Pilot Project, WA Health

National Coordination

The colleges represent the perspectives of RGM in many peak policy forums including the National Medical Workforce Advisory Council and the new Strengthening Medicare Taskforce and at a more organic and continuous level through forums such as the COVID 19 Clinical Evidence Taskforce.

The development of the clinical practice and workforce development infrastructure for RGM is being progressed at the national level through several key forums in which the colleges are leading participants.

- National Rural Generalist Strategic Council

  The national interjurisdictional governance body, the Rural Generalist Strategic Council is overseeing the implementation of the National Rural Generalist Pathway as prescribed by the recommendations of the National Rural Generalist Taskforce. This is providing a national coordination point for the full integration of RGM into health systems and clinical frameworks. It is led by the National Rural Health Commissioner and includes representatives of the

general practice colleges and jurisdictional health services and other key national stakeholders.

- National Rural Generalist Jurisdictional Implementation Committee

  This is a subcommittee of the National Rural Generalist Strategic Council and provides a forum for all state and territory health services to collaborate to support RGM training and practice throughout rural and remote health services. The general practice colleges also take part in this forum.

- DOHAC General Practice Training Programs Advisory Bodies

  The DOHAC Health Workforce section provides funding support for general practice training in Australia. Its national GP Training framework incorporates a designated Rural Generalist training pathway and ear-marked funding for Rural Generalist training positions. The Colleges are in constant consultation with the DOHAC staff in the operations of these training frameworks. There are several key forums which enable the general practice colleges to influence training frameworks in accordance with Rural Generalist standards, including the General Practice Training Advisory Committee. Another important governance committee which is currently being established is the Aboriginal and Torres Strait Islander GP Training Advisory Group which will provide a discussion forum for issues related to setting appropriate Rural Generalist clinical and training standards in the ACCHS and broader Aboriginal and Torres Strait Islander healthcare sector. This will include the general practice colleges, DOHAC, Australian Indigenous Doctors Association (AIDA), National Aboriginal Community Controlled Health Organisation (NACCHO), and the Indigenous General Practice Registrars Network (IGPRN).

Jurisdictional Rural Generalist Programs

State and Territory jurisdictions (either directly or through a subcontracted body) deliver Rural Generalist Training Programs. The programs were originally state funded but are now funded through the Commonwealth Government to serve as Rural Generalist Coordinating Units.

At minimum these programs manage a governance structure which includes representatives of the two colleges along with other key stakeholders. This provides a forum for discussion and resolution on issues around training placement, credentialing and capacity building across their respective states and Territories.

The Units have a brief to support and expand the training capacity for Rural Generalist trainees in rural community settings and rural hospitals. This occurs through a range of programs supporting the Rural Generalist Fellowship training as well as junior doctor and prevocational training and continuing professional development in RGM. Many of the programs also concurrently run prevocational training supported through the John Flynn Rural Doctor Program and post-Fellowship programs including providing post-Fellowship advanced skills training through the General Practice Placement Training Program (GPPTP). These initiatives, together provide a strong whole of Rural Generalist career support structure.

- New South Wales RGM Training Program (NSW RGMTP) (includes the ACT)
- Northern Territory Rural Generalist Program (NTRGP)
- Queensland Rural Generalist Program (QRGP)
- Rural Generalist Program South Australia (RGPSA)
- Tasmanian Rural Medical Generalist Pathway (TRMGP)
- Victorian Rural Generalist Program (VRGP)
- Western Australian Rural Generalist Program (WARGP)

Attachment 2.1: Jurisdictional Rural Generalist Programs Road Maps

Formal Arrangements for Rural Generalist Credentialing

Formal arrangements are in place in Queensland and Northern Territory to recognise the FACRRM and/or FRACGP plus FARGP certifying competency in the Rural Generalist scope. There is clearly a strong case to be made for nationally consistent arrangements to be established to facilitate workforce and employment portability and underscore a common understanding among health systems of nature of the Rural Generalist training and scope.

The Territory Government has recognised Rural Generalists and Rural Generalist Trainees in its Enterprise Agreement (See Appendix 2.1)[96, 97] 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.

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).[98,99] Queensland formally recognised the discipline of RGM in its State Industrial Award in 2008 (See Appendix 2.1), adopting a state specific definition of RGM based on the knowledge and skills of recognised RGM contained in the ACRRM curricula statements.[100] An industrial framework is also supported with an appropriate remuneration schedule for doctors employed in the public health system who hold the prescribed RGM credentials and are granted scope of clinical practice for these credentials.

Several jurisdictional credentialing frameworks have been established which explicitly incorporate consideration of specifically rural and Rural Generalist clinical standards. Some flagship forums include:

- The Rural and Remote Health and Hospital Services Medical and Dental Credentialing and Scope of Practice Clinical Practice Committee, of the Queensland Health, Office of Rural and Remote Health. This group is focussed on medicine and dental healthcare servicing as it occurs in rural and remote locations and has an appropriate membership to advise on the appropriate clinical and credential standards within these contexts. The group facilitates a whole-of-state approach to clinical standards and enables Rural Generalist practitioners and their health team colleagues a direct engagement with health planning.

  Attachment 2.2 TOR: Queensland Health Remote Medicine Credentialing and Scope of Practice Committee

- The Grampians Region, Credentialing and Appeals Committee, East Grampians Health Service, provides an exemplar of a health service forum which ensures the Rural Generalist standards are reflected in its credentialling frameworks. The service represents a series of small hospitals in rural and remote locations across the Grampians and provides an infrastructure with Rural Generalist representatives from both the general practice colleges to establish standards frameworks which reflect the Rural Generalist training and scope.

2.B There are standards for:

2.B.1 Medical practice in the specialty or field of specialty practice to ensure high quality healthcare

> Provide links to the standards for practice in the field of specialty practice
>
> Indicate how these standards were developed by what bodies and how they were developed

ACRRM and RACGP are accredited by the AMC to set and arbitrate standards in the discipline of general practice. The Fellowship standards are defined in the respective Fellowship curricula of the medical colleges.

- The ACRRM Fellowship curriculum is dedicated entirely to RGM. Fellowship of the RACGP (FRACGP) has a dedicated general practice curriculum which includes rural health as a core unit with core competencies in rural health mapped to each of the five domains of the general practice curriculum. To successfully obtain the RACGP Rural Generalist Fellowship candidates must demonstrate commitment to rural including that at least 12 of their 18 months general practice training was completed in an MM3-7 location (in addition to the core-emergency medicine and ARST requirements).

    - ACRRM Rural Generalist Fellowship Curriculum
    - RACGP curriculum and syllabus for Australian general practice (2022)
    - RACGP Rural Generalist Fellowship guidelines

The National Rural Generalist Taskforce commissioned medical educationalist consultants, Mod Med to undertake a review of the two curricula to ensure there was a common set of standards which could provide the basis for a national approach.

The consultancy confirmed that there was sufficient, their findings including:

> *A shared, agreed standard is essential of the definition of the scope of practice of positions with the title RG within the medical profession (Collingrove Definition)*
> *RG Training should be delivered through existing training pathways...*
> *All necessary curriculum elements are likely to be currently available…*[101]

The Rural Generalist Taskforce have reviewed the Mod Med Report and confirmed that it continues to be a relevant reflection of their respective curricula. They have also pointed out the key changes to their respective curricula since the report was written.

It should be noted that both the ACRRM curriculum and the RACGP curricula have progressed since the review.

Mostly notably, the ACRRM have combined their curricula (Primary and ASTs) to form a single Rural Generalist curriculum. The RACGP has revised their Rural Generalist Fellowship with a strengthened core-emergency medicine curriculum and revised Additional Rural Skills Training curricula since the Mod Med review.

Attachment 2.3: Mod Med Report and Cover letter from the Rural Generalist Taskforce

Development of Standards

ACRRM Fellowship Curriculum:

The development of a dedicated vocational curriculum was a natural extension of ACRRM's core vocational training and preparation role. A comprehensive Prospectus, and a Position Paper, both published in 1997, established the need for such a curriculum and indicated the major directions for further development.

The first edition of the ACRRM Primary Curriculum was published in 1998. The second edition was published in 2003, and the third edition in 2006. Minor revisions were made to the third edition in 2009.

The fourth edition (2013) followed a major review of both content and structure conducted between 2009 and 2010. The curriculum was developed by 18 subject area writing teams comprised of a team of content expert writers and a separate team of expert reviews. In total over 175 experts contributed directly to the curriculum writing. A stakeholder consultation was conducted with members and external stakeholders including the Health Consumers of Rural and Remote Australia.

The subsequent reviews of the ASTs curricula occurred in a staged process over 2016 to 2018. This involved a comparison with the relevant specialty/specialties curricula for each

AST and was further informed by consultation with the relevant speciality college/s and/or Joint Consultative Council.

Palliative Care was incorporated into the Fellowship as an eleventh AST option in 2020. It was initially assessed by the Education Council, following a formal application process which confirmed it met the College criteria for being included as AST option. The curriculum was developed by a team of Fellows with expertise in Palliative Care drawing on the literature and other Palliative Care curricula. The process involved consultation and input from the Royal Australasian College of Physicians (RACP), ACRRM members and key governance committees and ACRRM accredited training organisations. The curriculum was recommended for approval by the Education Council and endorsed by the College Board.

The College commenced its five-year review of the Primary Curriculum in 2018. This commenced with a two-day workshop led by the Education Council involving all senior staff and all key College office bearers including the President and Registrar Director.

New concepts arising from the workshop and subsequent development were further workshopped at stakeholder events including the ACRRM Open House in 2018.

A general survey to member and stakeholders for feedback was conducted

The draft curriculum was sent with an accompanying set of consultation questions to:

- ACRRM members and key governance committees
- Medical Colleges: Australian and overseas
- ACRRM accredited training organisations
- General Practice Registrars Association (GPRA) and General Practice Supervisors Association (GPSA)
- Universities including rural clinical schools and rural integrated training hubs
- Rural organisations including Rural Doctors Association Australia (RDAA), CRANA Plus, Royal Flying Doctors Service (RFDS), Rural Workforce Agencies (RWAs)
- Rural Generalist programs operated by state and territory health departments and the National Rural Generalist Taskforce (led by the National Rural Health Commissioner)
- ACRRM accredited Supervisors and Medical Educators
- ACRRM committees including registrar committee, training and assessment and working groups
- ACRRM members
- Primary Healthcare Networks (PHNs)
- Aboriginal and Torres Strait Islander peoples groups including: ACRRM Aboriginal and Torres Strait Islander Members Group, AIDA, ACCHO, IGPRN, Leaders in Indigenous Medical Education (LIME)
- National NGOs

The revised curriculum was reframed, the Rural Generalist Fellowship Curriculum and incorporated the 11 AST curricula into a single integrated curriculum. This was presented iteratively to Governance Committees. A team of medical educators, content experts, and expert staff redrafted the Curriculum. The ACRRM Aboriginal and Torres Strait Members Group provided important expert advice on the revision of the Aboriginal and Torres Strait Islander Peoples Health Domain. The curriculum was ultimately recommended for endorsement by the Education Council and approved by the College Board.

RACGP Fellowship Curricula:

The RACGP began the process of updating the Fellowship in Advanced Rural General Practice (FARGP) curriculum to align with the requirements of the national Rural Generalist training framework in 2019. The result of this was the launch of the RACGP Rural Generalist Fellowship on 1 July 2022. This Rural Generalist Fellowship incorporates the RACGP Curriculum and Syllabus for Australian General Practice 2022 as well as the additional Rural

Generalist training requirements of the Core Emergency Medicine Training Curriculum and the Additional Rural Skills Training (ARST) Curricula.

The RACGP has a history of developing peer-based, authentic and relevant curricula that have provided the foundation for Australian general practice training for many decades. The RACGP Curriculum and Syllabus for Australian General Practice 2022 builds on the strengths of the previous RACGP curriculum and introduces a syllabus for general practice training. The curriculum undergoes review every three years and is guided by the principles set out in the RACGP educational framework. It sits alongside the RACGP Standards for general practice training and the RACGP Progressive Capability Profile of the General Practitioner. The RACGP curriculum and syllabus is monitored and maintained on an ongoing basis. The curriculum and syllabus, along with the Progressive Capability Profile of the General Practitioner, provides the competencies and their indicators for blueprinting the RACGP assessments from entry to general practice Fellowship pathways, including selection, through progressive and workplace-based assessments, to Fellowship exams.

The review and revision of the curriculum was a collaborative process that included consultation and input from an expert advisory group, and RACGP faculties, groups and committees, including the Rural faculty and its education committee. A desktop review was undertaken, which included the review of regulatory body requirements, international medical curricula and medical literature. Other non-GP specialist medical colleges, schools and universities, regional training organisations and government and community organisations provided input, feedback and resources via an online survey and through individual submissions. The 13 core skills of the RACGP 2016 Curriculum (now termed 'core competencies') were reviewed and updated in the curriculum and syllabus, with the addition of two further competencies, making a total of 15 core competencies. These competencies describe the knowledge, skills, and attributes that all GPs require to practice safely and independently anywhere in Australia. The contextual units included in the RACGP 2016 Curriculum were rearranged and revised to reflect the current and evolving general practice environment. For the first time since 2004, the specific competencies relating to rural health and Aboriginal and Torres Strait Islander health were embedded throughout the curriculum and syllabus. Their standalone core units along with the core units of the five domains of general practice make up the seven core units which are the basis of the core competency framework.

The inaugural RACGP syllabus was developed collaboratively with GPs, supervisors, medical educators, cultural educators, and GPs in training and new Fellows. Development occurred in stages in a cyclical, rather than a linear way (*RACGP syllabus development process*). The project's Reference Group provided industry and community sector expertise and advice. The Reference Group comprised RACGP staff from the RACGP National Faculty for GPs in Training, the International Medical Graduate Committee, Assessment Development and Operations, RACGP Rural, RACGP Aboriginal and Torres Strait Islander Health, RACGP educational framework project team, RACGP curriculum review project team, and RACGP Education Strategy and Development. The Reference Group met bimonthly throughout the project to provide advice and feedback. Additionally, two think tanks were held to help determine the aims of the syllabus and its alignment with other educational processes within the RACGP. Governance of the project was monitored by a steering committee and the RACGP Portfolio Management Office.

The RACGP Curriculum and Syllabus for Australian General Practice 2022 was written and reviewed by GPs for GPs and was ultimately recommended for endorsement and approved by the College Board.

The RACGP Rural Faculty oversaw the review of the Additional Rural Skills Training (ARST) Curricula and the development of the new Core Emergency Medicine Training Curriculum. Extensive consultation with rural generalists, emergency specialists and broader stakeholder groups commenced in 2019. A team consisting of members of the RACGP Rural Education

Committee, medical educators, content experts, and specialist staff then developed and re-drafted the various curricula. This involved the analysis of current literature, comparison with relevant specialty college curricula, consultation with relevant speciality colleges and/or Joint Consultative Committees, and review by medical educators and specialists in each field. All curricula were updated to ensure community focused training outcomes and modern assessment processes. The Core Emergency Medicine Training Curriculum was also developed with input from the Australian College of Emergency Medicine to ensure that it reflected the requirements for Rural Generalists providing emergency medicine care in rural Australia.

The draft curricula were reviewed and endorsed by the RACGP Rural Education Committee and RACGP Rural Council before being released for wider consultation with internal RACGP stakeholders including the RACGP Council of Censors, Censor in Chief, Principle Medical Education Advisor, National Clinical Lead – Assessment, RACGP educational framework project team, RACGP curriculum review project team, National Faculty Aboriginal and Torres Strait Islander Health, and REC-pre-fellowship committee. After internal feedback was incorporated, the re-drafted curricula were then released for external consultation with key stakeholders including all training organisations, RG coordination units, Joint Consultative Committees, specialty medical colleges, rural training schools, universities, and government and community organisations.

Feedback was incorporated before final versions of the curricula were endorsed by the RACGP Rural Education Committee and Rural Council. These final curricula were then endorsed by the RACGP Council of Censors and approved by the RACGP Board.

Other policies, clinical guides, and standards:

The Colleges develop a wide range of other policies, clinical guides, and standards. They have a generic approach to developing all of these, which ensures, rigour of evidence-based investigation, broad consultation, process transparency and documentation, an incorporated process of review and evaluation, and appropriate governance in endorsement, management, and review. This is detailed at Section 1A above.

2.B.2 Guidelines and procedures for determining who will be Foundation Fellows/Members/Award holders of the professional body (NB the level of knowledge, skills and competence of Foundation Fellows/Members/award holders should be no lower than those who will complete its training program)

Provide details of all pathways to Fellowship and/or award of a qualification

Provide details of election /admission to Foundation Fellowship.

Have Fellows ever been ‘grand-parented’? If so

- How many/what percentage?
- What steps were taken to assure appropriate standards? Provide details (e.g. criteria used)
- Has the process ceased?

Provide details of the percentage of Foundation Fellows who hold different Fellowships of the applicant body and or other recognised medical colleges.

Pathways to award of Fellowship

Currently doctors may become Fellows either through the colleges' Fellowship training programs or through their Fellowship assessment programs. All programs are subject to assessment through the College AMC accreditation cycles.

ACRRM:

Fellowship Training Pathways

Doctors may enrol to train to ACRRM Fellowship through a range of enrolment options. The College is currently undergoing a transition of arrangements for registrars enrolled through AGPT and by April 2023 (excluding those enrolled through the Remote Vocational Training Scheme (RVTS)) all registrars will be selected and trained by the College in accordance with College standards and undertake the same College assessments.

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

Registrars are selected in accordance with the College's selection policy. They undertake training in accordance with the College Training Requirements detailed in its Fellowship Curriculum and Fellowship Training Handbook. This will include undertaking the College's Rural Generalist Education Program. They are required to successfully complete the College's programmatic assessment as detailed in the College's Assessment Handbook.

RVTS registrars will receive their training services predominantly through the RVTS program in accordance with ACRRM Fellowship standards. They will undertake ACRRM assessment.

Fellowship Assessment Pathways:

Specialist Pathway and Ad Eundum Gradum

Doctors who have ACRRM-recognised overseas specialist qualifications in general practice or family medicine may apply through the Specialist Pathway to undertake a process of assessment toward attaining qualification for ACRRM Fellowship.

Doctors deemed comparable are allocated a Medical Educator and have a Learning and Assessment Plan developed for them designed to ensure at successful completion of assessment they can be assured to have met all Fellowship standards. These doctors take part in the selected elements of the ACRRM Fellowship training and assessment support and assessments programs alongside other ACRRM trainees and Fellow through a single Fellowship ratification process.

Doctors that apply through for Specialist Assessment who are registered general practitioner specialists from Canada or New Zealand undertake a facilitated process through Ad eundem gradum arrangements.

Full details on this pathway are available on the ACRRM website.

Rural Experienced Entry to Fellowship (REEF) Pathway

This pathway enables eligible doctors who hold current specialist registration in General Practice (with no restrictions) with the Medical Board of Australia a facilitated process for achieving Fellowship with ACRRM (FACRRM).

To be eligible these doctors must meet the following medical experience requirements:

- Minimum five years of rural experience post Specialist registration.

- Demonstrated extended practice relevant to your community needs.
- Currency and compliance with an AMC-accredited continuing professional development program.

The requirements to gain to Fellowship through REEF are:

- Professional Development Program compliance including
- Advanced Life Support
- Multi-Source Feedback and/or Case Based Discussion

Further details of this process are available on the ACRRM website.

RACGP:

Pathways to Fellowship:

The RACGP has three Fellowships:

- The Fellowship of the Royal Australian College of General Practitioners (FRACGP)
- The RACGP Rural Generalist Fellowship (FRACGP-RG) which incorporates the FRACGP*
- The International Conjoint Fellowship of the RACGP (ICFRACGP) which is offered in conjunction with two international colleges: the Academy of Family Physicians Malaysia and Hong Kong College of Family Physicians. This Fellowship recognises the similarities in curricula between these colleges and the RACGP and acts as a steppingstone to FRACGP.

**The FRACGP-RG replaces the former Fellowship in Advanced Rural General Practice (FARGP)*

There are three pathways to Fellowship:

- The Vocational Training Pathway (VTP)
- The General Practice Experience (GPE) Pathway
- The Specialist Pathway.

Vocational Training Pathway (VTP)

Australian General Practice Training (AGPT)
The AGPT program is a government-funded program providing vocational training for non-vocationally registered doctors and medical graduates to become specialist general practitioners. The AGPT program has two streams general and rural. Registrars on the AGPT program may also elect to train towards the Rural Generalist Fellowship while on the AGPT program. From 1 February 2023, the RACGP will assume direct responsibility for delivering the AGPT Program under a profession-led, community-based model. This will bring general practice training into line with other medical specialist training programs across the nation. For more than 60 years, the RACGP has set the standards and curriculum for general practice.

Remote Vocational Training Scheme (RVTS)
The RVTS is a flexible, government-funded program providing vocational training for medical practitioners in rural, remote, and Aboriginal and Torres Strait Islander communities throughout Australia. It is run by an organisation of the same name. Supervision is facilitated remotely, and delivery caters to the unique needs of doctors working in remote communities by supporting them to achieve Fellowship through a distance education model. It allows training to be completed in an accredited post, without leaving their community.

General Practice Experience (GPE) Pathway
The GPE Pathway is for candidates who hold current medical registration in their jurisdiction of practice and are working in general practice but don't have an Australian specialist general practice qualification. Candidates are required to complete an assessment of general practice experience which is assessed by RACGP assessors.

Fellowship Support Program (FSP)
The FSP is a self-funded training program on the GPE pathway. It is an education and training program to support doctors on the GPE pathway to obtain Fellowship. The FSP has replaced the Practice Experience Program – Standard Stream who is still running for participants already enrolled but closed to new applicants

The Specialist Pathway
This pathway is for specialist international medical graduates (SIMGs) whose specialist qualification is considered by the RACGP to be partially or substantially comparable to the FRACGP, and whose primary medical qualification is recognised by the AMC and World Directory of Medical Schools. The Practice Experience Program Specialist Stream is the current training program on this pathway. It will be updated to the International Specialist Program in 2023

Practicing GP (for RACGP Rural Generalist Fellowship)
The Rural Generalist (RG) Fellowship offers a pathway for practising GPs that recognises the experience, skills, and qualifications of experienced rural GPs by offering them the opportunity to submit evidence that demonstrates how they meet specific criteria – or to train towards meeting the requirements.

All RACGP RG Fellowship practising GP pathway candidates must be an RACGP Fellow and member, in addition to satisfying the below requirements:

1. Minimum 12 months FTE community-based general practice in a rural MMM3-7 location
2. 12 months FTE Additional Rural Skills Training (ARST)
3. Six-month core emergency medicine training

Admission to Fellowship and Grandfathering

ACRRM:

Process for admission to Fellowship:

The College process for assessing and certifying candidates for award of Fellowship is as follows:

- The College receives notification that a person on a Fellowship or Specialist Recognition pathway has successfully completed all relevant training and assessment requirements through a standardised declaration form. The form contains all relevant information, reviewed by the education services staff and a declaration from the candidate that there are no current or past professional matters or proceedings that would reflect on their suitability to be admitted as a Fellow.

- The Censor in Chief (or the deputised Regional Director of Training) reviews the documentation. When satisfied that the requirements have been satisfactorily met, the Censor in Chief (or the deputised Regional Director of Training) recommends the candidate for Fellowship.

- The approved forms are forwarded to the Office of the CEO and compiled and tabled at the next scheduled meeting of the College Board.

- The Board considers the candidates being recommended for admission. The Censor in Chief is a non-voting ex-officio member of the Board and is available to respond to any questions. When satisfied with the application/s, Board resolves to admit the new Fellow/s.

    - All candidates approved for award of Fellowship are advised accordingly immediately after the Board meeting.

- A Fellowship Certificate is prepared, and an additional certified copy is sent to the new Fellow for submission to Ahpra. The College then uploads the admitted Fellows' details onto the Ahpra data portal.

- Admitted Fellows are directed to the professional development team and are advised regarding how to apply for Specialist Registration with Ahpra.

Fellowship processes across membership

ACRRM was established as a medical college in 1997. In 1998, the initial ACRRM Primary Curriculum in Rural and Remote Medicine was published, and ACRRM's rural training program and continuing professional development (CPD) program were established. The Fellowship criteria thus were able to be consistent with the training and CPD framework. The Fellowship criteria were advertised to foundation members in 1998 and members were invited to apply for Fellowship. Submitted applications included:

- Documentation against the key Fellowship Criteria which considered demonstrated capacity in primary care, emergency care, at least one area of advanced skill, and rural experience.
- A curriculum vitae
- Two peer references confirming good professional standing
- Documentation of medical qualifications
- Evidence of practice experience in rural and remote contexts
- Evidence of practice experience in primary care
- Documentation of clinical credentials or other advanced skills credentials

Each application was assessed against the Fellowship criteria giving consideration to all documentation and ratified by the Foundation Board.

The ACRRM Fellowship training programs were initially accredited in 2007 and fully accredited in 2011. The Fellowship ratification process evolved over those years to reflect the College's changing status with respect to the Medical Board's registration frameworks.

From 2007, in accordance with AMC requirements the grandfathering process ceased, and all grandfathered Fellows underwent an Advanced Standing Assessment which involved a Recognition of Prior Learning (RPL) process against the Fellowship Curriculum. This ratified their Fellowship in association with the College's accredited Fellowship curriculum and autonomous training program, the Independent Pathway.

From 1998 through to 2007, many other doctors completed training and assessment to ACRRM Fellowship via funded positions on the Government's AGPT and RVTS programs, or with positions on the ACRRM Independent Pathway.

Some 1200 doctors were Fellowed through these various arrangements. Around 200 of these doctors are no longer Fellows, (i.e., retired etc.). These doctors thus comprise around half of total current Fellows.

Diversity of Fellowships held by members

The ACRRM Fellowship is the only qualification offered by ACRRM.

As ACRRM didn't have independent recognition for vocational registration and Medicare purposes prior to its award of provisional accreditation in April 2007, all registrars that trained prior to this time needed to complete RACGP Fellowship as well as the ACRRM training program. For similar reasons the majority of experienced doctors that became ACRRM Fellows over that time (including Foundation Fellows) either held or undertook a recognition process to attain FRACGP.

RACGP:

Certifying and Awarding Fellowship

The College process for assessing and certifying candidates for award of Fellowship is as follows:

AGPT

- Upon successful completion of the three RACGP fellowship examinations candidates receive a letter of congratulations from the Censor in Chief inviting them to apply for Fellowship. The Regional Training Organisation provides confirmation that the member has successfully completed all training and assessment requirements and provides a Completion of Training declaration form.
- The member completes the prescribed application for Fellowship form, including a declaration regarding the veracity of information and any professional concerns, and submits the Completion of Training and application for Fellowship forms to the relevant state faculty office
- The forms are reviewed by faculty staff and once complete are forwarded to the relevant state faculty censor for review
- The state censor reviews the completed forms and if satisfied that all requirements are met, including that there are no concerns with professionalism, the censor will recommend the applicant for Fellowship
- The state faculty will forward completed applications to the Fellowship Administrator.

RVTS

- Upon successful completion of the three RACGP fellowship examinations candidates receive a letter of congratulations from the Censor in Chief inviting them to apply for Fellowship. RVTS provides confirmation that the member has successfully completed all training and assessment requirements and provides a Completion of Training declaration form.
- The member completes the prescribed application for Fellowship form, including a declaration regarding the veracity of information and any professional concerns, and submits the Completion of Training and application for Fellowship forms to the RVTS office
- The forms are reviewed by the RVTS staff and once complete are forwarded to the rural censor for review
- The rural censor reviews the completed forms and if satisfied that all requirements are met, including that there are no concerns with professionalism, the censor will recommend the applicant for Fellowship
- RVTS staff will forward completed applications to the Fellowship Administrator

GPE Pathway

- Upon successful completion of the three RACGP fellowship examinations candidates receive a letter of congratulations from the Censor in Chief inviting them to apply for Fellowship.
- The member completes the prescribed application for Fellowship form, including a declaration regarding the veracity of information and any professional concerns, and submits the Completion of Training and application for Fellowship forms to the relevant state faculty office
- The forms are reviewed by faculty staff and once complete are forwarded to the relevant state faculty censor for review
- The state censor reviews the completed forms and if satisfied that all requirements are met, including that there are no concerns with professionalism, the censor will recommend the applicant for Fellowship
- The state faculty will forward completed applications to the Fellowship Administrator.

Specialist Pathway

Substantially Comparable participants

- Upon successful completion of the prescribed workplace-based assessment (WBA), participants are invited to apply for Fellowship. Requirements for Fellowship include successful completion of the WBA and a minimum time working in general practice
- The member completes the prescribed application for Fellowship form, including a declaration regarding the veracity of information and any professional concerns, and submits the application for Fellowship forms to the relevant state faculty office
- The forms are reviewed by faculty staff and once complete are forwarded to the relevant state faculty censor for review
- The state censor reviews the completed forms and if satisfied that all requirements are met, including that there are no concerns with professionalism, the censor will recommend the applicant for Fellowship
- The state faculty will forward completed applications to the Fellowship Administrator.

Partially Comparable participants

- Upon successful completion of the three RACGP fellowship examinations candidates receive a letter of congratulations from the Censor in Chief inviting them to apply for Fellowship. Requirements for Fellowship include successful completion of the WBA and a minimum time working in general practice
- The member completes the prescribed application for Fellowship form, including a declaration regarding the veracity of information and any professional concerns, and submits the application for Fellowship forms to the relevant state faculty office
- The forms are reviewed by faculty staff and once complete are forwarded to the relevant state faculty censor for review
- The state censor reviews the completed forms and if satisfied that all requirements are met, including that there are no concerns with professionalism, the censor will recommend the applicant for Fellowship
- The state faculty will forward completed applications to the Fellowship Administrator.

FRACGP-RG

- Once the member has been admitted as a FRACGP and has completed all FRACGP-RG components, the member completes their RG portfolio and prescribed application for Fellowship form, including a declaration regarding the veracity of information and any professional concerns, and submits them to the relevant faculty office
- The forms are reviewed by the rural faculty staff and forwarded to an RG assessor to review
- The assessor will review the portfolio and provide candidate feedback along with a recommendation as to whether all requirements for the RG fellowship have been met within an RG assessment form.
- The RG assessment form is provided to the rural censor by rural staff
- The rural censor reviews the assessment form and if satisfied that all requirements for the Rural Generalist components of the FRACGP-RG (including ARSTs) are met, will endorse the application.
- The rural faculty will forward completed applications to the Fellowship Administrator
- This process is the same for those on the practising GP pathway

Recognition of prior learning and experience

- Eligible GPs who hold FARGP or FACRRM may apply for RG Fellowship via recognition of prior learning and experience.
- Applications must demonstrate their previous training and experience is similar to the current requirements via the training route.
- Applications are submitted to the rural faculty
- Faculty staff review the application and forward it to the rural censor
- The rural censor reviews the completed forms for recognition of prior leaning and experience. If they are satisfied that the application meets all requirements for the

FRACGP-RG, including that there are no concerns with professionalism, the censor will recommend the applicant for Fellowship. If the application is granted either partial or no recognition of prior learning, the applicant may resubmit upon completion of the requirements.
- The rural faculty will forward completed applications to the Fellowship Administrator

ICFRACGP

- Upon successful completion of the three conjoint examinations candidates are invited by the AFPM or HKCFP to apply for International Conjoint Fellowship. The International College (AFPM or HKCFP) provides confirmation that the member has successfully completed all training and assessment requirements and provides a Completion of Training declaration form (from HKCFP) and details of assessments undertaken (AFPM).
- The member completes the prescribed application for Fellowship form, including a declaration regarding the veracity of information and any professional concerns, and submits the application for Fellowship forms to the relevant International College.
- The International College forwards the collated forms to the Fellowship administrator who reviews the forms and forwards them to the relevant censor
- The relevant censor reviews the completed forms and if satisfied that all requirements are met, including that there are no concerns with professionalism, the censor will recommend the applicant for International Conjoint Fellowship

Common to all pathways

- Applications are collated and forwarded to the Censor in Chief who has delegated authority from the RACGP Board to ratify applications for Fellowship upon recommendation from the state censor.
- After approval, new Fellows are notified of their admission to Fellowship. Their details are uploaded to the Ahpra portal. A Fellowship certificate is ordered. Once ratified, new Fellows are provided with information regarding applying for specialist general practice registration with Ahpra.

Recognition of Prior Learning and Experience

The RACGP recognises that Registrars and GPs may have prior learning and/or experience that suitably meets some of the requirements of their Training Program, the RVTS or their Rural Generalist Fellowship training, therefore allowing them to safely reduce their program time. There are limits on the reductions available to ensure the appropriate standard of education and training is still obtained.

To be eligible to apply for RPLE the training and experience must be in clinical practice and the applicant must provide current, complete, and verifiable information in their application. Upon receipt of the application the relevant RACGP Censor will determine the outcome of the RPLE application. The RACGP will only approve an RPLE application if the Registrar or GP demonstrates that their experience meets the appropriate standard relevant to the application.

Details on the specific requirements and time recognition limits available for RPLE are outlined in the *Recognition of Prior Learning and Experience Policy*.

2.B.3 Training, assessment and certification in the specialty or field of practice.

Provide a copy of the training program(s) handbooks (this should contain all documentation concerning the training curriculum, competencies, and assessment)

In addition, please indicate:

- the requirements for entry to the training program
- the numbers of current trainees and those anticipated for the next five years
- how education, training, and supervision in the field of practice is delivered and assessed
- The extent to which advanced education, training, and supervision in the field of practice is accessible around the country
- What accreditation standards and accreditation processes are in place for the field of practice
- processes in place for recognition of qualifications and assessment of overseas trained practitioners in the field of practice

Training Handbooks and Fellowship programs Information

Key Fellowship information publications are provided at Attachments 2.3 and 2.4.

Attachment 2.4

- *ACRRM Fellowship Program Handbook*
- *ACRRM Fellowship Curriculum*
- *Fellowship Guide (inc. selection information)*
- *RGTS Eligibility Guide (inc. selection information)*
- *Assessment Handbook*
- *AST Handbooks*

Attachment 2.5

- *Your AGPT Application Handbook*
- *AGPT Registrar Handbook*
- *Your FSP Application Handbook*
- *FSP Registrar Handbook*
- *Practice Experience Program (PEP) Specialist Stream Participant guide*
- *2022 RACGP curriculum and syllabus for Australian general practice*
- *Progressive capability profile of the general practitioner*
- *Assessment and examinations candidate handbook*
- *Guidelines for the RACGP Rural Generalist Fellowship*
- *Core emergency medicine training curriculum*
- *Additional Rural Skills Training Curricula*

Entry Requirements

ACRRM Fellowship Training:

Eligibility:

Eligibility is determined by applicant's citizenship status, medical qualification, and medical registration. All applicants must have Australian Medical Council (AMC) recognised medical qualifications to be eligible for training.

Application and Selection:

1. The application process involves an online application – which includes a suitability assessment - written essay. The assessment is graded and used to shortlist applicants for the final stage of the selection process.

2. Applicants are required to provide contact details for two medical practitioner referees to support their application by completing an online survey.

3. Shortlisted applicants are invited to the Multiple Mini Interviews (MMIs) stage. The MMIs are a series of six interviews in which applicants have two minutes to read a scenario and eight minutes to respond. Questions are designed to allow applicants to display their ability to think logically about a topic and communicate your response and ideas effectively.

ACRRM selects candidates for entry into the Fellowship program based on the following criteria:

- demonstrated commitment to a career as a specialist general practitioner working in rural or remote Australia
- demonstrated capacity and motivation to acquire abilities, skills, and knowledge in the ACRRM domains of practice
- demonstrated connection with rural communities demonstrated commitment to meeting the needs of rural and remote communities through an extended scope of practice
- possesses the personal characteristics associated with a successful career in rural or remote practice.

Attachment 2.6 ACRRM Selection Policy,

RACGP Fellowship Training:

Eligibility:

Eligibility criteria for a fellowship pathway is determined by a doctor's medical qualification, medical registration, citizenship, and AMC requirements (for overseas trained doctors).

Application and Selection:

- Eligibility is confirmed through the submission of an online application and supporting documents
- Applicants must have a minimum of one exam semester remaining to complete all Fellowship exams
- For AGPT, successful applicants are required to cease training on any other vocational training programs
- For FSP, must be employed or have an employment offer in comprehensive general practice in an MMM 2-7 location at the time of application
- For FSP, must work in a training location that complies with the General Practice Fellowship Program Placement Guidelines if a Provider Number under the FSP is required.
- For FSP, must hold General or limited medical registration (Level 2 supervision and above, at the point of application, only) enabling full scope of practice
- For Rural Generalist pathway must demonstrate commitment to rural practice

National Entry Assessment

Eligible candidates sit the Candidate Assessment and Applied Knowledge Test (CAAKT), a computer-based tests featuring Knowledge Test questions and Situational Judgement

Test questions. The CAAKT is based on the RACGP Curriculum and focuses on knowledge, skills and attributes related to becoming a General Practitioner.

Interview and offers

The score obtained in the CAAKT determines progress to the next stage of selection and candidates may be allocated to an interview in line with their CAAKT score, cohort ranking, and stated training region and pathway preferences.

Format of the interviews can be either multiple mini-interview or a single interview with a panel. In some regions, interviews may be done remotely, and in some they may be face to face. There may be slight modifications to this process in 2023 with the move to College-led Training.

Candidates are notified of the interview outcome via email and must respond to any training offers in writing.

Numbers of Trainees

The DOHAC has been funding 300 designated Rural Generalist training places for the last few years through the AGPT program (150 ACRRM places, 150 RACGP places). Going forward the DOHAC has indicated it will increase the AGPT target should oversubscription point to demand.

Additionally:

- The DOHAC has funded 100 new places annually through the Rural Generalist Training Scheme for the past two years and going forward. (Noting all ACRRM Fellows complete RG scope training)
- ACRRM enrols an additional around 20 registrars through its Independent Pathway and the RVTS program annually.
- Whilst previously those on the RACGP PEP pathway were ineligible for the FARGP, the new FRACGP-RG has been opened for those on the independent Fellowship Support Program (FSP) which replaces PEP. It is estimated that 10-15 doctors may enrol in FRACGP-RG under RVTS and/or FSP annually.

This suggests that approximately 430 doctors a year are being enrolled to Rural Generalist Fellowship Training and given that this is a four-year training pathway, this would point to a training cohort of around 1,720.

Going forward five years, assuming increased interest in the field of RGM arising from the expanded training support and opportunities, and potentially specialist recognition, has been achieved, a conservative projection might be for a 5% increase overall, this would result in an increase to an annual intake of around 451 and a total training cohort of around 1,804.

Education, Training and Supervision and Assessment Delivery

The Rural Generalist training programs are run based on an apprenticeship model based in a network of accredited training practices with accredited supervisors through a range of different delivery providers. All training is delivered to the respective Fellowship standards and assessed by the respective college.

Currently the accreditation of training practices and supervisors for registrars training on the government funded AGPT program has been delivered through the nine Regional Training Organisations subcontracted by the DOHAC on behalf of each College. Going forward the Colleges are establishing a collaborative framework to undertake this work autonomously to optimise efficiencies. All accreditation is undertaken consistent with the respective college standards. Many training practices have dual accreditation.

Both Fellowship programs require all registrars undertake a formal teaching program additional to their practice-based learning. This involves a combination of independent online learning, group

online learning, and in person workshops and courses. Registrars are required to take assessment under a range of different modalities.

The training requirements include time in both general practice/primary care settings, and hospital settings and an additional one to two years of training in a selected Advanced Specialised Training (AST) option which has dedicated assessment.

The training pathways are summarised in Table 2.2.

Table 2.2 Fellowship Training Requirements for Rural Generalist qualification

	RACGP	ACRRM
Qualification	Fellowship of The Royal Australian College of General Practitioners (FRACGP) FRACGP + RACGP Rural Generalist Fellowship (FRACGP-RG)* *FRACGP-RG has replaced the 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	For FRACGP: 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 FRACGP-RG: • 12 months in a rural general practice setting (MMM3-7) • 6 months core-emergency medicine training (can be part of extended skills) • 12 months advanced rural skills training (ARST)	36 months Core Generalist Training Commence at postgraduate year (PGY) 2 or above. Train in regional, rural and remote General Practices, hospitals, Aboriginal and Torres Strait Islander health services and retrieval services. Complete the minimum full-time equivalent training in the following: • primary care - 6 months • secondary care – 3 months • emergency care – 3 months • rural or remote practice -12 months • paediatrics - 10 weeks • obstetrics - 10 weeks • anaesthetics - 10 weeks
	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.

Distribution of training posts and AST training

A substantial national infrastructure of accredited training posts to reflect the diverse training needs of Rural Generalist registrars has been established and continues to be developed. The

two general practice colleges have arrangements in place to work collaboratively to progress ongoing accreditation and training capacity development. This work will be supported by the Rural Generalist Coordinative Units. It should be noted that many of the training posts maintain dual accreditation and are able to support registrars from ACRRM and/or RACGP.

Table 2.3 Accredited training posts by type and rurality classification*

Training Post Type	ACRRM	RACGP
Total accredited posts	1082	3067
MM1	75	1655
MM2	178	379
MM3	233	310
MM4	198	192
MM5	268	321
MM6	84	91
MM7	65	119
Aboriginal Medical Services	93	309
Primary Care/Core Generalist	884	3067
ACRRM specific classifications:		
Hospital in-patient care	339	
Emergency Care	334	
AST- EM	68	
AST – Paediatrics	30	
AST- AIM	25	
AST - Mental Health	24	
AST - Palliative Care	22	
AST – Aboriginal/Torres Strait Is. health	15	
AST - Pop Health	14	
AST - Remote Medicine	11	
AST - Surgery	6	
AST - Academic Practice	3	

* Note ACRRM and RACGP have different systems for classification of some types of posts

Accreditation standards and processes

- The Fellowship curricula and their associated assessment programs set the broad professional standards for competent practice in the Rural Generalist scope.

- In the ACRRM program these form the basis for development of the training requirements as well as the basis for assessment of comparability of a doctors experience with the Fellowship competencies and scope.

- The RACGP Standards for general practice training 3rd edition were developed to outline requirements for general practice education and training, supervisors and training sites. The training standards are outcomes-based and focus on the quality of the outcomes for registrars and patients rather than on how these will be achieved. Interpretation of the training standards as they apply to supervisors and training sites was previously undertaken by training organisations. As a guide to the accreditation of training sites and supervisors delivering the AGPT program, the RACGP has written the *Accreditation Standards for training sites and supervisors: Guide to implementation*. This provides detailed guidance and expectations to ensure that accreditation supports consistent high-quality training.

- Both colleges have their own set of training accreditation standards which are applied to the assessment of supervisors and training practices that contribute to training in the two Fellowship Programs. The two colleges have separate accreditation standards but are building frameworks to enable collaborative assessments of posts to minimise duplication.

Attachment 2.7:

- *ACRRM Standards for Training Posts and Supervisors*
- *RACGP Standards for general practice training (3rd ed)*

Process for assessment of overseas qualifications for Fellowship

ACRRM:

Doctors who have ACRRM-recognised overseas specialist qualifications in general practice or family medicine may apply through the Specialist Pathway to undertake a process of assessment toward attaining qualification for ACRRM Fellowship. ACRRM recognition of qualifications is in accordance with its codified list in accordance with defined criteria.

ACRRM's specialist pathway assesses if the training and experience of an SIMG is comparable to that of a Fellow of ACRRM. A Fellow of ACRRM (FACRRM) is a medical specialist who has been assessed as meeting the requisite standards for providing high-quality rural generalist medical practice.

This involves being able to:

- provide and adapt expert primary, secondary, emergency, and specialised medical care to community needs
- provide safe, effective medical care while working in geographic and professional isolation
- work in partnership with Aboriginal, Torres Strait Islander peoples and other culturally diverse groups and
- apply a population approach to community needs.

SIMG's comparability is assessed against the competencies in the eight domains of rural and remote practice as described in the *Rural Generalist Curriculum:*

- Provide expert medical care in all rural contexts
- Provide primary care
- Provide secondary medical care
- Respond to medical emergencies
- Apply a population health approach
- Work with Aboriginal, Torres Strait Islander, and other culturally diverse communities to improve health and wellbeing
- Practise medicine within an ethical, intellectual, and professional framework
- Provide safe medical care while working in geographic and professional isolation

SIMGs are deemed non-comparable to a FACRRM if they cannot demonstrate:

- achieving their qualification through completion of a supervised training program
- partial or substantial comparability in each of the eight domains
- at least three years providing clinical care away from ready access to specialist medical, diagnostic, and allied health services, since achieving their specialist qualification
- extended practice relevant to community needs
- ongoing professional development that is comparable to MBA requirements.

RACGP:

The RACGP has developed the Practice Experience Program - Specialist Stream (PEP SP) to meet the requirements of the Medical Board of Australia's Specialist Pathway.

The curricula of international general practice qualifications are assessed against five core units as described in the curriculum of the RACGP curriculum and syllabus:

- Communication skills and the patient-doctor relationship
- Applied professional knowledge and skills

- Population health and the context of general practice
- Professional and ethical role
- Organisational and legal dimensions

If a Specialist International Medical Graduate (SIMG) has trained under a curriculum considered to be Substantially or Partially Comparable to that of the RACGP, they are eligible to apply for a comparability assessment.

A comparability assessment is a personalised assessment for individual SIMGs. It considers multiple aspects of the SIMGs training and experience, including:

- The curriculum under which they trained
- The nature and context of the training
- The nature of the assessments undertaken
- The nature and context of recent general practice experience
- Demonstration of recent Continuing Professional Development

Trained assessors consider an SIMG's application, and a Summary of Preliminary Review (SPR) is sent to the SIMG to provide any additional information or clarification requested. Further information is considered, and an outcome is issued. If an SIMG is assessed as Substantially or Partially Comparable, they may proceed to provide details of the intended job location. This must be in comprehensive general practice.

To be assessed as Substantially or Partially Comparable, and SIMG must demonstrate:

- They obtained their qualification via a supervised training program
- They have a curriculum considered to be Partially or Substantially Comparable
- They have at least 18 months of general practice experience, and at least 9 months of that is within the last 4 years
- The context of the general practice experience is at least partially comparable to that in Australia
- They meet CPD requirements

2.C The Australian professional body or bodies can demonstrate experience in all or some of the following:

- **health policy development**
- **health promotion and advocacy**
- **research facilitation**
- **the development and dissemination of the discipline's evidence base**
- **the education of other medical and health professionals**
- **engagement with health consumers**

Describe the track record of the professional bodies for the proposed field of specialty practice in:

- health policy development
- health promotion and advocacy
- research facilitation
- the development and dissemination of the discipline's evidence base
- the education of other medical and health professionals
- engagement with health consumers

Health Policy Development

The two Colleges are highly active in the policy space. Their work occurs at the local, jurisdictional, and national level, involving senior staff and members as representatives of the specialist field and the communities that its practitioners seek to serve. Each year hundreds of submissions, position papers, recommendations and representations are made to diverse policy forums to advocate for the respective vision and mission of the colleges.

The National Rural Generalist Pathway work which has led to this application, has been a key area of joint effort over many years. Alongside this application, the Colleges are contributing members to the broader agenda of the National Rural Generalist Strategic Council and the Jurisdictional Implementation Committee which is a sub-committee of the Council comprises of representatives from all jurisdictional health services.

The Colleges have contributed to all stages of the development of the Rural Generalist policy within the AGPT and the development of the brief and the ongoing operations of the Rural Generalist Coordinating Units. The Colleges have also worked to design and deliver the Rural Procedural Grants Program which is the key government program supporting Rural Generalists to maintain their advanced skills.

Some other key undertakings of both the Colleges have included:

- National Medical Workforce Strategy (NMWS) development through the NMWS Advisory Council
- Primary Care 10 Year Reform Strategy which will be continued through the Medical Strengthening Workforce, for both of which, the colleges have been leading members
- COVID 19 Taskforce – this involved weekly meetings during the peak of the pandemic to inform the Health Minister and the Chief Health Officer of ongoing events and provide input into policy decisions

At the state level some key undertakings have included providing submissions and testimonies to a series of jurisdictional Senate enquiries into the state of rural health services, as well as advocating on diverse issues such as the Voluntary Assisted Dying Laws, Aged Care, Mental Health, and Pharmacist Prescribing.

Attachment 2.8 ACRRM Position Statements, Policy Submissions
Attachment 2.9 RACGP Position Statements, Policy Submissions

Health Promotion and Advocacy

The Colleges engage on a wide range of campaigns to promote the health of communities and particularly people living in rural, remote, and Aboriginal and Torres Strait Islander communities. The Colleges actively engage in campaigns and events particularly relevant to their missions, such as RU OK Day, NAIDOC week, Breast Cancer Awareness, Domestic Violence, Rheumatic Health Disease, Deadly Ears, Doctor Wellbeing, national cancer screening programs, and addiction prevention and treatment. Both Colleges are active members of the Close the Gap Alliance and the National Rural Health Alliance.

During the COVID 19 pandemic both Colleges were active in contributing to the health and well-being of communities and their members. Their efforts included PPE distribution to rural doctors, development of rural respiratory clinics, regular webinars, and daily updates to members on developments related to COVID 19 guidelines and management and, ongoing contributions to the clinical evidence guidelines.

Another key area of advocacy which has been pertinent in recent years has been in development of toolkits, resources, and advice for communities to strengthen their capacity for emergency response to natural disasters particularly in small and isolated towns.

Education of other health professionals

The multi-disciplinary nature of rural team-based care means that many of our members are trained by, and train nurses and other health professionals in their health settings, particularly as part of their work with the Rural Clinical School network.

Another important avenue for cross-disciplinary heath education occurs through the National Rural Health Alliance. The two colleges are members of this network and are active contributors to its Scientific Forums and Conferences which happen in each alternate year.

Research facilitation and development of the discipline's evidence base

The Colleges have established committees and structures to foster the development of research and new generations of research-oriented members of the profession, and to provide a governance structure to assure its rigour and validity. The ACRRM Research Committee has a specific brief to foster research in the discipline of RGM. It includes an international team of researchers who regularly collaborate on research papers in the discipline.

The Colleges host annual conferences which include scientific papers and posters and a formal process of peer review of presentation abstracts. The RACGP peer-reviewed journal, Australian Journal of General Practice. ACRRM sponsors the Australian Journal of Rural Health in association with its membership of the National Rural Health Alliance.

Through the AGPT, both Colleges arrange the sponsorship through the Education Research Grants of registrars and medical educators to undertake research related to their training. ACRRM encourages registrars to undertake research specifically related to the RGM.

Both Colleges provide the option of an Advanced Training year focussed in gaining skills as an academic researcher. Several other Advanced Training options include the development of a Research Paper in the discipline as a major assessment for example, these are part of assessment for ACRRM Aboriginal and Torres Strait Islander Healthcare AST, Remote Medicine AST, and Population Health AST.

The two colleges' structures and work in this area are further detailed at *Section 1.B.1*

Engagement with heath consumers

Both Colleges have community representatives on their Board and key committees and councils. Both Colleges also routinely seek consumer input into the development of policy, standards and other major initiatives related to the discipline.

ACRRM has a Rural and Remote Community and Consumer Reference Group which includes the community representatives on its governance committees as well as people from a distribution of parts of rural and remote Australia including several people representing rural Aboriginal communities. The group advises the College on policy issues and contributes to its continuous quality improvement as an organisation committed to educating rural doctors to best serve their communities. The group meets and presents annually at ACRRM's national conference. ACRRM has a program of contributing to rural community group conferences and events which it does with the guidance of this Committee.

ACRRM and RACGP are both members of the National Rural Health Alliance which seeks to provide a voice for rural consumers speaking together with rural healthcare providers.

3. Regulation in the form of recognition of the specialty or field of specialty practice addresses service delivery, and quality of healthcare in Australia

3.A How the recognition of the scope of practice of the specialist field through the Health Practitioner Regulation National Law will address service delivery, including one or more of the following:

- **safety of service delivery**
- **quality of service delivery**
- **access to services for consumers**
- **efficiency of the health system**

Objectives of the National Registration and Accreditation Scheme:

- help keep the public safe by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- facilitate workforce mobility for health practitioners
- facilitate provision of high-quality education and training for practitioners
- facilitate the assessment of overseas qualified practitioners
- facilitate access to services provided by health practitioners, and
- enable the continuous development of a flexible Australian health workforce

The headline issues that a strong Rural Generalist workforce will help to address are:

- The much lower health status recorded by people in rural and remote areas including the people in remote Aboriginal and Torres Strait Islander communities relative to people in cities[102]
- The inequitable and unacceptably poor access to quality healthcare services for both acute and continuing care of these same people relative to people in cities[103]
- The persisting issues of attracting and retaining sufficient doctors to meet the breadth of services required in rural and remote areas[104]

There is clear evidence that lack of access to many specialist services is leading to people in rural and remote communities receiving less care than their counterparts in cities. There is also considerable evidence linking this lack of access, to the much poorer health outcomes experienced by people living in rural and remote areas.

RGM exists as a fit for purpose access solution which is intrinsically efficient, and delivers context-appropriate high-quality, safe care. The approach can be shown to have successfully delivered these outcomes in Australia and overseas.

RGM is a compelling service delivery option from a range of stakeholder perspectives:

- Delivers people in rural and remote communities - high quality, personalised and contextual care across the continuum of health services and from cradle to grave by doctors who have been trained and certified to meet these needs effectively within the isolated, low resource, low staff context in which they practice.

- Offers practitioners - the professional attractions of a broad, variety of practice, together with strong community connection.

- Offers health systems – an economical model whereby practitioners can fill multiple service tasks matched to the quantum and breadth of needs of their communities including by working in multi-professional (local and distal) healthcare teams within the resource base available in their clinical context. It minimises the need for the cost and safety risks associated with patient transfers wherever safely possible, including the considerable (potentially prohibitive) costs incurred by rural and remote people of travel and stays in cities for care.

The benefits of the Rural Generalist model and a strong Rural Generalist workforce in meeting some key areas of need for rural and remote communities are summarised at *Table 3.2*.

Development of a rural workforce that is trained and able to provide services to the Rural Generalist scope, continues to be hampered by structural barriers. These prevent the workforce from reaching its potential as a strong national network, fully integrated into, and supported by healthcare systems, and driving, evidence-based, continuous quality improvement within the discipline.

A key to addressing these barriers is national recognition of the specialist field. The barriers to growing the Rural Generalist workforce and the mechanisms by which specialist recognition can assist to address these are summarised at *Table 3.3*.

3.A.1 Evidence of unmet needs of rural and remote people

RGM seeks to address well documented disadvantage that is experienced by people in rural and remote areas in accessing quality medical care. This can be clearly linked to poor relative healthcare outcomes for these people. The evidence is summarised below.

The disparities of the health status of Indigenous Australians and those of remote Australians are intertwined. Aboriginal and Torres Strait Islander people represent a far greater proportion of rural and remote communities than of urban communities. Whereas 71% of non-Indigenous Australians live in major cities 65% of Indigenous Australians live outside of major cities and 32% of Aboriginal and Torres Strait Islander peoples live in remote areas.[105] The health impacts of lack of service access for all people based in remote areas are likely to be exacerbated for Aboriginal and Torres Strait Islander peoples living in these areas by the well-documented negative health impacts of colonization and intergenerational trauma.[106]

- **Declining use of healthcare services with remoteness**

    - It is estimated that there is an annual underspend of around $4b by government in funding for health services for rural people relative to that spent on people in major cities.[107] This reflects significantly lower use of government funded health services across most key Government programs including the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). The lower per capita use of MBS funded services by rural people is a major contributing factor in this inequity.

    - A steep decline in utilisation of MBS services occurs with increasing levels of remoteness. This service gap is especially significant for non-GP specialist services.

    - The per capita number of non-GP specialist services received by people in outer regional areas was 25% lower than in major cities, and 59% lower for people in remote and very remote areas. (Compared to a 9%, and 36% respectively for GP services).

    - Similarly, per capita MBS funding for non-GP services declined by 16% for people in outer regional areas, and 59% for people in remote and very remote areas, compared to that spent on people in major cities. (Compared to 8%, and 28% respectively for GP services).

Table 3.1: GP and Non-GP specialist MBS expenditure by geographic classification 202-21						
	GP Services			Non-GP Specialist Services		
	MBSs funding	**Services per 100 people**	**MBS funding per 100 people**	**MBS funding**	**Services per 100 people**	**MBS funding per 100 people**
National	$8,753,453,966	666	$34,064	$2,347,556,834	102	$9,135
Major Cities	$6,458,349,941	675	$34,349	$1,787,621,659	106	$9,507
Inner Regional	$1,587,951,436	675	$34,916	$412,071,860	104	$9,061
Outer Regional	$577,054,190	613	$31,730	$127,310,635	80	$7,000
Remote/ Very Remote	$130,098,399	431	$24,619	$20,552,680	44	$3,889

Source: AIHW. (2021). *Medicare-subsidised GP, allied health and specialist health care across local areas: 2019–20 to 2020–21.* Retrieved from https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2020-21

- **Unmet demand for local advanced and specialised care services**

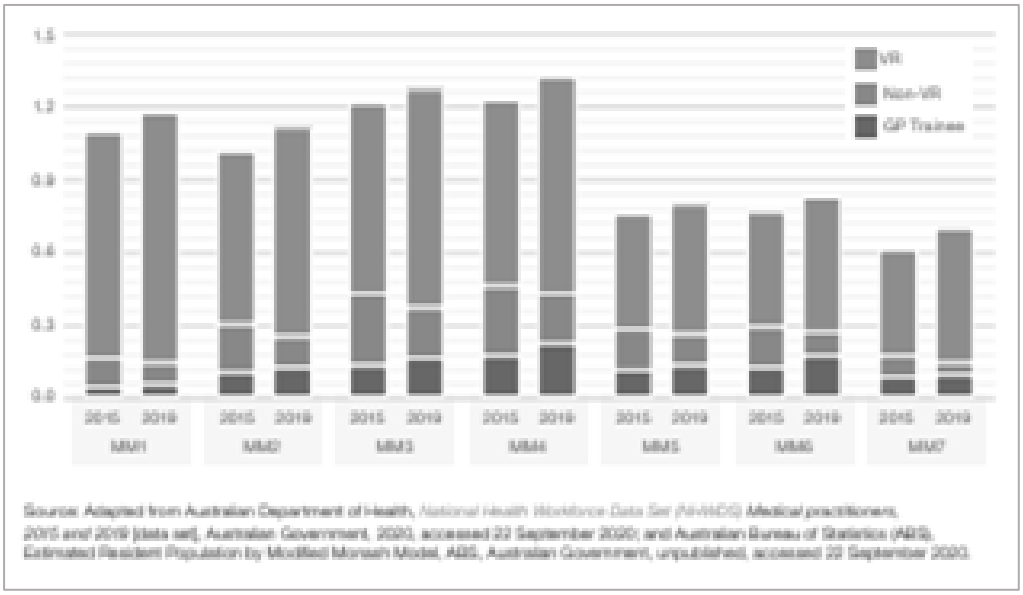
  Consistent with statements by the World Health Organization (WHO), there are a range of key advanced specialised services which are essential to primary healthcare in rural and remote contexts.[108] Some examples include, birthing and neonatal care, paediatric care, cancer treatments, renal care, end of life care, and addiction care.

  In cities, general practitioners frequently refer patients to consultant specialists for many of these services. In rural and remote communities where non-GP specialists are uncommon, patients can travel to see a distant non-GP specialist; or a Rural Generalist can provide those patients' care without them needing to leave their community. Travel involves financial, time and social cost and rural patients faced with travel will often opt to stay home and not access services. It should be noted that the patients and families for whom these financial and social costs are most likely to present the greatest barriers, are those who already face significant disadvantage (e.g., those who are very poor, aged, with mental illness, disabilities or chronic illness). In this way, where there are local services provided by Rural Generalists, there is greatly improved access to care for the highest needs people.

  Rural Generalists may provide immediate care in situ, or as is often the case with non-procedural care, they may provide the services they can for their patients between appointments with the city-based consultant specialists. They thereby improve the quality of service provision, reduce the frequency of review, and reduce the burden of travel.

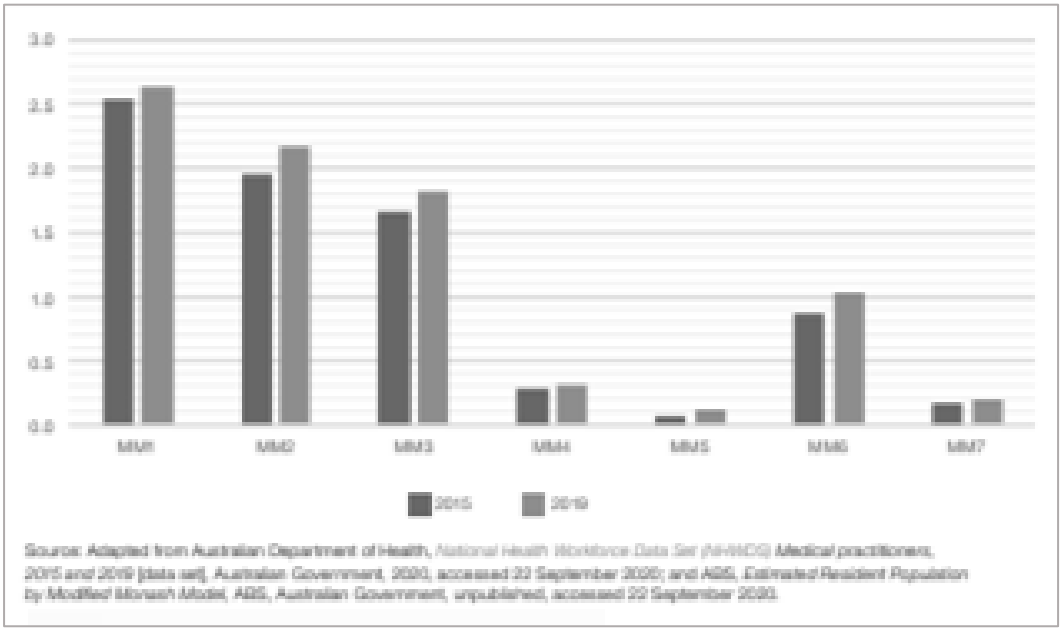
  There is a clear maldistribution of non-GP specialist doctors which is compensated to some degree by the number of specialist GPs in rural areas (See Figure 3.1). Similar patterns are replicated globally including for example in the United States[109] and Canada[110]. (Further detailed at *Section 3.A.5*)

Figure 3.1 General practitioners FTE per 1,000 pop, by MM and GP type 2015 and 2019[111]



Source: Adapted from Australian Department of Health, National Health Workforce Data Set (NHWDS) *Medical practitioners, 2015 and 2019* [data set], Australian Government, 2020, accessed 22 September 2020; and Australian Bureau of Statistics (ABS), Estimated Resident Population by Modified Monash Model, ABS, Australian Government, unpublished, accessed 22 September 2020.

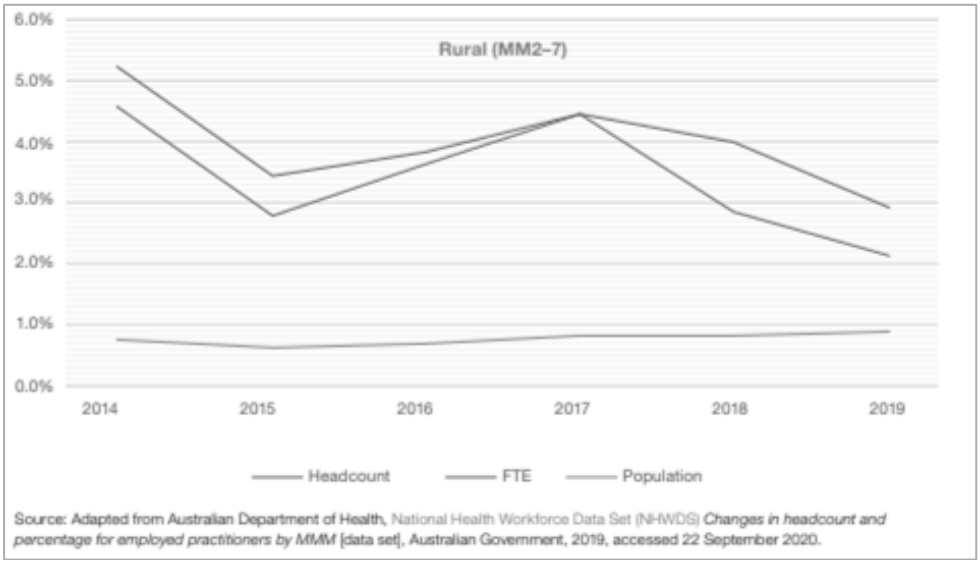
Figure 3.2 Medical specialists (GP and non-GP) FTE per 1,000 pop by MM, 2015 and 2019[112]



Source: Adapted from Australian Department of Health, National Health Workforce Data Set (NHWDS) *Medical practitioners, 2015 and 2019* [data set], Australian Government, 2020, accessed 22 September 2020; and ABS, *Estimated Resident Population by Modified Monash Model*, ABS, Australian Government, unpublished, accessed 22 September 2020.

These general workforce maldistributions are worsening over time despite a continuing national increase in the number of doctors overall. (See Figure 3.2)

Figure 3.3 Doctor (headcount and FTE) growth compared to pop growth, MM2-7[113]



Source: Adapted from Australian Department of Health, National Health Workforce Data Set (NHWDS) *Changes in headcount and percentage for employed practitioners by MMM* [data set], Australian Government, 2019, accessed 22 September 2020.

There is comprehensive evidence of people living in rural and remote communities not being able to access the care they need in areas of care typically provided by non-GP specialists.

A survey of over 800 people from across regional, rural, and remote New South Wales recorded respondents' feedback about whether they felt they had reasonable access to a range of key services. It highlighted gaps in fundamental areas of care provision in non-routine general practice/primary care services such as maternity care, palliative care, paediatrics, and mental health as well as hospital services.[114]

General Practice	96%
Ambulance	95%
Access to hospital or hospital service	90%
Emergency department (hospital)	87%
Pathology	89%
Aged care	86%
Dental	77%
Other allied health	67%
Early childhood services (including mother and baby)	55%
Palliative care	53%
Maternity services	51%
Psychology and mental health services	47%
Disability services and child development services	44%
Domestic/family violence, sexual assault services	42%
Oncology treatment	40%
Alcohol and other drugs treatment and services	39%

Rural doctors also recognise these gaps in the services available to their communities. The Rural Workforce Agency of Victoria survey of rurally-based general practice doctors found respondents felt they would meet their communities' needs better if they had further advanced skills training in a range of areas including dermatology and skin cancer care (39%), mental health (23%), obstetrics and gynaecology (including ultrasound and women's health) (18%), and emergency medicine (13%).[115]

The absence of locally available services is leading to critical and unacceptable delays in the time taken for patients to receive diagnosis and care. The New South Wales Parliamentary Inquiry into rural health services included testimonies of patients variously seeking specialised services who faced wait times and delays of:

- Four to six years to address developmental issues such as hearing loss, vision impairment, speech and language delay and behaviour
- Two years to see paediatricians
- Over 18 months for ENT specialists
- Over six months for psychiatrists.[116]

Lack of local access to these essential healthcare services can be shown to lead to many patients delaying or foregoing needed care. International studies have shown that longer journeys discourage the use of healthcare services.[117] National patient surveys have found that 58% of people in remote areas view the lack of a non-GP specialist nearby as a barrier to seeing one (compared to 6% in major cities). They found that the likelihood of forgoing seeing a specialist because there was none nearby increased with remoteness and that people in remote areas were 10% more likely to report this than people in major cities.[118]

There are considerable barriers to many people in rural and remote areas being able to travel extended distances to receive care. Groups such as the aged, people with disabilities and Aboriginal and Torres Strait Islander peoples face additional barriers.[119,120] A survey of rural people in New South Wales, found 42% of respondents viewed the costs to travel away from home for health treatment to be a deterrent and/or prohibitive.[121] The lack of public transport or other access to transport services is a key issue for many rural residents. It is noted that patient travel assistance schemes are administratively onerous and inflexible, and typically only partially cover costs. Kelly et al found that travelling to the city hospital is a significant barrier to remote and rural Indigenous patients and that arranging and supporting travel is time-consuming work not recognised by the healthcare system.[122]

Poor access to specialised and referred care services can also lead to fragmentation of care. The likelihood of care fragmentation due to lack of communication from specialists to patients' regular general practitioner increases with remoteness. People in remote areas are10% more likely than people in major cities to report that their usual general practitioner had not been informed about specialist care they had received.[123]

Health and safety impacts of lack of local services

With increasing remoteness comes significantly declining health status. For example, the death rates for coronary heart disease, chronic pulmonary disease, lung cancer and diabetes increase with remoteness. The rate of Potentially Preventable Hospitalisations (PPH) also increases with remoteness. The PPH rates in regional areas were higher than for *Major cities* and for those in *Very remote* areas were 2.5 times as high and in *Remote* areas were 1.7 times as high over 2017-2018.[124]

Accessing care itself can present a significant threat to rural people's safety. A study by Greenup et al into patients travelling to access hospital care identified a direct relationship between increasing remoteness and travel risk. The review identified 45 people who had died in road accidents in the process of obtaining medical treatment in Queensland between 2002 and 2015, an average of 3.21 deaths per year. They concluded that individuals living in regional and remote Queensland are exposed to a significantly larger risk than those living in the major cities of Queensland when required to travel to hospital for referred care.[125]

The extent to which these access issues are impacting rural and remote communities is demonstrated by their extensive coverage in community submissions to the 2021 New South Wales Inquiry into rural health services access and outcomes. Some examples are given below:

> *"Many residents, particularly the elderly, have lost faith in the provision of local healthcare & live their lives in fear of not being able to receive the necessary healthcare in their time of need. We are sure there are many instances of people who have either delayed or decided not to bother seeking medical treatment due to the difficulties in accessing it locally. This is obviously going to result in poorer health outcomes. …To not properly treat patients locally in the regions means one of two things occurs; (a) they must travel/be transported to another*

location, meaning added cost & stress, & a transfer of the cost of treatment to another cost centre within the Department, &/or (b) they are not treated adequately or at all, resulting in poor health outcomes including death. It simply does not make any moral or economic sense to under-resource healthcare in regional communities."[126]

"The waiting lists for visiting specialists can be long, with some patients waiting more than 12 months for an appointment. Given that many of the population sit in a low socio-economic band and cannot afford to travel for medical treatment, the trend of lower health outcomes will continue to be an issue for the region if not addressed."[127]

"The patient experience, wait-times and quality of care are ongoing issues. Wait times are increasing to access GPs, as well as wait times to access specialists in regional centres such as Wagga Wagga or Canberra. The cost to access specialists and specialised educators is far more than in metropolitan areas. Further, the additional costs of travelling to regional centres to access these services are an additional burden to those living in rural areas. Outpatient clinics are unavailable to those located in rural areas, when these services are provided at no cost to those living in metropolitan areas. Some patients are unable to afford the costs associated with seeking treatment by a specialist. The isolated travel fund allowance is cumbersome to access due to the excessive amount of paperwork required and the outcome of funding is very limited."[128]

"Council has been advocating for improved medical services for several years. For example, there are limited maternity services in Yass and residents have to travel to Queanbeyan, Goulburn or Canberra. Similarly, residents needing dialysis and oncology services must travel into the ACT. Many residents in Yass Valley rely on Community Transport to travel for these services. This has been particularly challenging during the COVID-19 restrictions as many of the community transport drivers are volunteers many of whom are vulnerable to the virus"[129]

"The local maternity ward is a much loved component of the Gunnedah Hospital,,, However, the operation of the maternity ward is dependent upon the availability of two local doctors and if they are unavailable, the ward, simply shuts with patients transferred to the Tamworth Hospital. It is unthinkable that metropolitan based mothers would have to deal with the possibility that the maternity ward at their local hospital may or may not be open on the day or hour they arrive to have their baby. It remains a great fear for the Gunnedah community that when we inevitably lose one of the local GP's required to operate the maternity ward, the service will go the way of so many other local health services and simply be closed forever and centralised to the regional city of Tamworth."[130]

"It should be remembered that there is very limited public transport available as a result patients are either driving themselves, utilising community transport or waiting and then travelling in ambulances...It is no longer possible for expectant mothers to give birth in the smaller rural hospitals because you need a team of specialists to deliver and care for a newborn and we simply don't have enough babies to justify having such a team on standby. This is even more challenging now that we have specialist maternity nurses."[131]

"Maternity, oncology, and renal care are most needed and called for locally. Despite a population of more than 17,000 people, Yass Valley mothers cannot deliver their babies at Yass Hospital and must travel to Queanbeyan, Goulburn or Canberra for labour and delivery. This causes additional anxiety and stress, over and above the normal fear women can have of labour and delivery. Yass Valley women have a high risk of an unplanned and unsupported highway birth, and are forced to be away from their other children and support networks to access maternity care. …Yass Hospital must resume full time maternity and delivery care with the midwifery continuity of care model for our growing population. The well-known and expanding 'continuity of care' model with local midwives and GPs working together would deliver more than 185 babies each year in Yass."[132]

Further evidence of these safety impacts and the specific contribution of the rural generalist model to patient safety is detailed further at *Section 3.B*.

3.A.2 RGM workforce as a solution

The rural generalist model can positively address these pervasive problems. Even without national recognition and the structural barriers to the model that exist, there is considerable evidence demonstrating that where the training and practice of the Rural Generalist workforce is given strong support and even limited recognition, considerable improvements can be made to the quality of care rural and remote communities can receive.

RGM is an essential component of healthcare if rural communities are to be assured of access to comprehensive primary care that is integrated with secondary and tertiary healthcare services.

The strength of RGM is the ability to deliver quality, personalised and contextual care across the continuum of health services and from cradle to grave. From a rural patient and community perspective, RGM has many specific advantages. These include ready access to skilled, culturally competent and locally-informed practitioners; improved continuity-of-care and follow-up; a better patient experience through familiarity, trust, personal relationships and patient-centred care; stronger integration of visiting consultant specialist services and telehealth; reduced healthcare costs; and less personal and economic disruption associated with transport to distant services.

RGM can be tailored to available resources and local healthcare priorities of communities. For Indigenous communities and marginalised groups, skilled local doctors practising RGM as part of a team offers the best prospect of assuring effective medical care that is culturally competent and responsive to priority community needs.

From a health systems perspective, RGM has doctors applying a broad and evolving skillset, thereby increasing professional satisfaction, productivity, and rural retention. Stable models of locally-based, team-care are promoted and there is a reduced reliance on locums. This in turn supports establishment of a strong, quality rural learning environment for students, doctors-in-training and others to create a self-sustaining workforce. Medico-legal costs and associated risks are reduced.[133]

Some key mechanisms by which a strong Rural Generalist workforce can address these service delivery issues for people in rural and remote communities are summarised below:

Table 3.2 Summary of how RGM addresses community needs

Communities Service Needs	Rural Generalist Workforce Solution
Rural and remote communities:	RGM:
Need better access to medical care (insufficient rural and remote doctors) *Evidence:* Rural and remote people's lower health status, workforce shortages, patient wait-times.[134] patient testimonies[135], Rural Generalist's long working hours.[136]	• Offers a highly attractive career path for a particular subset of the medical graduates • Is associated with unparalleled rates of rural retention.[137,138, 139]
Need stronger coordination of care (primary, referred, emergency) *Evidence:* GPs typically uninformed of outcomes of consultant specialist visits but required to provide follow up and emergency care.	• All care is primary/continuous care centred • Offers highly integrated patient care, as doctors provide services across primary, hospital in patient and emergency • Doctors trained for collaborative visiting consultant specialist models (telehealth, FIFO visits) to ensure local continuity of care, emergency care • Integrates care across the ACCHO sector and the hospital sector for Indigenous people

Table 3.2 Summary of how RGM addresses community needs	
Communities Service Needs	**Rural Generalist Workforce Solution**
Need local access to care in medical emergencies *Evidence:* Higher death rates, deaths by accidents, road toll etc. [140]	• Emergency medicine training is core competency of RGM required to be maintained through Fellowship CPD • Doctors trained rurally for low resource settings which may involve clinical assessment, stabilisation, management, and retrieval
Need as much access as possible to the spectrum of advanced care/specialised services (To provide access and to avoid the inequity of forcing the cost of travel to access care on to rural and remote people) *Evidence:* Rural and remote patients not receiving specialist care and having poorer health status across most categories (See *Section 3.A.1*)	• Fellowship curriculum includes high level skills across care spectrum (providing as much care as safely possible) • All Fellows attain at least one advanced care skill relevant to their community need. • Discipline includes key areas for local provision incl. maternity services, palliative care, mental health, Aboriginal and Torres Strait Islander peoples' health, and paediatrics
Need specialised care but cannot support business model for a locally-based consultant specialist *Evidence:* Very low representation of specialists in rural and remote areas.[141]	• Doctor capacity to work across settings means not dependent on single source of income and has highly adaptive business model to suit local demand • Trained to work in low resource settings with clinical models, standards, scope appropriate to context

1. **Improved access to care through more long-term, expert rural and remote doctors**

   As detailed at *Section 3.A.1*, rural, and remote communities have insufficient access to medical care. Furthermore, the rural workforce shortage and its impacts on rural and remote people is growing. These problems are exacerbated by an aging rural workforce.[142]

   Rural Generalist Workforce Solution:

   There is substantial evidence to demonstrate the attractiveness of the Rural Generalist model to many Australian doctors.[143,144,145,146,147] More recent studies have pointed to positive influence of Rural Generalist training on the attractiveness of rural careers for medical students,[148] and ultimately to retention outcomes.[149] National AGPT Registrar Surveys of ACRRM (rural) registrars have consistently reported key features of the Rural Generalist model such as 'practice variety', 'rural location', and 'procedural practice' as the most appealing aspects of training.[150-151]

   Evidence also clearly shows the strong association between rural retention and rural generalist practice. 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.[152] This is further demonstrated by 88% long-term rural retention outcomes of programs such as the QRGP as outlined below.

   A singular focus on a particular non-GP specialty area or on GP clinic-based practice is attractive to many medical students and early career doctors. Such doctors have access to clear training and career pathways including rural pathways and these are promoted to them in a manner likely to be appealing. However, evidence points to a substantial section of the emergent medical workforce for whom the diversity of rural generalist practice together with the adventure and community-orientation of rural and remote practice is highly appealing.

2. **Integrated, unfragmented care across the healthcare spectrum**

Care provided by general practitioners, in hospitals, by consultant specialists, or allied health specialists is offered by different individuals and organisations. In rural and remote areas, the discontinuity between these services is exacerbated by the fact that care provided by practitioners other than the general practitioner is commonly provided in distant cities, or by telehealth or outreach visits by city-based practitioners. As outlined above, unsurprisingly, the likelihood of general practitioners not being informed of their patients' treatments received by consultant specialists increases with remoteness.[153]

Sutarsa and associates in their study of patients in hospitals in rural New South Wales found that:

> *Employing GP-VMOs in rural hospitals enables the knowledge and sensitivity gained from their ongoing interactions with patients in primary care to be effectively utilised in the delivery of hospital care, thereby, allowing continuous, patient-centred care to be provided to rural and remote patients.*[154]

The rural generalist model can make an important contribution to care of Aboriginal and Torres Strait Islander peoples in rural and remote areas where Rural Generalist doctors work in ACCHSs and other Aboriginal Medical Services and GP clinics and provide services in hospitals. The Rural Generalists build relationships of trust through their community based, continuous care practice and by being part of the hospital system – can help patients to have confidence in hospitals as a culturally-safe space in which they can receive needed care.

3. Provision of minimum range of permanent, locally-available, advanced specialised services germane to primary care in rural and remote areas

There are a range of key advanced specialised services which in rural and remote contexts should appropriately be viewed as essential to primary healthcare.[155] For example, birthing and neonatal care, cancer treatments, renal care, end of life care, addiction care, and preventive screening.

Failure to provide local access to these is inequitable and is likely to lead to some patients delaying or foregoing needed care as well as to fragmentation of their care. It is likely the significant gap in health status which increases with remoteness is linked to this phenomenon. There is ample evidence to support these propositions as outlined at *Section 3.A.1*.

There is evidence that this lack of access inhibits patients receiving critical preventive care. For example, people living in *Remote and Very remote* areas also have lower rates of bowel, breast and cervical cancer screening[156,157]

As outlined above this is also associated with poor coordination of care between rural general practitioners and city-based specialists.[158]

4. Alternative model, given unfeasibility of full range of specialist services, staff, and resources of major cities

Due to relatively small patient catchments, it is unlikely that private practitioners and services, nor governments will ever establish the breadth and depth of medical, nursing, and allied healthcare services that exists in metropolitan areas in rural or remote areas. Geographic distances will continue to create a substantial barrier to these people accessing many of these services. This being the case alternative (non-urban) models of practice and service delivery are required to optimise the services that can be accessed locally.

There is ample evidence of the maldistribution of the non-GP specialist workforce between urban and rural and remote Australia and the corresponding difficulties in accessing to specialist services for rural and remote people. For example, although nearly a third of Australians live in rural and remote areas, 12% of Fellows of RACS (FRACS) live and work rurally and for five of the nine surgical specialties, less than 5% of surgeons were based

outside cities[159] The emergency medicine workforce is in national oversupply, projected to be 60% (1,300 doctors) oversupplied by 2030. However, there continue to job vacancies in rural areas.[160]

5. Alternative model, as highly specialised practice models cannot viably support permanent staff in rural and remote contexts with limited patient catchments

Financial viability and sustainability of clinical practice is an important consideration. It is not possible to sustain some specialty/subspecialty practices in rural or remote areas and it is not realistic to expect doctors to live and work in rural and remote areas if there is not a consistent and ongoing demand for their specialised clinical services.[161]

Non-GP specialist and subspecialist practice models rely on substantial population catchment numbers and caseload which are often not possible in rural and remote contexts. Additionally, these specialists' clinical practice models are often based on metropolitan tertiary hospital settings with immediate access to extensive specialist staff and resources which do not reflect rural and remote clinical contexts.

Rural Generalist Workforce Solution*: (Issues 2-5):*

RGM is an essential component of healthcare if rural communities are to be assured of access to comprehensive primary care that is integrated with secondary and tertiary healthcare services.

Consistent with statements by the World Health Organisation, there are a range of key advanced specialised services which are essential to primary healthcare in rural and remote contexts.*[162]* Some examples include, birthing and neonatal care, paediatric care, cancer treatments, renal care, end of life care, and addiction care. Many of these services can be partially or fully provided through Rural Generalist-led care.

In cities, general practitioners frequently refer patients to consultant specialists for many of these services. In rural and remote communities where non-GP specialists are uncommon, patients can travel to see a distant non-GP specialist; or Rural Generalists can provide those patients' care without them needing to leave their community. Travel has financial, time and social cost and rural patients faced with travel will often opt to stay home and not access services. In this way, where there are local services provided by Rural Generalists, there is greatly improved access to care especially for those with the highest needs.

Rural Generalists may provide immediate care in situ, or as is often the case with non-procedural care, they provide the services they can for their patients between appointments with the city-based consultant specialists. They thereby improve the quality of service provision, reduce the frequency of review and reduce the burden of travel.

Rural Generalists are trained to work across the care spectrum in a manner which is responsive to community need. They are trained in rural and remote contexts, and they specifically assessed for competence to provide these services in the high-community accountability, low-resource, small health-team environments of these locations.

RGM is an economical approach. Not only does it minimise the costs to both patients and health care systems of transporting patients to cities. Its generalist approach also foregoes the higher costs and staffing challenges due to more subspecialists being required to cover the full range of service needs.[163]

3.A.3 Impacts of Recognition of the specialist field

The practice of RGM and the establishment of a strong and sustainable Rural Generalist workforce continues to be limited by structural barriers to delivery (summarised at *Table 3.3*). These prevent it from reaching its full potential as a strong national workforce fully integrated in and supported by healthcare systems and driving, evidence-based, continuous quality improvements.

Despite the professional appeal of the Rural Generalist model, there is considerable evidence of the declining number of doctors providing advanced care services in rural areas which is occurring despite the considerable investment by the federal government in training this workforce.

New South Wales Rural Workforce Agency (NSW RDN) in its annual needs analysis has identified the decline in the:

> "*interest or preparedness of GPs to work as VMOs in hospitals"* and the declining rural procedural general practitioner workforce as a key issue, identifying that:
>
> *"RDN workforce predictions show by 2025 rural NSW will have less than 156 GP VMO Proceduralists.*
> *30% of the current proceduralist workforce is over 60.*
> *It can take seven years to attract, recruit and embed a GP Proceduralist….*
>
> *(This workforce shortage) Often leads to gaps in GP services available, including inpatient, ED and procedural services...*
>
> *Rural towns depend on GP Proceduralists to ensure ongoing access and sustainability of primary health care for rural communities. Declining numbers leads to a reduction in locally available services. Birthing services are unavailable in many remote locations. More pressure on existing GP Proceduralist workforce creates fatigue and burnout. LHD locum costs continue to escalate, while ongoing closure of financially unviable solo and smaller practices continue to exacerbate this."*[164]

The decline is further evidenced by community testimonies to the New South Wales Inquiry into health services.

> *…Instead we have observed an increasing tendency for our local GPs to disengage with the LHD and drift away from Visiting Medical Officer (VMO) work, which is what underpins our rural hospitals. It has now become common practice for Coolah, Dunedoo and Baradine not to have in person medical cover, especially on weekends and after hours. This places more pressure on Coonabarabran Hospital. Whilst Coonabarabran Hospital is meant to have 24hr in person medical cover on an on-call basis, it has had times when it has had to rely on telemedicine due to the LHO not being willing or able to supply in person cover.*[165]
>
> *"As an example of the downgrade to Narromine Hospital, during the tenure of the previous long-term doctors in the town, two of them conducted over 7000 procedures during their time serving the community. This, all at Narromine Hospital.*
>
> *The delivery of babies, setting broken limbs, appendix removed and other minor operations. Now there is basically nothing done there. Why is it a baby can be delivered in St George Hospital in western QLD but it can't happen in Nyngan, Bourke, Cobar or Narromine? All these mothers and families are forced to travel 3-400 kms in many cases. The distance to travel to seek good health services is also leading to significantly worse health outcomes because of the tyranny of distance. Many elderly people particularly will put off seeking advice on that lump or pain because it's too far to seek the advice. They suffer in pain and silence and their condition worsens. The cost to both them and government blows out. The cost cutting is counterproductive."*[166]

A key to addressing these barriers is national recognition of the specialist field. The barriers to growing the Rural Generalist workforce and the mechanisms by which specialist recognition can assist to address these are summarised below.

Table 3.3 Positive outcomes for building Rural Generalist workforce from specialist recognition

Barriers to Rural Generalist practice	Positive outcomes through Recognition
Quality assurance of specialist care is complex, arbitrary, and often not fit-for-purpose for specialist field	A single national standard which is associated with AMC accredited Fellowships, enabling: • Simplified, facilitated clinical credentialling • Standard matched to appropriate scope for Rural Generalist • Standard easily recognised and understood by patients, community, health sector
No named ''job'' to promote, employ, advertise or transfer credentials	Recognition will provide protected title which will be associated with an AMC accredited Fellowship • Workforce portability (nationally consistent role and clinical standard) • Job advertisements to a named, nationally recognised clinical role • Job remuneration reflects training/complexity • Promotion of named "job" to grow workforce • Promotion of named job/career to universities and high schools
Training in hospital and other sectors is often poorly recognised and supported	Recognition in health service systems will facilitate better supported and coordinated training in the discipline
Lack of systems' recognition for planning, resource allocation and representation in decision-making'	• Named role is included in workforce measurement • Named role is considered in resource planning and community recruiting • Practitioners with 'named" Rural Generalist appointments are included in clinical decision making
No incentive to undertake additional year to two years of difficult training	• Recognition and valuing of the scope attained, maintained, and practiced
Profession lacks clear sense of common identify and a well-defined focus for academic effort	• Stronger workforce building through a professional with strong sense of common identity • Common identity will support mentoring, peer support, and, professional pride • More focussed disciplinary research, evidence-based clinical guidance

1. **Quality assurance, safety, and credentialing systems can incorporate and reflect the formal status of practitioners and their skill set**

   Specialist title will allow rural generalist practice to be moderated by safety and quality systems with a consistent, nationally understood reference point linked to a common qualification standard.

   Many practice models that predominate in urban centres are highly specialised with strongly defined protocols around the assignment of clinical roles and the associated training and skills maintenance. In these contexts, homogeneity within specialities is common, and highly structured training and professional development frameworks for

their associated clinical credentialing are appropriate. These models typically assume access to tertiary resources.

These protocols are a poor fit for Rural Generalists that have a diverse scope of practice, less depth of specialisation, a low resource clinical setting and a necessarily different set of metrics for defining the safest and optimal clinical point for referral or patient transfer to major centres for care.[167]

The consequence is that to provide these services Rural Generalists must manage and continuously meet an excessive range of credentialing measures and processes. Furthermore, it commonly occurs that compliance expectations are prohibitive to practice in rural and remote areas even where these may be practiced safely. Moreover, not providing these services locally, presents a material risk to patient safety. While many standards may reflect best practice safety in urban contexts, a more nuanced, flexible, and holistic approach may be needed to achieve best practice safe care for rural people utilising the Rural Generalist scope and skillset.

A recent study found that procedural sedation is practiced extensively by non-specialist doctors across rural hospitals in New Zealand with positive outcomes for patients including avoidance of patient transfers and with acceptable levels of quality and safety. The study identified points of conflict with nationally set minimum clinical standards, preventing what was safe and practicable in rural hospitals. It saw need and value for a national quality and safety framework which safely and realistically, reflected this model of care in rural areas and defined appropriate standards for the distinctive rural professionals involved with its delivery in the resource context of rural hospitals.[168]

The current administrative complexity and unpredictability of hospital credentialing is a recognised barrier to Rural Generalists providing procedural services. Both the Rural Doctors Association of Australia (RDAA) and the Australian Medical Association (AMA) have identified this as a priority issue. The RDAA have developed a position statement on the issue.[169] The AMA conducted a survey of rural doctors in 2019 which ranked *"Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities"* as one of their top ten priorities.[170] The Rural Workforce Agency of New South Wales in its submission to the NSW Inquiry into rural health services identified decades of increasingly prohibitive compliance regulations as a major contributing factor to the decline in the rural procedural workforce in that state.[171]

Similar patterns of hospital credentialing systems reflecting urban specialist standards and preventing safe healthcare provision by general practice doctors in rural areas has also been evidenced in the United States and Canada.[172,173] An American Academy of Family Physicians paper identified the common practice of family doctors providing emergency services in rural areas and noted that the establishment of the emergency medicine specialty had led to:

> *"experienced family physicians sometimes denied credentialing, regardless of their emergency department work experience, with some being replaced in their practice environment by less experienced emergency medicine residency trained providers."*[174]

Some positive outcomes can be observed in Queensland where jurisdictional title is established, (noting the lack of national recognition means their effectiveness and broad adoption are limited).

In Queensland, rural people's healthcare benefits from their health services' employment and planning being informed of the credentials, skillset, trainee numbers, scale, and distribution of its Rural Generalist workforce.

Employment of Rural Generalists within the hospital system is advertised with titled positions. The subsequent appointment of a Rural Generalist confirms attainment of the Fellowship of ACRRM, or the Fellowship of RACGP + FARGP (including specific

certification of advanced specialised/rural skills) or equivalence as the associated clinical standard.'[175]

The clinical standard is consistent across the state, and clear and broadly understood throughout its health services. The Rural Generalist title confers that the employee has successfully completed training in at least one advanced specialised skill, has attained advanced emergency medicine skills, has expanded general practice skills for practice in rural clinical settings and training, experience, and capacity as a community-based general practitioner. The Fellowship curriculum, assessment and continuing professional development standards are published and freely available.

The title also helps patients to make informed choices about the care they receive. For example, hospital service patient guides to maternity care options can point to the availability of Rural Generalists.

Attachment 3.1: Sample Consumer Information: Emerald Hospital Patient Maternity Options

2. A named 'job' can provide transparent, effective, workforce marketing and recruitment and provide a basis for job portability

Specialist title will lend a common job title to enable job portability, more effective, simplified workforce recruitment, career marketing, and enhance job status and appeal.

There is no capacity to employ people (except in Queensland and Northern Territory) to the job of Rural Generalist. In the jurisdictions where this is possible, the job is accepted on the understanding that it will have no status in other jurisdictions, should the doctor decide to relocate.

As outlined above, the absence of title is a statement to doctors seeking to pursue careers in this field of the lack of esteem the national profession holds for it. At a practical level, it also means that they cannot anticipate that their credentials will have explicit recognition by potential employers as a coherent body of skills and experience that they would bring to the workplace, nor that they might be fairly remunerated. These factors all present disincentives to attaining high quality skills, experience, and accredited training in this area of critical workforce need.

This also inhibits healthcare employers seeking to employ people with this skillset in rural and remote areas. They cannot easily advertise for, nor actively recruit Rural Generalist qualified doctors, forcing them to use inefficient and ineffective processes.

In Queensland, the Government advertises for Rural Generalists. These employment opportunities are highly visible to all doctors in the state especially junior doctors that are considering their career options. They also showcase career opportunities for doctors on the Rural Generalist training program. As outlined above, all Rural Generalist positions have automatic recognition of Fellowship credentials irrespective of the area within Queensland Health in which they may be employed simplifying transfers and providing some assurance that their training and skillset will be recognised. It can be expected that this has contributed to the successful building of the Rural Generalist workforce in Queensland.

In the Northern Territory, although specialist title has not been established as a clinical standard, industrial recognition has been established and the position of Rural Generalist is incorporated in the Territory Enterprise Agreement. [176,177] Rural generalist positions are able to be advertised and appointed in the Territory health services. Industrial recognition has helped establish positions and Rural Generalist training hubs at Tenant Creek, Katherine and Gove Hospitals and the training to Fellowship of over twenty Rural Generalists in recent years in these area of significant workforce shortage.

It should be noted that for doctors in these two jurisdictions, this recognition does not extend beyond their borders and cannot support them, should they wish to relocate.

Conferring a 'name' to the career path will enable Rural Generalist careers to be marketed in schools, medical schools and hospitals and build workforce

There is a self-evident challenge to promoting a career option that has not been conferred a professional title. The lack of national title not only creates language barriers to describing a future career path but underscores to the emergent workforce the lack of value and status placed by the national health sector in the role.

The Australian Medical Students Association Rural Health Committee have also highlighted that *students feel that rural generalism isn't as ''clear cut'' or defined as other specialties,* and that, *recognition as separate from mainstream general practice will reduce confusion the student population has regarding generalism;* and hence assisting AMSA to promote rural generalism as a career.[178]

This is particularly of concern given that the Medical Deans of Australian and New Zealand (MDANZ) annual data report, found final year medical students ranked 'medical school experience of the speciality' and 'consultant/mentor influence' respectively as their 2nd and 6th top ranked reasons for choosing a specialty.[179]

Thus, from the outset of doctors' careers the value proposition of the considerable additional effort involved in pursuing rural generalist training is substantively undermined.

This is particularly so, when in choosing a rural generalist training pathway, these future doctors are asked to opt for the challenges that are associated with rurally-based training; an additional one to two years of training compared to a standard general practice Fellowship; and, a far more complex training pathway across different work settings, with the extended responsibility, work and time commitments of hospital and emergency work, in addition to the commitments and challenges of the general practice clinic.

Attachment 3.2: Sample job advertisements for Rural Generalists, Queensland, and Northern Territory

There is a strong inter-relationship between the establishment and success of the QRGP and its associated Rural Generalist specialist title and the James Cook University (JCU) medical school. JCU graduates represent almost half of all QRGP trainees (41% of all trainees and fellows).[180]

Table 3.4: Queensland medical schools' annual intake and participants in QRGP

Medical School	Student intake 2018[181]	Total trainees and fellows in/completed the QRGP as at 2022[182]
Bond University	128	24
Griffith University	207	72
JCU	200	234
Queensland University	385	162

While recruitment in all Queensland medical schools is likely to be positively affected by the establishment of specialist title within the state, JCU can and does strongly market RGM as a career pathway to its students. Qualitative analysis of graduate's explanations for their choices of specialty pathways shows that JCU graduates typically know of and name, *rural generalist* career options when discussing their preferred careers.[183]

It is noted that while the concept can be marketed in Queensland, it is marketed in the context of a national system that does not recognise the title. These developments are thus viewed as suggestive but not equal to the status and broad awareness that could be achieved with national title.

3. **Professional training pathway is clear, structured and supported through specialist title and by extension recognition of the appropriate skill set associated with its training and supervision**

   Historically, Rural Generalist trainees have been required to negotiate their own path through hospital, general practice, and other work settings in order to gain the requisite Fellowship training and experience and have faced system complexity and obstruction.

   Rural Generalist training programs in all states and territories are being supported by the federal government to actively address these issues. In seeking to facilitate training within their own hospital systems, the lack of a reference point of professional title, (with the exception of Queensland and Northern Territory*), is creating systems barriers for the program administrators.

   The absence of an agreed title linked to formal training qualification creates problems for example, in enabling trainees to access hospital training posts and appropriately experienced supervisors and in appropriately recognising registrars' training and experience to enable their clinical practice. Furthermore, without professional title, determinations regarding Rural Generalist training technically cannot stipulate a Rural Generalist's input. The lack of professional title also makes it difficult to formalise hospital linkages with the private general practice sector as there is no clear, official terminology by which the trainees or their profession can be described.

   Without professional title, it is possible that many states and territories will see the need to follow the example of Queensland and legislate individually for professional title creating further potential for inconsistencies and involving duplicative effort from all legislatures.

4. **Specialist title will enable rural doctors with the Rural Generalist skill set to be incorporated into workforce and health service resource planning**

   Logically, resource allocation for the benefit of improving health services is based on the available data on what skilled clinicians are or could be made available. The evidence arising from the New South Wales inquiry into rural health services strongly suggests that health service planning has not intrinsically considered the Rural Generalist workforce and their resource support requirements in rural hospitals. It also points to the long-term decline in resourcing rural hospital and health services that has resulted.[184]

   As outlined above, the New South Wales Rural Workforce Agency (NSW RDN) in its annual needs analysis identified the decline in the rural procedural general practitioner workforce as a key challenge and recommended the following actions to address this:

   > "…*Ensure the new rural generalist pathway is supported and integrated with LHD and GP workforce planning.*
   > *A better understanding of the future demand for proceduralist services is required to aid workforce planning initiatives.*
   > *A better understanding of the capability required to succeed in rural medicine will allow tailoring of training and ongoing CPD support.*
   > *Integrated acute and primary health care service planning in rural communities, involving public, private and not-for-profit sectors.*
   > *Adopt a holistic approach to attracting, training, supporting and retaining the incoming proceduralist workforce.*
   > *Recognise and value the unique and highly skilled contribution of GP Proceduralists as the cornerstone of rural primary health care. Families and partner support is essential to ongoing retention and requires the engagement of the community."* [185]

   All these goals rest on a capacity to bring better recognition, valuing and coordination to the development of a Rural Generalist workforce and the need for a common language to monitor, measure and drive progress for this key area of professional practice.

Kerr et al in their international study of rural emergency departments, identified the diversity of employment arrangements including the extensive use of general practitioners skilled in emergency medicine. They concluded that there was a need for consistency of language to describe these to allow a base for effective communication between governments, training providers and policy makers who are seeking to improve health systems and health outcomes.[186] Similarly, the American Academy of Family Physicians, in noting the significant contribution of rural family physicians to emergency medicine workforce saw a need for changes to workforce modelling to include the role of these family physicians particularly in rural areas.[187]

The National Medical Workforce Reform process is establishing a new workforce planning framework and commissioned development work is underway. Currently there is no role designation which can denote this workforce and their contribution. Specialist title can provide a mechanism and terminology to incorporate the Rural Generalist workforce in this fundamental planning framework. This is particularly pertinent as despite the lack of specialist title, the National Medical Workforce Strategy specifies implementation of the NRGP as a key element of national workforce development.[188]

In Queensland where specialist title is established within the state health services, the Rural Generalist role is defined and incorporated in the state's *Rural and Remote Health Services Framework*.[189] As outlined above, Queensland has been exceptional in its capacity to sustain the provision of advanced care services by Rural Generalists and the QRGP reports that 87% of doctors that have undertaken the program continue to provide the advanced care services they attained.[190]

Attachment 3.3: Queensland Rural and Remote Health Services Framework 2014

5. Conferring national recognition and status will incentivise doctors to undertake the extra training, commitment and effort entailed in RGM

While it is not possible to demonstrate the impacts of national title without this having been attained, it can be noted that Queensland which is the only state that has conferred recognition to its Rural Generalists working in its state health system can be shown to have achieved significant improvements within its jurisdiction in terms of providing a Rural Generalist workforce, and that its achievements in this area are stronger than anywhere else in Australia.

While Queensland (5.2m pop, 20%), is the third largest jurisdiction in Australia behind, New South Wales (8.2 m pop, 32%) and Victoria (6.7m pop, 26%) it appears to have the highest number of practicing rural procedural general practitioners including among all other states and territories.

The Rural Procedural Grants Program (RPGP) is the seminal national scheme to support rural generalist practice. It supports vocationally registered general practitioners to maintain their clinical credentials in key rural generalist areas of practice namely, supports procedural obstetrics, anaesthetics, surgery, emergency, and emergency mental health services.. As such, it is generally understood that most active procedural Rural Generalists take part in the scheme. Queensland has consistently recorded the highest number of doctors of any state or territory subscribing to any part of the national RPGP.

Table 3.5 Enrolments in procedural skills support program in largest states, by state and year

	2018		2019		2020		
	Obs, Surg, Anaest	EM	Obs, Surg, Anaest	EM	Obs, Surg, Anaest	EM	Mental Health EM*
ACT/NSW	335 (18%)	884 (21%)	308 (17%)	864 (21%)	309 (17%)	878 (21%)	22 (11%)
VIC	328 (18%)	680 (16%)	322 (18%)	681 (16%)	329 (18%)	695 (16%)	24 (12%)
QLD	482 (26%)	912 (22%)	484 (27%)	898 (22%)	506 (28%)	937 (22%)	109 (54%)

National Total	**1836**	**4159**	**1803**	**4136**	**1835**	**4237**	**202**

**Support for Mental Health Emergencies training introduced in 2020*

Queensland appears to contribute the most Rural Generalist trainees to the AGPT training program.

Table 3.6: Rural Generalist enrolments in AGPT by state as at April 2021

State/Territory	Number of RG registrars[191]
NSW & ACT	108
NT	39
QLD	270
SA	44
TAS	16
VIC	64
WA	87

Queensland records a disproportionately strong rural workforce at the internship level. It is likely that these numbers reflect the implementation and consolidation of the Queensland Rural Generalist Program (QRGP) which enlists participants from Postgraduate Year 1 (PGY1). This suggests both that there are sufficient rurally based senior medical practitioners to support these internships and that there are sufficient junior doctors motivated to undertake them. This positions the state strongly toward building its future Rural Generalist workforce.

Table 3.7: Number of rural internship positions and interns by state in 2018[192]

	Rural intern positions* for PGY1 doctors (2018)	PGY1 doctors undertaking rural internship (2018)
New South Wales	111	109
Victoria	232	232
Queensland	253 (33%)	253 (33%)
South Australia	5	5
Western Australia	10	10
Tasmania	94	94
Northern Territory	48	48
ACT	8	8
National	**761**	**759**

**Internships where all or majority is undertaken in MM2-7*

6. National recognition will build common identity and professional purpose to grow workforce and drive its supporting scholarship

Currently, Rural Generalists and their shared body of clinical knowledge and expertise operate and are defined under broad and inconsistent labels that do not accurately describe or frame the scope practiced by this workforce.

Recognition and the sense of common identity this will confer on practitioners and on the discipline in general, will serve as a spur to grow a well-connected, mutually supporting workforce, and to drive scholarship and pursuit of excellence in clinical standards within this professional group.

Professional mentors named as Rural Generalists will inspire future generations to careers in the field. This already occurs but will be greatly strengthened when the senior members of the profession can have a professional title which is recognised by health and education systems.

3.A.4 Evidence of positive outcomes of Recognition

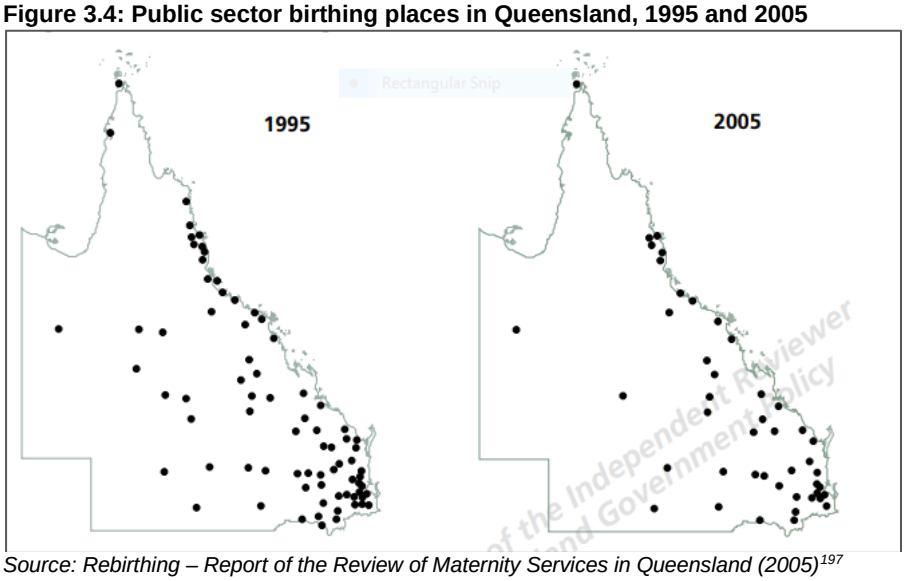
Indicative evidence of the positive workforce outcomes associated with strong support for Rural Generalist training and some degree of recognition of specialist title for Rural Generalists are given below.

Outcomes from Queensland Rural Generalist Program

The 2005 Public Hospitals Inquiry following a series of high-profile adverse events, found rural hospitals had heavily relied on International Medical Graduates to staff their hospitals with insufficiently robust qualifications assessment. The Inquiry also identified that Queensland was experiencing the worst medical shortages of anywhere in the country, and that there was endemic, under-resourcing, understaffing and unsafe working hours occurring particularly in the state's rural and regional hospitals.[193] Thirty-nine birthing units closures occurred over 1996 to 2005, this coincided with doubling of the rate of babies born before arrival (BBA) the highest rates occurring in regional and rural areas.[194] A 2005 Queensland Government report found that 62% of women living in rural areas of the state had to travel away from home to give birth. Of the 75% of these women that received public healthcare, 46% were deemed as low risk births and of these (1,600) women, 83% travelled for care because they did not have a choice as there was no local birthing service.[195]

A multi-pronged approach to restoring the Rural Generalist workforce was taken. In 2008, the FACRRM or FRACGP+FARGP qualifications were credentialed for clinical scope of practice in RGM which was recognised as a discipline specified by the respective Fellowship curricula. An industrial award associated with this credential was established for doctors employed in state hospitals.[196] The QRGP supported training designed for Rural Generalist practice toward the credential Fellowships including prevocational training.

Figure 3.4: Public sector birthing places in Queensland, 1995 and 2005



Source: Rebirthing – Report of the Review of Maternity Services in Queensland (2005)[197]

In 2008, rural retention rates associated with general practice training in Queensland were exceptionally low. It was found that **27%** of general practice registrars in Queensland that had undertaken training on the designated "rural" training pathway had continued to be 'rurally' based.[198]

In 2022, of QRGP alumna, five or more years out from Fellowship, **88%** have spent five or more of these years based rurally.[199] These QRGP outcomes can be benchmarked by contemporary standards, against the most recent rural retention figures available from the AGPT which found that of all its former designated "rural" pathway registrars, **42%** had remained working rurally 5 years out from Fellowship.[200]

An Ernst and Young review in 2013 found the QRGP met communities' needs by reducing critical medical workforce shortages and enabling of health services to expand service delivery making services more accessible and affordable to local residents. The review identified due recognition of the profession by Queensland as one of the critical success factors for the program. [201]

Since the commencement of the QRGP, four Rural Generalist led rural maternity units have been reopened.[202] Queensland has 32 (of its total of 40) state facilities that provide birthing, antenatal and postnatal care - in regional, remote, and very remote areas. Twenty of these are in predominantly Rural Generalist-led facilities in outer-regional, remote, and very remote areas.[203, 204]

Studies have confirmed the Rural Generalist-led birthing units have been providing patients in rural Queensland with birthing care to a quality and safety standard equivalent to that in cities including for more complex deliveries.[205] Queensland has the highest ratio of general practitioners in regional, rural, and remote areas per 100,000 population of all states and territories, with 115.6 doctors in these areas per 100,000 people, compared to a national average of 108.1.[206]

Further evidence suggesting the relative success of the QRGP in providing a permanent rurally-based workforce for its rural communities is that despite being the most decentralised state in the country Queensland has recorded the lowest or second lowest usage of locum staff of any state or territory. Looking at the FTE rate of employed doctors from major cities who worked at a second location in a rural area for general practitioners, the national rate was 1.2 and Tasmania and Queensland had the lowest rates at 0.4 and 0.8 respectively. For specialists, the national rate was 5.5 and Queensland and Tasmania had the lowest rates (2.6 and 2.9 respectively).[207]

Evidence of QRGP outcomes for primary care provision:

The value proposition of the RGM model is to create an agile, community responsive workforce. The QRGP commenced with a specific goal of addressing the critical shortfall in rural hospital services and has over time evolved to meet changing community needs. Its workforce outcomes reflect these shifts. It commenced providing advanced training in emergency medicine, obstetrics, surgery, and anaesthetics. It now supports training in over 10 advanced specialised training areas including mental health, palliative care, and addition medicine.

The program is contributing to essential and underserviced areas of rural healthcare (both hospital and clinic-based care). Program records also show that as the workforce crisis levels in hospitals have been addressed, the program and its doctors has been able to pivot, providing more services in the clinic-based areas of Rural Generalist care.

Table 3.8 QRGP alumna practice types, 2015 and 2022

2015	2022
13% undertake GP clinic practice only	18% undertake GP clinic practice only
72% undertake hospital-based practice only	55% undertake hospital-based practice only
15% undertake blended practice[208]	27% undertake blended practice[209]

Evidence from New Zealand

The New Zealand Rural Hospital Medicine (RHM) program was recognised by the Medical Council of New Zealand as a vocational scope of practice in 2008. The RHM program culminates in the Fellowship of the Division of the Rural Hospital Medicine New Zealand (FDRHMNZ) and is offered with the option of a combined RHM-GP training pathway. The combined RHM-GP training program has been identified by its practitioners as "*similar to Australian rural generalist pathways"* and has been designed in acknowledgement of the Cairns Consensus statement on RGM [210] While there are important points of difference with this model, it provides some further indication of the impacts of dedicated, nationally recognised Rural Generalist training.

As in Queensland, the recognition of the scope of RHM in New Zealand came in response to serious rural hospital workforce shortages and lack of any recognised training pathway.[211]

Similarly to Queensland, the program has produced exceptional rural retention outcomes and while addressing the need for rural hospital practitioners, it has also contributed to skills acquisition and practice in rural community-based care.

The assessment of the graduate outcomes for the 29 Fellows that had completed the program over its first 10 years found:

- 83% were working in rural areas
- 59% had completed dual training and gained GP and FDRHMNZ Fellowship

Of the graduates practising rurally:

- 91% were working in rural hospital practice
- 36% were working in hospital and community general practice
- 18% were working in hospital and emergency medicine practice[212]

Evidence from Canada

While RGM has no formal status in Canada, increasingly the terminology and approach are used by rurally-focussed medical schools and rural doctors organisations including in the National Rural Roadmap of the peak rural doctor's professional associations. The latest *Roadmap Report 2021* has specified action priorities to progress accreditation of RGM and rural generalist models of care.[213, 214]

Memorial University medical school in Newfoundland provides what it describes as training pathways to Rural Generalist practice. It describes *rural generalist medical practitioners as "rural GPs or rural family doctors, … who provide primary medical and community-oriented primary care and often hospital-based secondary care such as emergency medicine, in-patient hospitalist care, intra-partum obstetrics and, sometimes, basic anaesthesia and surgery*". An analysis of national data found that **26.9%** of Memorial Family Medicine postgraduates were practicing in a rural location two years after completing their postgraduate training compared with the national average of **13.3%** (2004–2013)[215].

Northern Ontario Medical School (NOMS) provides a self-described *Rural Generalist* medical education program from medical school through to Fellowship qualification.[216] It is establishing a formally named *Rural Generalist Training Pathway*. A review in 2016 of the program's first 10 years of operation found the following outcomes:

- 92% of all medical students were from Northern Ontario, including 7% Indigenous and 22% Francophone students.
- 62% of all NOSM medical graduates had chosen family practice (predominantly rural) training.
- 69% of the graduates of NOSM's postgraduate education were practising in Northern Ontario.
- 94% of the doctors who completed undergraduate and postgraduate education with NOSM were practising in Northern Ontario.[217]

3.A.5 International Perspectives

The Australian experience is not unique, it reflects inherent aspects of the experience of all communities living at a distance from major population centres.

While Australia is at the vanguard of developments in this specialist field. It's experience in terms of workforce issues and associated health disparities for rural people is mirrored across the world, As the literature consistently attests, other countries are looking to Australia for guidance and leadership in this area.[218, 219, 220, 221]

As outlined above the there is considerable evidence of the prevalence of the Rural Generalist scope of practice elsewhere including from Canada [222], New Zealand[223], the United States[224,225] and, Africa[226,227] and Asia[228].

There is recognition of the importance to rural healthcare of the workforce of doctors centred in family practice but able to extend their services to hospitals and other key service areas. There is

also recognition that external factors are leading to this workforce diminishing and there is an urgent need to take action to stem this decline.

Dr John Cullen, a family physician who provides obstetric services, has described family physicians with a comprehensive scope of practice as the *'rural safety net".*[229]

As Quinlan has posited in an article in the Journal of Clinical Obstetrics and Gynaecology:

Of the 28 million rural women of reproductive age in the United States, ~7 million of them live in areas of limited access to maternity care. While only 6.7% of Family Physicians currently provide maternity care, they are the only delivering physicians in 27% of rural hospitals. Of the 1.6% of Family Physicians performing cesarean deliveries as a primary surgeon, 57.3% do so in a rural county and 38.6% do so in a county without an obstetrician. Cultivation of the next generation of Family Physicians providing maternity care is essential to prevent further spread of existing maternity care deserts.[230]

Petersen and associates have identified similar issues with the vital contribution of rural family physicians in the United States providing emergency care services.[231]

The American Academy of Family Physicians (AAFP) have identified industrial issues and credentialing frameworks as presenting key barriers to practice for these doctors.[232]

An article by Kim and associates in the Bulletin of the World Health Organization identifies these issues as pertinent to high income, middle income and low income countries. The article identifies the Australian and Canadian experience and dedicated Rural Generalist curricula such as the ACRRM Fellowship curriculum, and the Cairns Consensus definition of RGM, as directions for adoption. It documents the value of family physicians being trained to provide hospital based essential surgery in areas such as Nepal and sub-Saharan Africa.[233]

Nixon and Lawrenson in their guest editorial to the New Zealand Journal of Primary Healthcare highlighted that:

"…*Extended scopes of rural generalist practice therefore need explicit recognition in medical education and training."*[234]

The WHO has developed evidence based International Guidelines for health workforce development in rural and remote areas. The Guidelines build on the work from its initial Global Policy Recommendations[235] and have been developed based on a systematic review of the related literature. RGM aligns with all recommendations but most particularly, Recommendation 6:

> *Enable rural health workers to enhance their scopes of practice to better meet the needs of their communities.*

The Guidelines recommend introducing and regulating enhanced scopes of practice for health workers in rural and remote areas and further that:

> *Enhanced scopes of practice are based on the needs of the populations and available resources. Ensure that enhanced scopes of practice and working to top of scope are compensated adequately. Regulate existing enhanced scopes or newly developed enhancements of scopes of practice by rural health workers. Ensure appropriate supervision, support and a system of referral are available to rural health workers with an expanded or enhanced scope of practice*[236]*.*

3.B How the recognition of the scope of practice of the specialist field through the Health Practitioner Regulation National Law enhances protection of the public and addresses quality of healthcare in one or more of the following dimensions:

- **effectiveness of health care as defined by improved health outcomes**
- **appropriateness of health care as defined by providing care relevant to the patient's needs and based on established standards**
- **safety of care (e.g. significant reduction of harm experienced as a result of receiving healthcare)**

To address points 1-4:

- Describe and document the record of the professional organisations for the discipline in leading quality and safety improvement processes within relevant clinical settings
- Demonstrate the link between patient safety and the specific skills and expertise of specialist practitioners in the discipline
- Demonstrate the professional organisations' track record of quality and safety initiatives aimed at promoting a quality and safety culture amongst its members and trainees
- Discuss how safety and quality themes are specifically addressed in the training and professional development programs of the professional bodies

The general practice colleges both have vision statements related to improving community health outcomes and are organisationally oriented to attaining these aspirations through supporting doctors to provide excellent healthcare.

Promotion of quality and safety culture and practice improvement among membership

ACRRM:

The College has a governance framework to support a practice Quality and Safety culture throughout the Colleges activities. This is headed by the Quality and Safety Council which is one of the College three peak bodies which has several Rural Generalist subcommittees in various sub-areas of the specialty such as mental health, obstetrics and anaesthetics which drive activity in the respective areas. The College has a General Manager (Quality and Safety) to provide operational leadership to this work.

The College promotes and supports quality and safety in its members practice through a diverse range of activities. Common to all these activities is a commitment to provide guidance relevant to their rural and remote practice:

- ACRRM provides over a hundred bespoke online courses to members all of which have been designed by/with Rural Generalists to be directly relevant and implementable in their clinical practice.

- It provides a range of face-to-face workshop styled courses designed and delivered by Rural Generalist instructors in diverse locations across the country including rural and regional centres to make these as accessible as possible. These include:
  - Advanced Life Support
  - Rural Emergency Obstetric Training
  - Mental Health Disorders Training
  - Rural Anaesthetic Crisis Management
  - Pre-hospital Emergency Care

- ACRRM also provides moderated forums such as TeleDerm, EM Forum and Ophthal Assist, which between them have thousands of participant rural doctors. These activities over many years, have enabled the development of resource libraries of facilitated discussions on actual rural clinical presentations that members can use for reference and study. The College regularly delivers educational webinars on topical issues for members practice such as Implanon training, Thunderstorm Asthma, Rural Domestic Violence and Rural Drug and Alcohol Addition management.

- ACRRM uses its website and communications channels to promote awareness of the latest clinical information. Including any important updates and alerts from the Government, the Medical Board, the Australian Commission in Safety and Quality in Healthcare, Therapeutic Goods Association etc. A key initiative, during the COVID-19 pandemic was to provide fortnightly webinars conjointly with the Rural Doctors Association of Australia (RDAA), which presented the latest medical information and provided a forum for questions to experts and to provide information to feedback to the Health Minister and Deputy Chief Health Officer in the College regular meetings. These attracted hundreds of participant doctors every fortnight.

- Annual Conference provides an opportunity for presentations, and scientific papers to showcase and share clinical learnings specific to the discipline with fellow Rural Generalist practitioners as well as many other professions typical of the rural healthcare team setting including rural and remote area nurses, rural non-GP specialists and other rural GPs. These attract around a thousand rural doctors every year.

- The College provides clinical discussion forums through its Connect@ACRRM platform. These are automatically logged for recognition as professional development hours, to increase member engagement and emphasise their value.

- The College provides clinical guides for practitioners readable from mobile devices with all guidelines reviewed to be those most relevant to rural generalist practice.

RACGP:

The RACGP released the *Standards for General Practices (5th ed)* (The Standards) in 2017 with the purpose of protecting patients from harm by improving the quality and safety of health services. The Standards have been updated on numerous occasions since their initial publication, to ensure the requirements remained contemporary, particularly through the pandemic. The Standards also support general practices in identifying and addressing any gaps in their systems and processes. The fifth edition of the Standards was developed over a three-year period in consultation with general practitioners, practice managers, nurses, consumers, technical experts, and many other stakeholders. The process included:

- targeted stakeholder workshops throughout Australia
- three rounds of public consultation
- three rounds of testing and piloting.

The fifth edition introduced a modular structure, which enables modules to be updated separately and be adapted for other healthcare settings, such as correctional service locations. The Core and Quality Improvement modules are relevant to all healthcare settings.

The third module (General Practice) can be adapted to accommodate the specific needs of each healthcare setting/ environment. Additionally, the fifth edition was written to be outcomes-focussed and patient-centred, where possible. This is a change from previous editions, where processes were prescribed. By focussing on outcomes, general practices can

develop systems and processes that reflect their preferred way of working and how they demonstrate the intent of each requirement.

The RACGP develops a range of resources to assist in improving the safety and quality of general practice in Australia. This includes the development of standards in a variety of settings including:

- *Standards for point-of-care testing (5th Ed)*
- *Standards for infection prevention and control (5th ed)*
- *Standards for health services in Australian immigration detention facilities (2nd ed)*
- *Standards for health services in Australian prisons*
- *Standards for Garrison Health Facilities in the Australian Defence Force.*

The RACGP has several expert committees committed to providing advice and direction on matters of clinical excellence, quality care and safety. This includes the RACGP Expert Committee – Quality Care, and the RACGP Expert Committee – Standards for General Practices.

The Standards are accredited with the International Society for Quality in Health Care, receiving international recognition for their robust alignment to best practice systems of quality and safety. The RACGP sends a quarterly Standards newsletter, has developed the *RACGP Patient Charter* and resources for implementation, and encourages the conduction of peer audits for quality and safety.

The RACGP develops evidence based clinical guidelines, tools and resources to support GPs in their practice. There are currently 20 published clinical guidelines including *guidelines for preventive activities in general practice (the Red book)*, *abuse and violence – working with our patients in general practice (the White book)*, and the *RACGP aged care clinical guide (the Silver book)*.

Quality and Safety focussed Professional Development

ACRRM:

The College's Professional Development Program draws upon the ACRRM Online library of online courses as well as allowing participants to choose from a wide variety of alternative activities, webinars and face-to-face workshops outlined above which are all specially tailored to be relevant to rural generalist practice. The program includes Maintenance of Professional Skills programs for each of the AST disciplines to enable Fellows to maintain their skills for safe, quality practice with a minimum of administration complexity.

As outlined above, the College provides clinical discussion forums through its Connect@ACRRM platform. These are automatically logged for recognition as professional development hours, to increase member engagement and emphasise their value.

All Fellows are required to regularly under Advanced Life Support training to maintain what is considered an essential Rural Generalist skillset.

RACGP:

The RACGP educational framework contains three guiding instruments, the Profile of the general practitioner, Curriculum for Australian General Practice and RACGP education policies and standards. The educational framework informs the delivery and development of the RACGP's training programs, including CPD.

The RACGP's Continuing Professional Development (CPD) Program supports Australian GPs to maintain and improve their professional knowledge and skills in order to provide the best possible care for patients and their communities.

CPD activities are quality controlled through our education accreditation process and our quality improvement framework. The program offers access to core, and extended skills content specifically curated to be relevant to a GP's scope of practice, interests and learning preferences. We provide access to an extensive CPD provider network, who deliver activities that meet our CPD standards. The RACGP also require all RACGP members who are participating in our CPD Program to complete one Basic Life Support course every three years.

The CPD program is supported by enhanced technologies making it easy for members to record their CPD and reflect on their learning. Online access is made available to resources such as the John Murtagh Library and the Australian Journal of General Practice for continued self-development. Other opportunities of self-guided learning are available in Cognitive Behavioural Therapy Strategies for General Practitioners and a catalogue of on-demand videos and webinars.

For those looking for more interactive participation, both online and face-to-face opportunities are available.

Examples of education developed and delivered by the Rural Faculty include:

- Rural Health Webinar Series held once a month throughout the year covering topics requested from our rural and remote members.
- Focused Psychological Strategies (FPS) Skills Training is a flexible, innovative training package using a combination of technology, peer learning groups and locally available resources to provide GPs with access to FPS skills training whilst remaining in their practice and community. This package is GPMHSC accredited and on completion, GPs can register for additional MBS numbers.
- Emergency Medicine for Rural GPs Online Workshop is an accredited activity that allows for GPs to discuss case scenarios in small groups online, exploring the critical considerations involved in managing rural emergency cases, packaging patients for retrieval, communicating effectively with retrieval teams, debriefing and self-care.
- Emergency Medicine for Rural GPs Workshop is also offered as a face-to-face workshop that provides the opportunity to engage in simulated scenarios that reflect the challenges GPs face in rural and remote practice.
- Introduction to Point of Care Ultrasound (POCUS) for Rural GPs Workshop which is a full-day workshop increasing the understanding of the applications of POCUS in the diagnostic process, introducing GPs to basic techniques using advanced, high-end mobile ultrasound equipment.

Link between Rural Generalist skills and expertise and patient safety and quality care

Rural Generalists provide care that may otherwise not be accessible to people in rural and remote locations. They are specifically trained to provide this as safely and effectively as possible within their safe scope and within the clinical conditions in which they practice which are characterised by the limited staff and resources. The rural generalist model which emphasises the integration across the spectrum of health care delivery and cradle to grave, maximises the integration of patient care with the quality and safety benefits that this entails.

Many practice models that predominate in urban centres are highly specialised with strongly defined protocols around the assignment of clinical roles and the associated training and skills maintenance. They are usually based on an assumption of ease of access to highly technical equipment and other highly specialised personnel. These models are a poor fit for doctors serving rural and remote communities and very few of these specialist practitioners live in these areas. It commonly occurs that compliance expectations associated with these models of care are prohibitive to practice in rural and remote areas. Not providing these services locally, presents a material risk to patient safety.

While many standards may reflect best practice safety in urban contexts, a more nuanced, flexible, and holistic approach may be needed to achieve best practice safe care for rural people utilising the rural generalist scope and skillset.

Rural Generalists have a diverse scope of practice, with typically less depth of any single specialisation than a sub-specialist, skills for working in low resource clinical settings and a necessarily different set of metrics for defining the safest and optimal clinical point for referral or patient transfer to major centres for care.[237]

The testimonies of rural communities on these issues given to the New South Wales inquiry into rural health services evidence the need for essential permanent emergency (and other advanced skilled services) capacity in the local area:

> *"I gave birth to my third baby on the side of a highway in the middle of the night in 2011. Going into labour two weeks before her due date, I feared I wasn't going to make it to the birthing hospital in the ACT. I went directly to our local hospital (Yass). I was packed into an ambulance and sent down the Barton Highway in the dark, in the middle of the night, going at speed. I still think about that night and I still think about the stress of worrying what was going to happen to my baby. Was my baby going to be okay? Was I going to be okay? What if we hit a kangaroo? Lucky I was ok and so was my baby, now 9 years old. But if we don't resume births at Yass Hospital, there will come a time when a Barton Highway birth is fatal for mother or baby or both".[238]*
>
> *"Just some examples of poor outcomes resulting from limited access to health services in Wee Waa include:*
>
> *A woman who died at home alone because she didn't want to go to hospital as she knew there was no doctor there. She had specifically stated in a care plan that she wanted to die in hospital.*
>
> *A terminally ill resident who, after being treated in Tamworth hospital, was unable to return to Wee Waa due to the absence of a VMO, despite his wishes. He died in Tamworth and his family were burdened with the additional expense of bringing his body back to Wee Waa.*
>
> *A teenager with a severe laceration having to drive himself from Wee Waa to Narrabri as he was unable to be treated at Wee Waa hospital.* [239]

There is ample evidence that appropriately trained Rural Generalists and healthcare teams with appropriate healthcare resources provide high quality, safe care to rural and remote people as detailed below.

Some examples of the quality and safety implications of the Rural Generalist body of skills and expertise in some key areas of care are detailed.

- *Mental Healthcare*

  Rural Generalists have training in both management of psychiatric emergencies, and hospital care as well as community clinic based mental health care. These skills are learned as part of core training and learned in rural and remote contexts. Some Rural Generalists choose to obtain advanced specialised skills in mental health. This reflects the significant demand for these services experienced in rural general communities.

  People in rural and remote areas have higher rates of mental health disorders and risk of suicide than other Australians.[240] In 2016, the number of suicides in rural and remote Australia was 50% higher than in the cities with the rate increasing with remoteness. The suicide rate in rural and remote Australia has been growing more rapidly than in the cities. Aboriginal and Torres Strait Islander people represent significant proportions of many rural and remote communities and the suicide rate they experience is twice that for non-Indigenous people.[241] Drug and alcohol addiction is a major cause of rural morbidity, mortality, and social breakdown. Crystal methamphetamine 'ice' use has been particularly destructive and is significantly more prevalent among rural Australians than

other Australians[242] and yet in remote communities access to support services is less than a third of that available in cities.[243]

- *Emergency Care*

  In emergency scenarios such as accidents and obstetric and psychiatric emergencies provision of care locally can often be vital to patient safety.[244,245,246]

  Rural Generalists are trained in emergency care as a core skill which is maintained throughout their careers through their professional development requirements. They are specifically trained and assessed to provide high quality emergency care in the clinical context of rural and remote locations with low staff and resources and complexities involved with patient transport and collaborating with distal specialists.

  Studies demonstrate that safe Rural Generalist-led care can and is provided in rural and remote Australia. For example, a study of anaesthetic care provision in rural South Australia[247] and of provision of urgent myocardial infarction management in rural Victorian hospitals.[248]

  Pinidiyapathirage and associates identified the prevalence of serious injuries related to agricultural industries, machinery and large animals, presenting to rural hospitals in southwest Queensland. It noted that the delays in presenting to hospital were commonly a factor in clinical outcomes. Their study proposed that Rural Generalist model hospitals provided an appropriate model of care in these situations which, with appropriate planning, design, adequate resourcing, and links to city-based specialist services, can manage most of these presentations locally.[249]

  Extensive literature documents the risks associated with patient travel to access distant health care.[250,251,252] One study of stroke care for example found that the clinical risks of longer journeys outweighed the benefits of accessing the tertiary service. [253] 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. [254]

  Incidences of hospitalisation and death related to accident and injury rise dramatically with remoteness across virtually all metrics. Providing better emergency care closer to the point of injury through expanded provision of rural and remotely based Rural Generalists may not address all these issues but must logically contribute to improvements.

  In 2019–20, the likelihood of hospitalisation and death due to accident and injury increased sharply with remoteness. People living in outer regional areas were 32% more likely to be hospitalised and 56% more likely to die from an injury than people from major cities, while people living in *Very remote* areas, were: 2.3 times as likely to be hospitalised, and 2.0 times as likely to die from an injury.

  Regional and remote road crashes accounted for 65% of Australia's fatal crashes from 2010-2018. The road crash fatality rate per population increases dramatically with level of remoteness.[255,256] Land transport accidents are a leading cause of death in *Remote* and *Very remote* areas. The death rate being nearly three times as high for *Remote* areas and nearly four times as high for *Very remote* areas, compared with Australia overall.[257] Access to emergency care clearly plays a significant role in these rural fatalities. While the distances involved are likely to be a factor in the higher mortality rates these should logically be offset by the greater risks in urban areas of the concentration of vehicles.

- *Hospital and in-patient care*

  Hays and associates have highlighted that access to local advanced and hospital services is the preferred model of care for many rural and remote people and thus providing this is germane to providing 'quality care''.[258] More recently Sutarsa and associates have conducted qualitative studies finding that locally-based, general practice

doctors providing hospital services were strongly associated with quality care by rural and remote patients. They found these patients *understood quality of care primarily through the lens of ongoing and respectful relationships with their doctors across primary and secondary care.* These relationships, *were considered crucial for improving the perceived quality of care: ensuring continuity of care; promoting integrated rural health care systems; cultivating trust from communities; and enhancing patient satisfaction.*[259]

- *Maternity care and birthing services*

  Local maternity services are essential to deal with obstetric emergencies and studies have clearly linked the need for extended travel time to access maternity services to increased rates of mortality and adverse outcomes.[260] Canadian studies have found that women with no local access to maternity services have significantly greater incidence of adverse perinatal outcomes than women from similar communities with local access to rural birthing services with caesarean section capability.[261] In Australia, Born Before Arrival (BBA) rates which are associated with higher risks of negative maternal and neonatal outcomes have been linked to geographic distance from maternity services.[262]

  Rural Generalist services in Australia can be shown to provide high quality, safe care. Studies have confirmed the rural generalist led birthing units have been providing patients in rural Queensland with birthing care to a quality and safety standard equivalent to that in cities including for more complex deliveries.[263] Similar findings have come from Rural Generalist-led maternity units in Western Australia[264] and New South Wales [265]. Studies in rural Queensland have also identified safe provision of neonatal care involving Rural Generalists. [266]

  Over and above safety considerations, access to maternity care is a significant quality of care issue for people living in rural and remote settings. There is a strong preference in Aboriginal and Torres Strait Islander communities for birthing on country.[267] This is also a strong preference for many people in rural and remote communities.[268] Local birthing services are likely to be most important to the people with the least financial and/or social support to enable them to spend extended periods of time in distant major centres.

3.C That the recognition of the scope of practice of the specialty or field of specialty through the Health Practitioner Regulation National Law will not adversely affect the quality of healthcare in Australia by promoting:

- **unnecessary fragmentation of medical knowledge and skills (e.g., where this serves to increase the risk of medical errors and/or inefficient or inappropriate care)**
- **unnecessary treatment, and unnecessary fragmentation of medical care (e.g., where patients are required to see multiple practitioners for care at a significant coordination cost**
- **unnecessary deskilling of other medical practitioners (e.g., General Practitioners and other primary health care providers)**

When addressing dot point 1-3, the applicant is invited to address each of these widely held concerns that the published literature has shown to be the unintended consequences of medical (over-) specialisation.

The applicant is invited to show how the dominant model of care within the discipline serves to mitigate such effects; likewise, what steps has the supporting organisation itself has taken to minimise or alleviate them.

- **inequitable access to health care as defined by socioeconomic status, geography, or culture.** [iii]

In Australia, there exists systematic inequalities in health status that cannot be explained by individual make-up or behaviour. Such inequalities are most apparent amongst Indigenous Australians and the socioeconomically disadvantaged. Because such health inequalities are both avoidable and systematic, they are better described as **health inequities.**

Describe the extent of **health inequities** in the burden of disease relevant to the proposed specialty? Present data on these. Will specialty recognition lead to any improvements in this area?

Based on the best available international evidence, it could be argued that specialty recognition might lead to increased **inequity of access** to services.[2] Discuss how this would ***NOT*** be the case if recognition of this proposed specialty were granted. Describe how the applicant body will measure this over time should recognition be granted.

This application is presented on the basis that people living in rural and remote Australia including the many Aboriginal and Torres Strait Islander peoples in these areas, experience substantial and growing unmet healthcare need for all aspects of healthcare along the primary, secondary, and tertiary care spectrum. Strengthening the RGM workforce and enabling its safe, quality practice, through recognition will provide a critical element of the structural reforms needed to stem the inequity.

It is acknowledged that increasing sub-specialisation of the medical workforce (which tends to produce a highly urbanised workforce) is a key contributing factor to the growing gap in the care that rural and remote people can access relative to people living in cities. This application does not propose a sub-specialty rather a specialist field which extends the generalist remit of

iii See, for example, The Royal Australasian College of Physicians (2005) *Inequity and Health: a Call to Action – Addressing Health and Socioeconomic Inequality in Australia.* www.racp.edu.au/hpu/pdf%20files/inequality.pdf

Van Doorslaer, Masseria, Koolman & OECD Health Equity Research Group (2006). Inequalities in access to medical care by income in developed countries. *CMAJ*. 2006 Jan 17;174(2):177-83. http://www.cmaj.ca/cgi/content/full/174/2/177

A longer version of this research detailing methodology is available at: Van Doorslaer, Masseria & OECD Health Equity Research Group (2004). Income-related Inequality in the Use of Medical Care, in 21 OECD countries. In: *Towards High-performing Health Systems: Policy Studies*. Paris: OECD; 2004. p. 109-66.

practitioners within the discipline of general practice while requiring all its practitioners to maintain the essential general practitioner scope.

Unnecessary fragmentation of medical knowledge and skills

RGM is the epitome of an approach which integrates medical knowledge and skills. As its name suggests it is grounded in a generalist approach to medicine, which requires its practitioners to be grounded in the full scope of medical care and have advanced skills relevant to their local needs. And it incorporates effective team care as a core element of the Rural Generalist skillset.

As Strasser has proposed:

> *The Rural Generalist's key role is in ensuring access to care at all levels, whether this care is provided directly by the rural practitioner or by other specialists who might interact with patients in person, by telemedicine, or at a larger centre to which the patients have to travel.* [269]

The broad scope to which Rural Generalists are trained, allows them to work in multiple settings using diverse elements of their skillset.

Their training also allows them to change and adapt over time to their community's changing needs and also to their changing personal circumstances. They may opt to revert to different areas of practice over time and their broad scope generalist training together with the professional development program mechanisms can facilitate this.

Unnecessary fragmentation of medical knowledge and skills

RGM offers the ultimate coordinated care model. It enables the practitioner to stay within their locale and provide cradle to grave patient care integrated across the spectrum from preventive primary care through to secondary and some elements of tertiary care. While not all practitioners opt to provide services across the entire spectrum, they should have the essential knowledge base and the approach to practice that encourages them to pivot to provide the scope of services (basic or advanced) that meet the needs of their community.

Unnecessary treatment, and unnecessary fragmentation of medical care (e.g., where patients are required to see multiple practitioners for care at a significant coordination cost)

RGM is unlikely to lead to unnecessary overservicing as it, by definition, occurs in locations which are characterised by a low resource and low healthcare staff base. Furthermore, rural and remote areas not only in Australia but across the developed and developing world all commonly record a pattern of healthcare workforce scarcity and pervasive shortages.[270] People in rural and remote locations have recorded a consistent pattern of significant under-utilisation of healthcare services relative to people in cities which is likely to reflect lack of sufficient medical workforce and access to services. This is detailed in *Section 3.A*.

Unnecessary deskilling of other medical practitioners (e.g., GPs)

It is recognised that there are doctors with skills extended from the core general practice skillset, who are not trained and assessed to the full scope necessary to become recognised Rural Generalists. This application does not propose any barriers to practice for these doctors. Under current arrangements many such general practitioners can and do provide extended scope care in a range of specialist fields particularly in cities and the status quo would be maintained under the proposal.

The proposal does however seek to offer 'facilitated' recognition, training, credentialing, and employment, and other such practice enablers for the doctors who do attain and certify this full Rural Generalist skill set.

This approach benefits patients and healthcare systems by providing an efficient and reliable mechanism for recognition of a quality-assured scope of practice. It also addresses current systems barriers and thus encourages wider provision of this extended and evolving scope practice in the rural and remote areas where it is needed. Furthermore, the establishment of these facilitated pathways to practicing the full specialist scope will lead to more Rural Generalists who can become trainers and mentors, building training capacity and the opportunity to grow the skilled workforce.

To maximise the number of rural general practitioners whose extended scope services benefit from recognition, the general practice colleges have both established mechanisms to enable a relatively simple assessment process for specialist general practitioners to attain qualification as Rural Generalists. This are detailed at *Section 2.B*.

Recognition may lead to more general practitioners in rural areas who are Rural Generalists with the capacity to work in a range of settings focusing on specific areas of scope at the expense of other areas needed by communities.

The first point that should be made is that in rural and remote communities all areas of healthcare services are in scare supply and often in shortage, as such there is low risk that rurally-based doctors will be providing services that are redundant, unnecessary or excessive. Ideally, the flexibility, community orientation and commitment to teamwork, of the Rural Generalist model together with these doctors' broad scope of practice will encourage and enable them to fill the local care gaps.

From the perspective of the specialist discipline the concept of not providing needed local services is anathema to its design and intent. RGM intrinsically mitigates against any service distortions through its core ethos of community-responsiveness. This approach is naturally reinforced for rural practitioners through the experience of training, living, and working in a rural community and the sense of accountability that this engenders.[271,272] The inclusion of the word "Rural" in the name of the specialist field anchors it in a community-oriented paradigm. RGM should be distinguished from special interest medicine or niche general practice. As indicated in the Collingrove and the more detailed Cairns International Consensus definitions - the scope of practice is defined by community need.

Collingrove Definition

A Rural Generalist is a medical practitioner who is trained to meet the specific current and future health care 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 specialist care in hospital and community settings as part of a rural healthcare team.

Cairns Consensus International Statement on RGM

RGM is 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*

(From the Cairns Consensus, International Statement on RGM, 2014)

Market distortions can be created by policy settings which provide less remuneration for some types of services compared to others. This is particularly an issue with respect to the current remuneration gap between the non-procedural and procedural elements of this scope of care. There is risk, that General Practitioners with Rural Generalist recognition may opt to not provide the primary care aspects of their scope as a result. While government funding policy is appropriately beyond the scope of this application, the applicants recognise this as an important issue and are strongly advocating for policies to strengthen payments to support providers of medical primary care.

As indicated in the definitions above, RGM seeks to train doctors to have a broad scope of practice which not only enables them to provide services in a variety of work settings (across primary and secondary care) it also prepares doctors to be able to pivot throughout their careers from one to the other of these responsively to their communities needs but also in alignment with their own life progression. Rural Generalists thus have the agility to meet different needs as their context changes and the colleges' curricula and the professional development programs are designed to enable this.

Rather than drawing general practice doctors away from providing primary care services the converse may well be true, and there is evidence to suggest that the prospect of becoming a Rural Generalist is drawing doctors who might otherwise have pursued careers in subspecialist medicine into the professional sphere of rurally-based general practice.

It is likely that there is a national pool of doctors attracted to the concept of a diverse scope of practice which includes community-based, hospital and emergency care. Such doctors may well feel limited by either option of office-based general practice, or highly specialised consultant care.

The introduction in 2021 of the option of RGM as a top career choice in a survey of Australian medical graduates this year, saw 5.1% selecting RGM making it the 9th most popular specialty choice. The addition of the RGM option corresponded with a 1.8% decrease in the number of graduates indicating general practice as their first preference but a 3.3% decrease in the number of graduates indicating non-GP specialties. This suggests that while RGM is drawing some of its practitioners from within its own general practice pool, it is drawing more doctors from the pool that would otherwise have opted for other medical specialties. As such, strengthening the speciality would grow the pool of doctors in general practice.[273] Projections based on the outcomes from the MDANZ survey, would suggest that even if fewer than half of those indicating they would become Rural Generalists were to provide their care in General Practice clinics, the RGM specialist field option would still increase the total pool of General Practice clinic based doctors and would be attracting these doctors to careers in rural and underserviced areas.

Table 3.8 Medical graduates first preference of specialty for future practice – (Domestic students)[274]

Most preferred specialty	2020	2021	% Change
GP	16.5	14.7	-1.8
All other specialties	83.5	80.2	-3.3
RGM	0	5.1	5.1
Total GP inc. RG	**16.5**	**19.8**	**3.3**

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

AAFP	American Academy of Family Physicians
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community-Controlled Health Service
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
AIDA	Australian Indigenous Doctors Association
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
CFPC	College of Family Physicians of Canada
CPD	Continuing Professional Development
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
FRACGP	Fellowship of the Royal Australian College of General Practice
FRACGP-RG	Fellowship of the Royal Australian College of General Practice Rural Generalist
FARGP	Fellowship in Advanced Rural General Practice
GP	General Practitioner
GPRA	General Practice Registrars Association
GPSA	General Practice Supervisors Association
HETI	Health Education Training Institute
IGPRN	Indigenous General Practice Registrars Network
MABEL	Medicine in Australia – Balancing Employment and Life (data set)
MBA	Medical Board of Australia
MBS	Medical Benefits Schedule
MDANZ	Medical Deans of Australian and New Zealand
MMM	Modified Monash Model
MSRPP	Medical Superintendent with Right to Private Practice
MWRAC	Medical Workforce Reform Advisory Committee
NACCHO	National Aboriginal Community Controlled Health Organisation
NSW RGMTP	New South Wales Rural Generalist Medicine Training Pathway
NRGP	National Rural Generalist Pathway
NRHA	National Rural Health Alliance
NRHSN	National Rural Health Students Network
NTRGP	Northern Territory Rural Generalist Program
PATS	Patient Assistance Transport Scheme
PBS	Pharmaceutical Benefits Scheme
PDP	Professional Development Program
PGY	Post Graduate Year (e.g. PGY1, PGY2 etc.)
QRGP	Queensland Rural Generalist Program
RACGP	Royal Australian College of General Practice
RDAA	Rural Doctors' Association of Australia
RG	Rural Generalist
RGPSA	Rural Generalist Program South Australia
RPGP	Rural Procedural Grants Program
RVTS	Remote Vocational Training Scheme
SIMG	Specialist International Medical Graduate
SRPC	Society of Rural Physicians of Canada
TRMGP	Tasmanian Rural Medical Generalist Program
VRGP	Victorian Rural Generalist Program
WARGP	Western Australian Rural Generalist Program
WHO	World Health Organization
WONCA	World Organisation of National Colleges, Academies and Academic Associations of Family Doctors

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Attachment 1.1

Review of Rural Generalist Medicine related literature from May 2017 to Sep 2022: Summary of included papers

This review acknowledges and follows from a 2018 review of Rural Generalist Medicine literature from 1988 to April 2017 conducted by Schubert and colleagues and has applied the same search criteria.[1] The 2018 review publication includes a similar summary of included papers and can be viewed here: https://human-resourceshealth.biomedcentral.com/articles/10.1186/s12960-018-0332-6

Article	Date	Location	Report type	Findings/critique
Baker et al[2]	2022	Australia	Quantitative data analysis	*Rural emergency care facilities may be adapting to their context: A population-level study of resources and workforce* This discusses different workforce models for rural Emergency Department services and references Rural Generalism in this context.
Bishop et al [3]	2022	Australia	Qualitative study	*Evaluation of a novel salaried medical officer position on service provision and performance at a rural health service: An exploratory mixed-methods study* This assesses the value of dedicated Rural Generalist roles in hospitals to support the work of Rural Generalists that work in the hospitals and in local GP clinics and finds value in these.
English et al [4]	2022	Australia	Quantitative data analysis	*Assessment of the validity of the beta-lactam antibiotic allergy assessment tool for use in the rural context, Qld* A study of the appropriateness of this assessment tool for use by Rural Generalists in rural settings. .
Martin et al[5]	2022	Australia	Qualitative study	*Title-blended supervision models for post-graduate rural generalist medical training in Australia: an interview study.* Explored blended supervision models for rural generalist training in rural settings and found that these can be effective if well-planned and where they can fit in the context.
O'Sullivan et al[6]	2022	Australia	Program Description	*Developing supervision capacity for training rural generalist doctors in small towns in Victoria.* This explored and identified the key themes in developing fit for purpose postgraduate rural generalist training in Victoria.
Padley et al[7]	2022	Australia	Qualitative study	*Contemporary Australian socio-cultural factors and their influence on medical student rural career intent.* This explores influencers to encourage medical

Article	Date	Location	Report type	Findings/critique
				students to rural careers. It identifies Rural Generalist training opportunities as a key positive motivation.
Pendrey et al[8]	2022	Australia	Descriptive opinion piece	*Surveying the changing climate of Northern Territory medical workforce retention.* Considers impact of climate change on retention of rural doctors including Rural Generalist workforce in Northern Territory.
Roxburgh et al[9]	2022	Australia	Qualitative study	*Satisfaction with general practitioner obstetrician-led maternity care in rural Western Australia.* Assessment patient satisfaction with the Rural Generalist model of obstetrics and finds high levels of satisfaction with quality and model of care.
Seal et al[10]	2022	Australia	Quantitative data analysis	*Influence of rural clinical school experience and rural origin on practising in rural communities five and eight years after graduation.* This considers the key factors leading to retention outcomes and recognised Rural Generalist training as a key factor to support positive outcomes.
Strasser [11]	2022	Australia	Descriptive opinion piece	*Beyond rural clinical schools to "by rural, in rural, for rural": Immersive community engaged rural education and training pathways.* Reflects on a range of studies and identifies that the rural generalist training programs have been part of successful strategies for rural retention particularly due to their enabling of rurally based and community-engaged training.
Telford et al[12]	2022	Australia	Quantitative and qualitative data analysis	*Giving birth in the Murrumbidgee region: A quantitative and qualitative approach to general practice obstetrics in a rural region.* This considers the quality and safety of Rural Generalist obstetrics in Murrumbidgee region Hospitals, considering both patient satisfaction as well as clinical outcomes and finds that care is both safe and of high quality.
Wazir et al[13]	2022	Australia	Qualitative study	*General practitioner obstetricians' models of care in rural Western Australia.* Explores the skill set and models of care of Rural Generalist providing obstetrics in rural Western Australia and found that these doctors are providing an essential part of rural maternity services and their model of care has evolved to meet the needs of the communities they serve.
Sutarsa et al[14]	2021	Australia	Scoping review	*Effects of employing primary care doctors in hospital to improve the quality of care and health outcomes of rural patients: A systematic scoping review.*

Article	Date	Location	Report type	Findings/critique
				This scoping review found that employing primary care doctors in hospital care can fill delivery gaps in acute care, emergency medicine and maternity care. These doctors bring advanced clinical skills and a patient-centred approach to the hospital. They also improve the quality of referrals leading to freed-up clinical capacity of tertiary hospitals to treat more serious conditions.
AMA [15]	2021	Australia	Position statement	*Integration of GPs into rural hospitals - Position Statement* Statement of support for Rural Generalists and the National Rural Generalist Pathway and describes the features of effective Rural Generalist models for working in both rural GP clinics and rural hospitals.
Kitchener et al [16]	2021	Australia	Qualitative study	*Queensland Rural Generalist Pathway: why do trainees separate without achieving a Rural Generalist end point?* Explores reasons for trainee departures from Rural Generalist training and finds there is value in employer-provided coordinated prevocational placements/training, potential benefits of guiding rural-interested graduates who ultimately enter other specialist training, need for greater liaison with external AGPT administration organisations to coordinate trainee transitions, and the need to address accessibility of advanced training.
Kitchener [17]	2021	Australia	Qualitative study	*Local and regional workforce return on investment from sponsoring rural generalist-based training for medical students* This study found that investment in increasing training capacity in rural generalist health facilities can produce significant retention of medical graduates for the junior medical workforce. Retaining students in the regional health service for longer periods increases the likelihood of retention upon graduation.
O'Sullivan et al. [18]	2021	Australia	Program Description	*Supervision Roadmap: Rural generalist training in Victoria. Bendigo: General generalist training in Victoria* Explores the challenges and solutions for providing high-quality supervision in rural and remote settings for the Rural Generalist training program in Victoria.
Sutarsa et al [19]	2021	Australia	Systematic review	*Effects of employing primary care doctors in hospital to improve the quality of care and health outcomes of rural patients: A systematic scoping review.* This examines relevant literature which points to the value in terms of service quality of locally based Rural Generalist, (i.e., doctors who also provide local general practice services) in hospitals and that these are associated with rural

Article	Date	Location	Report type	Findings/critique
				patients' preferred care models.
Williams et al [20]	2021	Australia	Descriptive opinion piece	*A cross-jurisdictional research collaboration aiming to improve health outcomes in the tropical north of Australia.* Describes a research collaboration to improve health outcomes in northern Australian and identifies the National Rural Generalist Pathway as a positive solution to these issues.
Woolley et al [21]	2021	Australia	Qualitative study	*"We learnt it, then we lived it": Influencing medical students' intentions toward rural practice and generalist careers via a socially-accountable curriculum.* This paper looks at the influences for rural retention in JCU medical school experience and identifies the inter-relationships with Rural Generalist training, and Rural Generalism as a common career outcome.
Woolley et al [22]	2021	Australia	Quantitative data analysis	*Mid-career graduate practice outcomes of the James Cook University medical school: key insights from the first 20 years.* This reviews outcomes for graduates in their mid-careers. Findings include above average graduate rural retention and 11% of graduates practicing as Rural Generalists.
Woolley et al [23]	2021	Australia	Quantitative data analysis	*A return-on-investment analysis of impacts on James Cook University medical students and rural workforce resulting from participation in extended rural placements* This measured the outcomes of longitudinal placements in terms of workforce outcomes. It found that these improved self-assessed clinical capacity and positively influenced rural workforce outcomes by increasing number of graduates taking up rural generalist and other careers in rural locations.
Bond and Chong [24]	2020	Australia	Qualitative study	*Investing in Queensland's rural medical leaders: Lessons from the Queensland Rural Generalist Program.* This reviews a pilot leadership training program within the Rural Generalist training program found that further support for leadership training was warranted to enable the Rural Generalist workforce to continue to meet the complex, context-specific needs of their communities.
Hanson and Chong [25]	2020	Australia	Qualitative study	*Prevocational Integrated Extended Rural Clinical Experience (PIERCE): cutting through the barriers to prevocational rural medical education* This examines a pilot pre-vocation program and its merits in providing foundational training for Rural Generalist fellowship training.

Article	Date	Location	Report type	Findings/critique
O'Sullivan [26]	2020	Australia	Qualitative study	*A Realist Evaluation of Theory about Triggers for Doctors Choosing a Generalist or Specialist Medical Career* A study looking at influences upon doctors' decisions to become specialists or generalists which identifies Rural Generalism as a confounder as its identity relates to both.
O'Sullivan et al [27]	2020	Australia	Qualitative study	*Understanding the field of rural health academic research: a national qualitative, interview-based study* An examination of the state of rural health academic research which notes the role of Rural Generalist programs in nurturing rural researchers.
Sen Gupta at al [28]	2020	Australia	Program Description	*Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) Assessment: a review of the first 12 years.* This reviews the development of the ACRRM Fellowship assessment which quality assures attainment of the ACRRM Rural Generalist curriculum.
McGrail et al (2020) [29]	2020	Australia	Quantitative data analysis	*Faculties to Support General Practitioners Working Rurally at Broader Scope: A National Cross-Sectional Study of Their Value* Measures factors associated with rural retention among general practitioners and finds the rural generalist scope and training approach to be key contributors.
Shen et al [30]	2020	Australia	Quantitative data analysis	*Can neonatal pneumothorax be successfully managed in regional Australia?* This study analyses the incidence of pneumothorax diagnosis and outcomes in central Queensland in terms of local Rural Generalist led hospitals' management of the condition. Satisfactory outcomes.
Tennett et al [31]	2020	Australia	Quantitative data analysis	*Access and outcomes of general practitioner obstetrician (rural generalist)-supported birthing units in Queensland.* This study reviewed clinical outcomes of rural generalist led birthing units in rural Queensland and found they had been providing patients with birthing care to a quality and safety standard equivalent to that in cities including for more complex deliveries.
Wenham et al [32]	2020	Australia	Program Description	*Improving palliative and end-of-life care for rural and remote Australians.* Describes the development and implementation of the Far West NSW Palliative and End-of-Life

Article	Date	Location	Report type	Findings/critique
				Model of Care which is a rural generalist type model whereby specially-skilled local GPs work systematically with Palliative Care specialists based in cities to deliver advanced specialised palliative care in their communities.
Beattie et al [33]	2019	Australia	Qualitative study	*The role of vertically integrated learning in a rural longitudinal integrated clerkship* This discusses training design for rural careers and considers the rural generalist approach.
Campbell et al. [34]	2019	Australia	Quantitative data analysis	*Outcomes of a 1-year longitudinal integrated medical clerkship in small rural Victorian communities.* Analysis of an undergraduate program of training with Rural Generalist doctors which has had observable positive impacts on future rural practice outcomes.
Igaku [35]	2019	Australia	Program Description	*Rural Generalist Program Japan* Overview of the Rural Generalist Program of Japan which provides vocational training for work in island settings. .
Martin et al [36]	2019	Australia	Qualitative study	*Rural competencies in emerging medical practitioners: Beyond clinical skills* Review of evaluative data from four years of clinical skills workshops to prepare trainees for the Queensland Rural Generalist Training Pathway. These were found to be valued by trainees.
O'Sullivan et al [37]	2019	Australia	Quantitative data analysis	*Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence* This reviews the national capacity to produce a rural medical workforce without dependence on international trained doctors. It finds rural and remote areas continue to be reliant on these doctors. It identified the need for new approaches and identified the National Rural Generalist Pathway as one such solution.
Pinidiyapathirage et al [38]	2019	Australia	Quantitative data analysis	*Analysis of agriculture-related life-threatening injuries presenting to emergency departments of rural generalist hospitals in Southern Queensland.* This review identified the prevalence of serious agriculture-related injuries presenting to rural hospitals and the need for these to be appropriately prepared including for delays in presentations. It identified that Rural generalist hospitals provide an appropriate model of care that could be augmented with medical imaging and closer links with orthopaedic and neurological services to manage the majority of these injuries locally.

Article	Date	Location	Report type	Findings/critique
RDAA [39]	2019	Australia	Position statement	*Credentialing and defining the scope of practice of Rural Generalists* This paper identifies the barriers to Rural Generalists providing their advanced skills in hospitals due to the administrative complexity and unpredictability of hospital credentialing.
Saurman et al [40]	2019	Australia	Qualitative study	*A mapping study to guide a palliative approach to care.* Details and mapping study toward developing a rural model of care for palliative services which involved general practitioners providing advanced palliative care in collaborative multidisciplinary networks.
Woolley et al [41]	2019	Australia	Quantitative data analysis	*Career choices of the first seven cohorts of JCU MBBS graduates: producing generalists for regional, rural, and remote northern Australia* Reviews the career choices of JCU graduates and found they were more likely than Australian graduates on average at choosing generalist careers and that 7% of surveyed graduates were Rural Generalists. It notes that the program has been a major contributor to the Queensland Rural Generalist Program.
Worley et al [42]	2019	Australia	Descriptive opinion piece	*From locum-led outposts to locally led continuous rural training networks: the National Rural Generalist Pathway* Discusses the Rural Generalist training model of rural health services as locally led continuous rural teaching health service networks, developing their own doctors, creating relevant evidence for best practice, and producing high quality, cost-effective and sustainable health care.
Aust Govt: NRHC [43]	2018	Australia	Government Report	*National Rural Generalist Taskforce Advice to the National Rural Health Commissioner on the development of a National Rural Generalist Pathway* This report documents the outcomes of the national consultation recommendations developed by a series of working groups for establishment of a National Rural Generalist Pathway including seeking specialist recognition for Rural Generalist Medicine.
Pandit et al [44]	2018	Australia	Qualitative study	*Managing Emergencies in Rural North Queensland: The Feasibility of Teletraining* This study documents a study of rural generalist registrars perspectives on tele-training as a tool for learning skills for emergency medicine.

Article	Date	Location	Report type	Findings/critique
Schubert et al [45]	2018	Australia	Systematic review	*International approaches to rural generalist medicine: a scoping review.* A scoping review of thirty years of literature into the emerging field of rural generalist medicine.
Sen Gupta [46]	2018	Australia	Descriptive opinion piece	*Producing a general practice workforce: let's count what counts.* This is a broad review of strategies to improve development of the rural medical workforce and includes consideration of the role of the Queensland Rural Generalist Pathway and the National Rural Generalist Program.
Sen Gupta et al [47]	2018	Australia	Program Description	*Growth of the James Cook University Medical Program: Maintaining quality, continuing the vision, developing postgraduate pathways* This study reviews the JCU medical program within the context of broader developments. It highlights the key role of the Queensland Rural Generalist Training program in providing a pathway for students in the medical program.
Sturman et al [48]	2018	Australia	Qualitative study	*Medical student contact with specialty trainees: Missing out in general practice?* This reviewed opportunities medical students are given for exposure to rural generalist and rural general practice training and its impact on speciality vs general practice choice.
McIver et al.[49]	2021	Asia-Pacific Islands	Descriptive opinion piece	*Rocketship and the Rural Health Workforce Revolution in the Pacific: Growing Skilled Medical Generalists Across the "Blue Continent"* Reviews recent developments in medical training across island countries in the Asia Pacific. Notes major shift toward Rural Generalist model training programs focused on the generalist disciplines of family, community, and rural hospital medicine.
Orrantia [50]	2022	Canada	Quantitative data analysis	*Northern Ontario's Obstetrical Services in 2020: A developing rural maternity care desert* Quantitative analysis of rural maternity services which found major reduction birthing services offered in rural areas by family physicians despite a constant number of physicians in those areas.
Falk et al [51]	2022	Canada	Program Description	*Surgical Task-Sharing in the Western Canadian Arctic: A Networked Model Between Family Physicians with Enhanced Surgical Skills and Specialist Surgeons* Discusses a collaborative model of practice (Rural Generalist) general practitioners with advanced surgical skills working with distal specialist surgeons to provide services in far northern Canada.

Article	Date	Location	Report type	Findings/critique
Hogenbirk et al [52]	2022	Canada	Quantitative data analysis	*Ten years of graduates: A cross-sectional study of the practice location of doctors trained at a socially accountable medical school* Review of 10-year workforce outcomes of Northern Ontario Medical School, self-described Rural Generalist model program from medical school through to Fellowship qualification. Review highlights rurally-based/oriented training and selection as key strategies and notes 92% graduate rural retention.
Robinson and Kornelsen [53]	2022	Canada	Qualitative study	*Documenting surgical triage in rural surgical networks: Formalising existing structures* A review of Rural Generalists and other rural surgical and obstetric maternity care providers in rural British Columbia. It found five key components to rural clinical decision-making which should be reflected in clinical guidelines and policies: (1) Clinical Factors, (2) Physician Factors, (3) Patient Factors, (4) Consensus Between Providers and (5) the Availability of Local Resources.
Hutten-Czapski [54]	2022	Canada	Descriptive opinion piece	*Wave theory of rural medicine* Reflections on the positive and negative progress of Rural Generalist Medicine and the work of Rural Generalists.
Iglesias et al [55]	2022	Canada	Position statement	*Consensus statement on networks for high-quality rural anaesthesia, surgery, and obstetric care in Canada* Joint statement by range of specialist colleges including college of family physicians and the Society of Rural Physicians of Canada. It promotes collaborative care involving Rural Generalists (i.e. rural family physicians with advanced specialised skills) and consultant specialists working together to delivery high quality rural care.
Irvine et al [56]	2022	Canada	Qualitative study	*Exploring how pregnant women in a remote northern community select a delivery location* Reviews preferences and experiences of both local Rural Generalists and city-based birthing services of mothers in a rural community. It identified a range of preferences and perceived barriers to accessing care locally.
Lespérance et al [57]	2022	Canada	Qualitative study	*Systemic challenges and resiliency in rural family practice* Discusses the perspectives on rural family physicians including Rural Generalists in experiencing and coping with personal challenges arising from their job. Includes consideration of impacts of working in obstetrics, rural hospitals, afterhours, a variety of work settings.

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Reece [58]	2022	Canada	Descriptive opinion piece	*The Heart of Generalism* Personal reflection of time working as a Rural Generalist and Indigenous community in far northern Alberta. Reflects on scope and challenges of Rural Generalist practice and impacts of close community engagement.
Grierson et al [59]	2021	Canada	Qualitative study	*Motivations for Pursuing Enhanced Skill Credentials in Family Medicine: A Study of the Certificates of Added Competence in Canada.* Study of the reasons for family physician trainees to undertake advanced skill credentials. The study notes that many of these are taken to practice in rural areas and notes that there is a risk that these will lead to a drift to subspecialisation and recommends that credentialling should be linked to responsiveness to community need.
Rural Road Map Implementation Committee [60]	2021	Canada	Position statement	*Rural Road Map: Report Card on Access to Health Care in Rural Canada.* Report Card on the Road Map, a joint initiative of the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) in collaboration with broadly representative stakeholder implementation group. The Road Map uses the terminology of Rural Generalist Medicine and goals include building support networks for rural generalist practice and an accredited rural generalist education pathway.
Falk et al [61]	2020	Canada	Systematic review	*Surgical Task-Sharing to Non-specialist Physicians in Low-Resource Settings Globally: A Systematic Review of the Literature* Reviews the global prevalence across countries of all income groups, of generalist doctors in rural, low-resource settings providing needed surgical services. It concludes that this model should be supported and expanded to close the gap in services in rural and remote settings.
Tromp [62]	2019	Canada	Descriptive opinion piece	*Family physicians as generalists* Reflection of progress of Rural Generalist Medicine as it relates to SRPC mission of 'championing rural generalist medical care through education, collaboration, advocacy, and research.
Advancing Rural Family Medicine: The Canadian Collaborative Taskforce [63]	2018	Canada	Program Description	*The Rural Road Map for Action – Directions.* Road Map actional plan, a joint initiative of the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) in collaboration with broadly representative stakeholder implementation group. The Road Map uses the terminology of Rural Generalist Medicine.

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Iglesias and Kornelsen [64]	2018	Canada	Program Description	*An evidence-based program for rural surgical and obstetrical networks.* Overview of the 'Joint position paper on rural surgery and operative delivery" of the SRPC, CFPC, and the obstetrics and surgical colleges. This highlights the key role of family physicians in providing rural obstetric services (Rural Generalists) and discusses appropriate collaborative models.
Rourke et al [65]	2018	Canada	Quantitative data analysis	*Does rural generalist focused medical school and family medicine training make a difference? Memorial University of Newfoundland outcomes.* Quantitative review of workforce outcomes of Memorial university medical school which delivers a Rural Generalist program. This found graduates had rural retention rates well above the average in Canada.
Rourke et al [66]	2018	Canada	Program Description	*From pipelines to pathways: the Memorial experience in educating doctors for rural generalist practice.* This report describes the concept and mission of the Medical Faculty at Memorial University, Newfoundland which is a self-described rural generalist training program.
Rourke et al [67]	2018	Canada	Quantitative Data analysis	*Pathways to rural family practice at Memorial University of Newfoundland.* This report assesses the graduate outcomes in terms of rural retention of the Memorial University Medical Program and finds its extensive rural placements and rural family practice training have resulted in more rural generalist physicians in family practice in Newfoundland and Labrador and across Canada.
Strasser and Cheu [68]	2018	Canada	Qualitative study	*Needs of the many: Northern Ontario School of Medicine students' experience of generalism and rural practice.* This report reviews students' and graduates' of the Northern Ontario Medical Schools' experience of rural generalism and finds this is positive and highly influential in determining their career directions, including specialty, scope, and location of practice. Students and graduates report that NOSM's distributed community-engaged learning prepares them well for rural generalist practice.
Kolhatkar et al [69]	2017	Canada	Qualitative study	*Understanding how emergency medicine physicians survive and thrive in rural practice: a theoretical model* This studied different rural practitioners who work in emergency departments including Rural Generalists and their experiences of stress in the

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				workplace to identify common themes. Common themes included, challenges posed by the variation in practice environments, and the need to creatively respond to barriers arising from the healthcare system's inability to respond to local needs.
Mohan and Kumar [70]	2019	India	Descriptive opinion piece	*Strengthening primary care in rural India: Lessons from Indian and global evidence and experience*. This article reviews the discussions of the world rural health conference and summarises what works for rural primary care in India. Its solutions include recognition of the Rural Generalist program in Queensland and its approach.
Kumar and Kumar [71]	2018	India	Position statement	*Rural Health Scenario – Role of family medicine: Academy of Family Physicians of India Position Paper* This describes the need for rural family physicians and their appropriate role. It notes that in rural areas they may work in healthcare teams and their role may extend to obstetrics, emergency, and other expanded scope areas.
Ostini et al [72]	2021	International	Qualitative studies	*Building a sustainable rural physician workforce* This study considers the perspectives of rural physicians and paediatricians with reference to their attitudes and considers how these line up with the rural generalist approach.
Kim et al [73]	2020	International	Systematic review	*Delivery of essential surgery by family physicians* This considers the practice of surgery by family physicians (Rural Generalists) in rural areas across the world and describes the benefits of this model for improving access to care in rural areas. It recognises the Rural Generalist training and Fellowships in Australia.
Konkin et al [74]	2020	International	Qualitative study	*Exploration of rural physicians' lived experience of practising outside their usual scope of practice to provide access to essential medical care (clinical courage): an international phenomenological study.* The study elucidated six features of the phenomenon of *clinical courage* through the narratives of the lived experience of rural generalist doctors.
O'Sullivan et al [75]	2020	International	Qualitative study	*A Checklist for Implementing Rural Pathways to Train, Develop and Support Health Workers in Low and Middle-Income Countries.* This WHO-sponsored research aimed to develop a Rural Pathways Checklist. Its purpose was to guide the practical implementation of Rural Generalist teams training, development, and support in low and middle-income countries

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Rural WONCA [76]	2019	International	Position statement	*Albuquerque Attestation on the Future of Rural Family Medicine in the United States* This statement which arose from the discussion of the Rural WONCA World Rural Health Conference provides an instructive description of Rural Generalist Medicine and its goals as part of the future of rural family medicine in the United States.
Rural WONCA [77]	2019	International	Position statement	*Island Medicine Statement: A WONCA 'World of Rural Health' Legacy in 2019* This statement discusses the role Rural Generalist medicine approaches as an appropriate model of care for provision of healthcare in remote island contexts.
Chater [78]	2021	International	Descriptive opinion piece	*To a Blueprint for Rural Health* This provides an overview of the Blueprint for rural health and provides the current international context of rural health policies and strategies.
Rural WONCA [79]	2021	International	Position statement	*Blueprint for Rural Health* This identifies, producing *Rural Generalist family doctors* as a key strategy for improving rural health, particularly where these doctors are supported by health care teams with rural generalist scopes within their respective professions.
Saito et al [80]	2020	Japan	Program Description	*Development of the Rural Generalist Program Japan: meeting the needs of Japanese rural communities* This provides an overview of the Rural Generalist Program of Japan and its outcomes for healthcare on Japanese islands.
Watanabe et al [81]	2019	Japan	Quantitative data analysis	*Successful stent implantation in a rural area on a patient with superior vena cava syndrome through specialist intervention: a case report* A review of a case whereby a Rural Generalist in a small rural hospital worked cooperatively with a cardiologist to perform stent implantation concluding the value of Rural Generalist collaborations in enabling rural access to care.
Fonken et al [82]	2020	Krygyzstan	Qualitative study	*Keys to Expanding the Rural Healthcare Workforce in Kyrgyzstan* Assessment of national policies in Kyrgyzstan to progress its primary care workforce and strengthen its rural healthcare and especially its rural generalists. Progress was measured against the WHO rural pathways checklist.
Gauchan et al [83]	2018	Nepal	Program Description	*Role of the general practitioner in improving rural healthcare access: a case from Nepal* This provides a descriptive case study of how GPs are adding value in rural Nepal by exploring clinical, leadership, and educational roles currently performed in a rural district-level hospital. It supports the expansion of GPs to additional district hospitals in Nepal's public sector

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				and describes their work in obstetrics, surgery, and other expanded scope areas.
Blattner et al [84]	2022	New Zealand	Qualitative study	*New Zealand postgraduate medical training by distance for Pacific Island country-based general practitioners: a qualitative study* Explores the experience of Pacific Island country-based doctors from the Cook Islands, Niue, and Samoa, studying in New Zealand's University of Otago distance-taught Rural Postgraduate program. The doctors completed the New Zealand two (GP and rural hospitalist) qualifications adapted from the Australia Rural Generalist training program.
Kiuru et al [85]	2021	New Zealand	Qualitative study	*Exploratory survey of procedural sedation and analgesia practice in sample of New Zealand rural hospitals: existing guidelines do not support current rural practice.* The study reviews the experiences of Rural Generalists in providing procedural sedation in rural hospitals. It identifies barriers to practice presented due to inapt clinical regulation which not reflect or recognise the training of these doctors.
Marshall and Aileone [86]	2020	New Zealand	Program Description	*COVID-19 pandemic and rural generalism: the West Coast's rural workforce solution* This is a descriptive case study of the strategy implemented by West Coast District Health Board (WCDHB) to ensure the full spectrum of care delivered by rural generalists in light of the disruption to workforce caused by the COVID-19 Pandemic
Withington et al [87]	2020	New Zealand	Program Description	*Transition of the medical model of care at Ashburton hospital over 10 years: the perspective of rural generalists.* Documents differences in the medical model of care at Ashburton Hospital before and after a 10-year period of transition from a secondary specialist to a rural generalist medical mode of care.
Blattner et al [88]	2019	New Zealand	Qualitative study	*A scope of practice that works 'out here': exploring the effects of a changing medical regulatory environment on a rural New Zealand health service.* This explores whether better equipping medical practitioners for rural hospital work and strengthening hospital systems and standards, the rural hospital medicine scope has met its intentions at Hokianga Health. It concludes that the rural hospital medicine pathway is a necessary partial solution to rural medical practitioners maintaining a broad skill set.

Article	Date	Location	Report type	Findings/critique
Nixon et al [89]	2019	New Zealand	Quantitative data analysis	*Use of point-of-care ultrasound for the assessment of intravascular volume in five rural New Zealand hospitals* Quantitative analysis of clinical outcomes in rural hospitals of use of point-of-care ultrasound (POCUS) by doctors specifically including Rural Generalists in rural hospitals in New Zealand. This found that in the rural context, POCUS provides new information that frequently alters the clinician's estimation of a patient's intravascular volume.
Nixon and Lawrenson (eds) [90]	2019	New Zealand	Descriptive opinion piece	*Guest Editorial: Failing to thrive: academic rural health in New Zealand.* This discusses the development of the Rural Generalist training pathway of the Northern Ontario medical school and its outcomes and considers their similarities with developments in New Zealand and potential for adoption. It specifically makes the point that: "*Extended scopes of rural generalist practice therefore need explicit recognition in medical education and training."*
Nixon [91]	2018	New Zealand	Descriptive opinion piece	*Rural generalism: the New Zealand way. Address for the Eric Elder Medal. RNZCGP Conference* This describes the New Zealand model of Rural Generalist qualification, its basis in the Cairns Consensus statement and the rationale for its points of difference to be fit for purpose for New Zealand.
Nixon et al [92]	2018	New Zealand	Quantitative data analysis	*Point-of-care ultrasound in rural New Zealand: Safety, quality and impact on patient management.* An analysis of the safety, accuracy and efficacy and impact of POCUS on patient management and management when performed by rural generalist doctors. It found that there are issues in learning and maintaining these skills, Further consideration is needed on developing safe Rural Generalist scopes of practice, training, credentialing, and quality assurance.
Nixon et al [93]	2018	New Zealand	Qualitative study	*Scope of point-of-care ultrasound practice in rural New Zealand* Mixed methods descriptive study of the scope of POCUS practiced by Rural Generalists and their perspectives on this. This found that Rural Generalists consider the broad scope of POCUS to be important but challenging. Clinical governance, including an agreed scope and standards may improve quality and safety of rural POCUS.
Naidu and Chu [94]	2021	South Africa	Qualitative study	*District hospital surgical capacity in Western Cape Province, South Africa: A cross-sectional survey*

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				This considered the importance of district hospitals in providing needed surgical care and concluded that with appropriate training and support, family practitioners could play an essential role in providing surgery in these hospitals.
Von Pressentin et al [95]	2021	South Africa	Qualitative study	*The family physician as a primary care consultant - the Mossel Bay experience* This analysis based on an audit of patient consultations found value in strengthening the role of family physicians in acting as expert consultant advisors working in both primary healthcare teams and hospitals and recommended designated hospital-based roles to better integrate care between primary and secondary delivery.
Barnacle et al [96]	2020	South Africa	Qualitative study	*Investigating competencies needed by European-trained doctors in rural South African hospitals.* This investigates the skillset necessary for doctors in rural hospitals and found this needs to incorporate more training in family medicine and generalism to reflect patient needs. This informed the design of the Postgraduate Diploma in Rural Medicine which has been developed to address these skill gaps.
Meyer et al [97]	2020	South Africa	Quantitative data analysis	*What presents to a rural district emergency department: A case mix* This analyses the patterns of patient presentations to general practitioner led rural district hospitals. It finds that patients with conditions from all categories of the ICD-10 present for management at these hospitals and the doctors working in this setting need to independently diagnose and manage a wide range of Emergency Department presentations and execute an assortment of procedures.
Erumeda et al [98]	2019	South Africa	Qualitative study	*A self-assessment study of procedural skills of doctors in peri-urban district hospitals of Gauteng, South Africa*. This was an analysis of the procedural skills of doctors in mixed urban-rural district hospitals. It found that there should be provision for generalist doctors and specialists, such as family physicians, to practise a wide range of procedural skills dependent on their experience and competence in a district hospital setting, based on rural– urban contexts and district service delivery packages.
Doyle et al [99]	2020	Scotland	Qualitative study	*Time to revisit the skills and competencies required to work in rural general hospitals.* This analyses the distinctive generalist focussed nature of medical teams working in Rural General Hospitals in Scotland, and their perspectives and experiences to inform development of a remote and rural medical training pathway. The article

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				recognised ACRRM, and the Rural Generalists programs in Canada as positive models for consideration.
Deutchman et al [100]	2022	United States	Quantitative data analysis	*The impact of family physicians in rural maternity care* This article measures the significant reliance of rural hospitals in the United States on the services of family physicians to provide essential obstetric care and identifies an urgent need to sustain and grow this workforce.
Kenamond et al [101]	2022	United States	Descriptive opinion piece	*No oncology patient left behind: Challenges and solutions in rural radiation oncology* This identifies an urgent need to address access to radiation oncology services for rural people in the United States. It identifies the broad scope role of rural family physicians in supporting specialist radiologist services as a critical element in service provision.
Quinlan [102]	2022	United States	Descriptive Opinion piece	*The Role of the Family Physician in Rural Maternity Care* This identifies family physicians as having a critical role to play in providing obstetric services to people in rural areas and the need to train more of these Rural Generalist scope family physicians to prevent further spread of maternity care deserts.
American Academy of Family Physicians (AAFP) [103]	2021	United States	Position statement	*Cesarean Delivery in Family Medicine (Position Paper)* This statement looks at the role of family physicians in the United States in obstetric surgery particularly in rural areas. It examines the barriers to this provision including those created by credentialing frameworks.
Barreto et al [104]	2021	United States	Qualitative study	*Distribution of Physician Specialties by Rurality* This study measured the availability of physician specialties in rural counties. It found that specialties including emergency medicine, cardiology, psychiatry, diagnostic radiology, general surgery, anaesthetics, and Obstetrics were less available than primary care physicians in all rural counties. It concluded that policy efforts should focus on maintaining the training and scope of practice of family physicians to serve the health care needs of rural communities where other specialties are less likely to practice.
Nasim et al [105]	2021	United States	Qualitative study	*The Declining Scope of Practice of Family Physicians Is Limited to Urban Areas* This review of family physicians self-reported scope of practice found the urban family physicians scope was narrowing however the rural physicians continue to have a

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				broad scope of practice, which may ensure access to care in rural areas that rely on FPs to provide a large portion of health care services. However, county characteristics like persist
Tong et al [106]	2021	United States	Quantitative data analysis	*The Essential Role of Family Physicians in Providing Cesarean Sections in Rural Communities* This study measured the number of physicians providing obstetric services in rural areas. It found that a substantial proportion of family physicians who perform cesarean sections do so in rural counties and in counties without an obstetrician/gynaecologist. It recommended supporting obstetric fellowship training in family medicine and promoting policies that facilitate obstetric credentialing of family physicians with adequate training.
Peterson et al [107]	2019	United States	Quantitative data analysis	*Family Physicians' Contributions to Rural Emergency Care and Urban Urgent Care* This study finds a sharp increase in the proportion of family physicians working primarily in rural emergency departments and proposes that these doctors are likely to continue to be the backbone of emergency care in rural America.
American Academy of Family Physicians (AAFP) [108]	2018	United States	Position statement	*Family Physicians Delivering Emergency Medical Care -Critical Challenges and Opportunities* This Position Paper describes the scope of rural family physicians working in emergency medicine and highlights their importance and challenges to their continuing provision of services particularly in rural areas.
Kozhimannil KB et al [109]	2018	United States	Quantitative data analysis	*Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States.* This found that in rural US counties not adjacent to urban areas, loss of hospital-based obstetric services, compared with counties with continual services, was associated with increases in out-of-hospital and preterm births and births in hospitals without obstetric units in the following year; the latter also occurred in urban-adjacent counties. These findings may inform planning and policy regarding rural obstetric services.

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Attachment 2.1

Road-Map for Jurisdictional Rural Generalist Program

Contact details:

- Dr Linda Macpherson MoH
- Dr Louise Baker Statewide Director HETI
- Mr Rod Peadon Snr program Manager Strategic Partnerships(HETI)
- Ms Karen Beattie Snr Program Manager Training Support (HETI)

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Aim: Helping to secure a stable medical workforce for rural and remote communities within NSW now and for the future.

KEY SUPPORTS OF THE PROGRAM

- Close liaison with local health districts for both training and career opportunities with Funded AST training opportunities in excess of workforce
- Career navigation from Rural Director of Training
- Specific Rural Generalist (RG) education
- Introduction workshop by specialty
- Mentorship from RGs
- Education Scholarship for trainees
- Data collection monitoring and reporting

Programs Supported

- RJDTIF-RG
- JFPDP
- NSW RGTP
- GPPTP

Take Homes

- Strong state support MoH
- 54 Funded Positions for AST annually increasing to 66 by 2026
- 20FTE funded GPPTP for AST annually
- Career Navigation by RDoT
- Stakeholder engagement
- Governance in place since 2012
- NextRG Database
- My Health Learning Preparing for Your AST Year
- Marketing
- Research

Road-Map for Jurisdictional Rural Generalist Program

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Regional LHNs | SA Health
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RURAL GENERALIST PROGRAM
SOUTH AUSTRALIA

Elevator Pitch –
Rural Generalist Program South Australia

Dedicated rural generalist training networks

High functioning/quality fit for purpose rural generalist training programs support the establishment and maintenance of both a strong primary and secondary health care system that will provide better population health and distribution (equity) and improved economy in the use of resources.

Communities will realise

- Enhanced viability of rural general practice that supports the delivery of local hospital services
- Improved attractiveness of rural career pathways that are visible, recognised, and valued increasing access and retention of a skilled workforce
- Improved business models for specialised services that rural generalists provide
- Improved quality and range of medical services provided locally to meet community need
- Improved connection between primary care and secondary care

Regional local health networks will realise

- A stronger primary care system prevents illness and maintenance of good health reducing the burden on hospitals and other medical resources
- An increase in supply of rural generalists to meet workforce needs
- Improvements in collective and manageable workloads, job satisfaction leading to increased attraction and retention of doctors to rural areas
- Improved clinical leadership capability and overall coordination of regional health services
- Improved overall health system performance and population health including:
  - Improved consumer-centred care
  - Improved health system functioning across the continuum of care
  - Improved efficiency of care

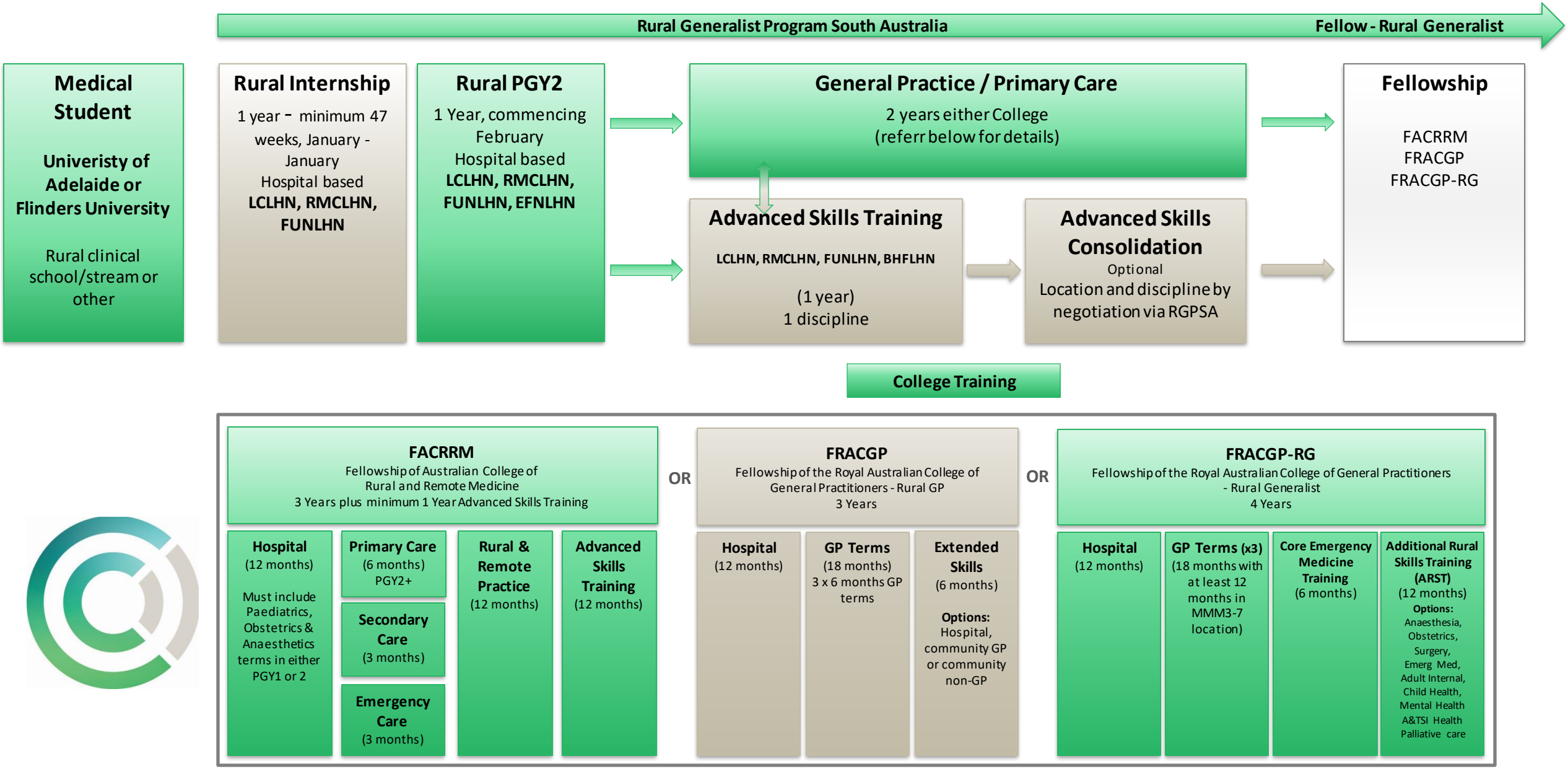
Key messages

More than just a career
Train with passion and purpose
Broader clinical experience
Rural lifestyle
Community minded medicine
Quality training experience

RGPSA Eligibility Criteria

- Medical students in the last two years of medical school who are serious about pursuing a rural generalist career
- Aboriginal and Torres Strait Islander medical students at any level who are interested in exploring the rural generalist pathway and transition to rural training
- Junior doctors, TMOs on the rural generalist pathway or wanting to explore the rural generalist pathway
- Fellowed GPs wanting to train to be a rural generalist

Entry at any point
No exit as aim to develop a community of rural generalists with the inclusion of Alumni program (TBA) that supports supervision capacity development and mentors for incoming trainees.


Rural Generalist Program South Australia
Fellow - Rural Generalist
Medical Student
Univeristy of Adelaide or Flinders University
Rural clinical school/stream or other
Rural Internship
1 year - minimum 47 weeks, January - January
Hospital based
LCLHN, RMCLHN, FUNLHN
Rural PGY2
1 Year, commencing February
Hospital based
LCLHN, RMCLHN, FUNLHN, EFNLHN
General Practice / Primary Care
2 years either College
(referr below for details)
Advanced Skills Training
LCLHN, RMCLHN, FUNLHN, BHFLHN
(1 year)
1 discipline
Advanced Skills Consolidation
Optional
Location and discipline by negotiation via RGPSA
Fellowship
FACRRM
FRACGP
FRACGP-RG
College Training
FACRRM
Fellowship of Australian College of Rural and Remote Medicine
3 Years plus minimum 1 Year Advanced Skills Training
Hospital (12 months)
Must include Paediatrics, Obstetrics & Anaesthetics terms in either PGY1 or 2
Primary Care (6 months) PGY2+
Secondary Care (3 months)
Emergency Care (3 months)
Rural & Remote Practice (12 months)
Advanced Skills Training (12 months)
OR
FRACGP
Fellowship of the Royal Australian College of General Practitioners - Rural GP
3 Years
Hospital (12 months)
GP Terms (18 months) 3 x 6 months GP terms
Extended Skills (6 months)
Options: Hospital, community GP or community non-GP
OR
FRACGP-RG
Fellowship of the Royal Australian College of General Practitioners - Rural Generalist
4 Years
Hospital (12 months)
GP Terms (x3) (18 months with at least 12 months in MMM3-7 location)
Core Emergency Medicine Training (6 months)
Additional Rural Skills Training (ARST) (12 months)
Options: Anaesthesia, Obstetrics, Surgery, Emerg Med, Adult Internal, Child Health, Mental Health A&TSI Health Palliative care

Supports for trainees

Access supports and services to guide your journey to becoming a rural generalist.

By signing on to the rural pathway in South Australia, trainees will get a range of benefits and services that will ensure a supported journey to becoming a rural generalist through either ACRRM or RACGP, that will continue into Fellowship.

	Medical Students	Interns	PGY2+	GP Training	Fellowed GPs
Career Navigation and advice	✓	✓	✓	✓	✓
Case management and support	✓	✓	✓	✓	✓
Mentoring	✓	✓	✓	✓	✓
Access to rural education and training program		✓	✓	✓	✓
Support to apply for RACGP or ACRRM		✓	✓		
Access to advanced / additional skills training			✓	✓	✓
Skills consolidations support and grants			✓	✓	✓
Rural generalist community, networking and events		✓	✓	✓	✓
Alumni					✓

Take Home

Evolution of RG Pathway in SA

Implementation of specific supports:

- Formal case management and career guidance
- Education and training supports and coordination
- Access to RG community through mentors and alumni
- Expanding training positions in training networks matched to trainees and community needs

Evolution of RGCU in SA

Moving from project based to business as usual.
Generic project roles now specialised:

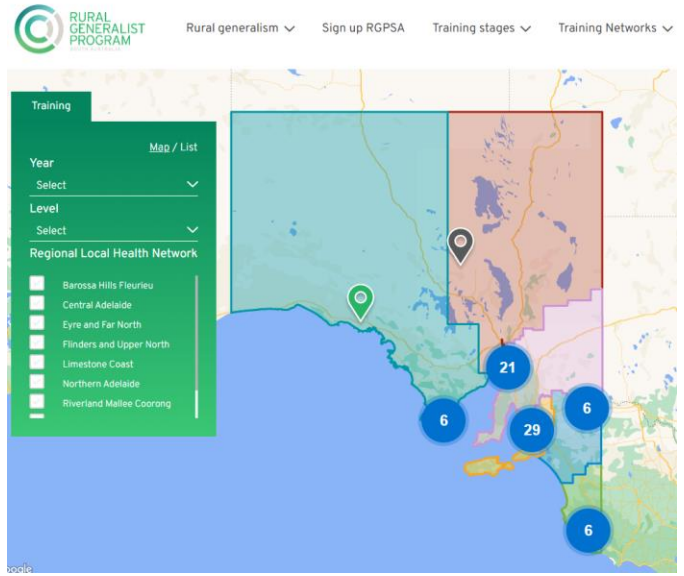
- Recruitment and Accreditation Officer
- Rural Generalist Education Coordinator
- Systems and Program Advisor
- Business Manager
- Administration
- Clinical Leads – more defined DCT-like role

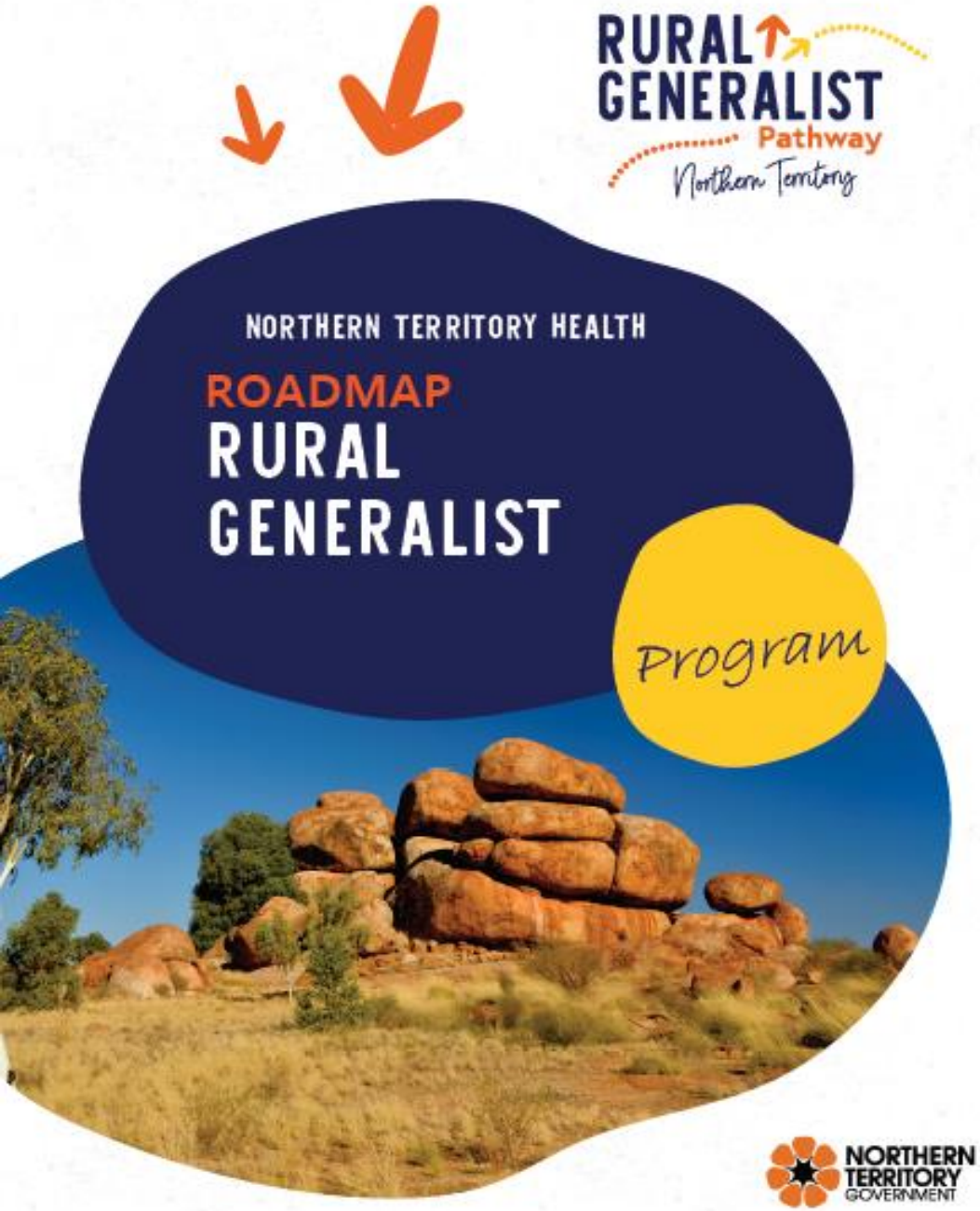
RGPSA website

Website acts:

- To provide high level information
- to raise awareness of the rural generalist pathway
- To combat misconceptions
- To promote rural training and employment opportunities
- To give access to supports and resources
- To promote rural as places to live and work
- As portal to stakeholders, partners and other services for more detailed information

Social media channels drive audience to website





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VISION

Our vision is that all Territorians have access to medical services and doctors who are equipped to meet rural and remote community needs. An increased number of rural generalists in the NT will enable the provision of decentralised, patient-centred and culturally safe care across multiple health services, resulting in fewer inefficiencies and, ultimately, better patient outcomes by reducing hospital admissions, reducing the use of locum services, and limiting the need for patient travel.

MISSION

To incorporate rural generalist medicine into the NT health system and its employment models through optimising the rural generalist scope of practice, embedding patient-centred models of care that better accommodate the rural generalist model and ensuring appropriate governance structures are in place to support and promote the medical generalist workforce model in the NT.

This strategy provides a coordinated training pipeline, increasing opportunities for advanced skills training and post-fellowship training for rural generalists. Under this strategy, NT Health will expand the rural generalist workforce into primary care settings where new models of care incorporate rural generalist medicine principles. The Rural Generalist Strategy aims to ensure that approximately 40% of the NT population has access to medical services and doctors who are equipped to meet rural and community needs.

PRIORITIES

- Build the generalist capability of the NT medical workforce.
- Support medical professionals who pursue rural generalism with the opportunity to train and work in both hospitals and primary healthcare settings.
- Incorporate rural generalist medicine into the NT Health system and promote integrated employment models through optimising the rural generalist scope of practice and embedding patient-centred models of care.
- Ensure appropriate governance structures are in place to support and promote the rural generalist workforce.
- Develop and support rural generalist medicine models of care and service models that meet the community's needs.
- Identify sustainable and ongoing funding models for rural generalist medicine.
- Target medical students and advocate for the Rural Generalist profession.
- Provide excellent case management, career navigation, mentoring and support.
- Collaborate with key stakeholders to address workforce maldistribution.
- Improve working conditions in rural areas to attract and retain Rural Generalists.
- Provide safe and supportive supervision in hospital and primary care settings.
- To ensure that adequate infrastructure is available to support the Rural Generalist program.

NT CONTEXT

250K POPULATION

1% of Australian population

The NT population's burden of disease per person is **80% higher** than the total Australian population

30% of the NT population are Aborginal.

In comparision to 3.3% in Australia.

Of that 30%, 80% reside remote.

GOVERNANCE

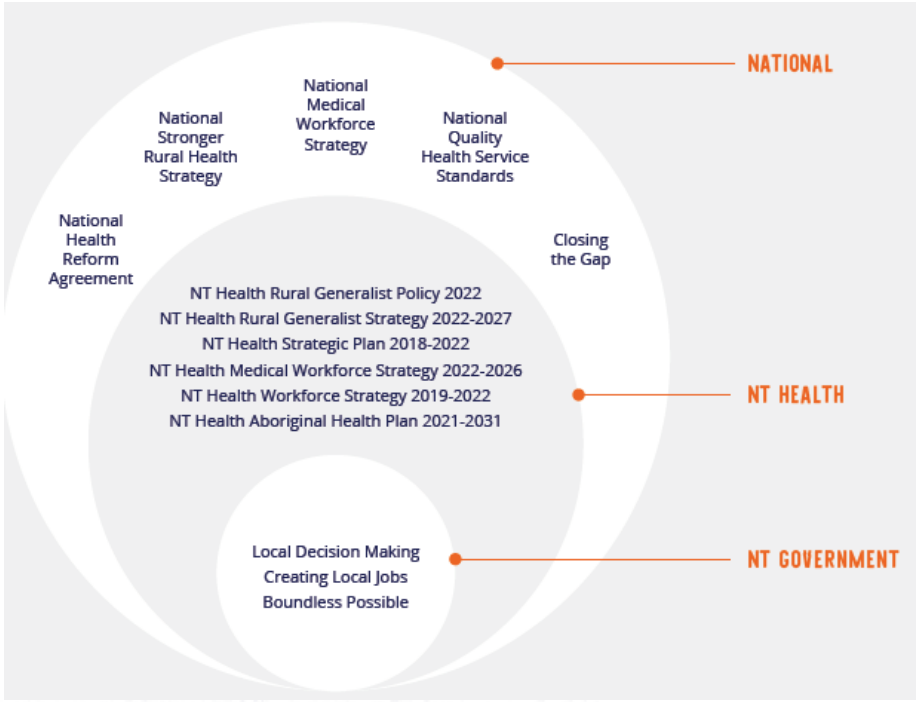
Minister for Health

Chief Executive NT Health

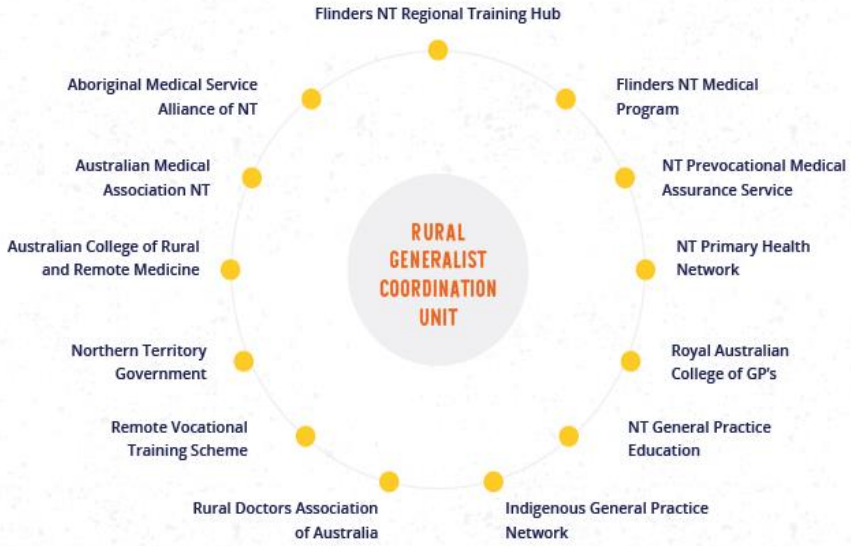
NT Reference Committee

Figure: Governance structure

POLICY AND PLANNING CONTEXT



THE NT RURAL GENERALIST COORDINATION UNIT



EVALUATION

NT Health will conduct an internal mid-term evaluation in 2025, followed by a formal evaluation before the strategy's expiration in 2027. The current plan focuses on the next five years due to the rapidly changing landscape of the pandemic environment. The benefit is a more targeted roadmap for system implementation and adaptation. Over the course of the project, meaningful data will be gathered to assess the pathway's outcomes and impact. The evaluation results will be used to inform and adjust the pathway's long-term planning.

2022 IMPLEMENTATION AND MONITORING

2025 INTERNAL MID TERM REVIEW

2027 FORMAL EVALUATION

MEASURING OUR PERFORMANCE

We will use indicators and targets to measure our progress against the strategy in our annual reporting, performance reporting, and strategic planning reporting, and then in a more formalised implementation plan. The implementation plan on pages X- X will outline how the strategic focus areas will be delivered, as well as performance benchmarks and milestones.

Figure 7: Monitoring progress

RURAL GENERALIST Pathway Northern Territory

Medical School - Expression of Interest
Australian Community Based Placements
Intern Application Preference Indicated – Rural Generalist Program

Initial Expression of Interest
Intern application
(Final Year Students indicate preference for Rural Generalist Pathway)

Flexible Entry and Lateral Entry also available at each level of the Pathway

---

Prevocational Years 1-2
RURAL GENERALIST FOUNDATION YEARS
Internship - Hospital trained (Core Terms)
+/- Primary Health Care rotation/Regional Hospital

Foundation Training Rotations

(2 year NT Government Employment Contract Offered – All Regions)
*Minimum of 2 Primary Health Care Rotations in first 3 years on the Rural Generalist Pathway

- General Surgery
- General Medicine
- Emergency Medical Care
- Paediatrics
- Obstetrics & Gynaecology
- Anesthetics/ICU or ProStart
- Mental Health
- Primary Health Care Rural and Remote

Prevocational Years 3-4
RURAL GENERALIST CORE TRAINING
Senior Resident Medical Officer
+/- Hospital Trained/Primary Health Care Trained

Core Training Rotations

(NT Government Employment Contract Offered – All Regions)
Core training is individual and based on experience
May have enrolled in Vocational Training by end of PGY3
Option to complete 6mths Extended Skills Training in PGY4

- Primary Health Care Rural and Remote
- Regional Hospital
- Mental Health
- Paediatrics
- Obstetrics & Gynaecology

Vocational Years
RURAL GENERALIST TRAINEE
Registrar
Hospital Trained or ACCHS or Private Practice

General Practice Training

(Can be undertaken at either or both GP Specialist College of choice)
Vocational Trainees enter pathway at the point appropriate to their training readiness and/or eligibility for Specialist College recognition of prior learning (RPL)

- Australian College of Rural and Remote Medicine
- Royal Australian College of General Practice

Vocational Years
ADVANCED/ADDITIONAL SKILLS
Rural Generalist Trainee - Registrar
Minimum 12 months (can be undertaken after enrolled in GP Specialist College of your choice)

Advanced/Additional Skills Training

(Can be undertaken any time after enrolled with GP Specialist College of choice)
Vocational Trainees enter pathway at the point appropriate to their training readiness and/or eligibility for Specialist College recognition of prior learning (RPL)

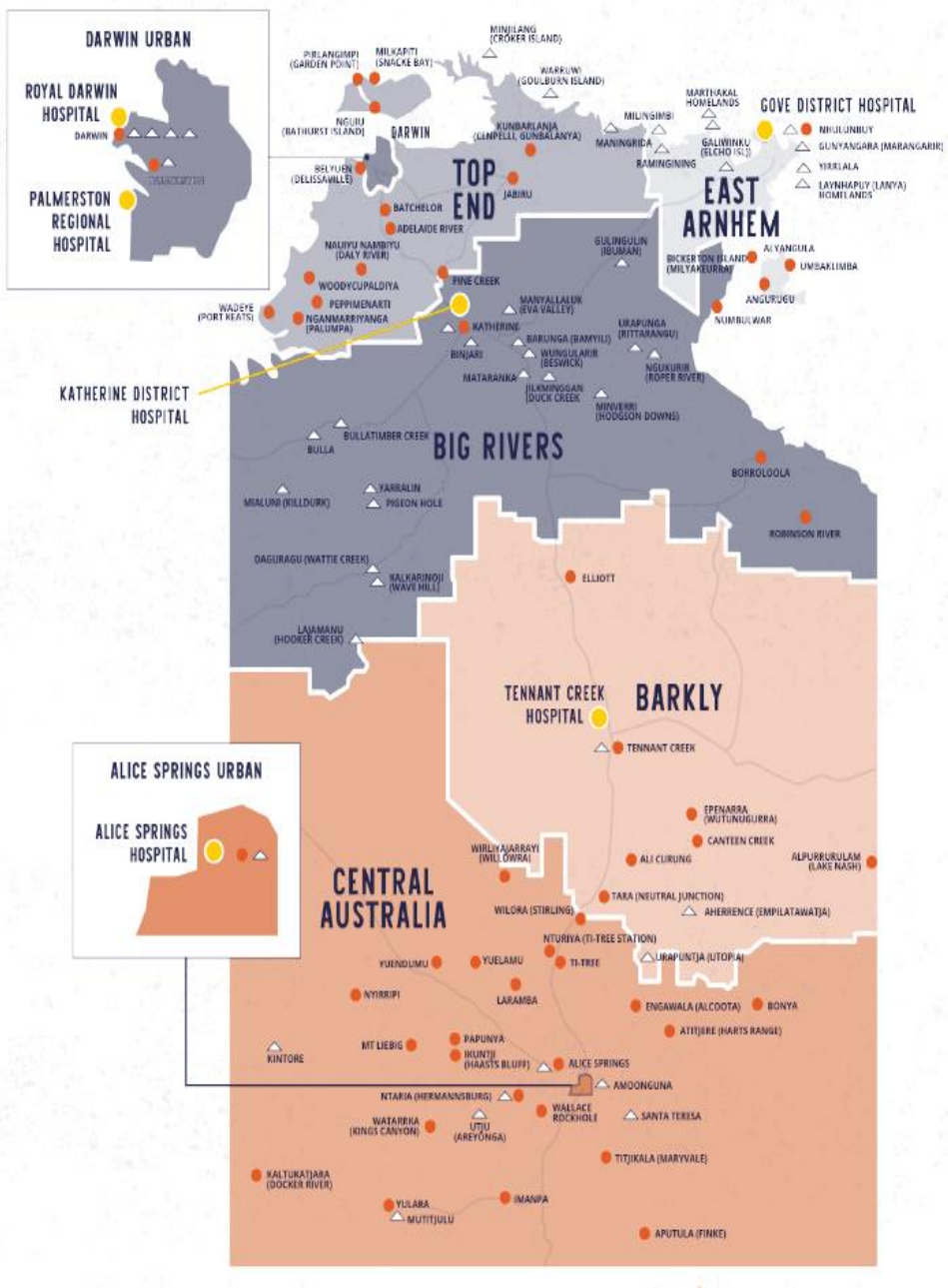
- Anesthetics
- Surgery
- Emergency Medicine
- Paediatrics
- Obstetrics & Gynaecology
- Remote Medicine (ACRRM)
- Adult Internal Medicine
- Population Health (ACRRM)
- Mental Health
- Palliative Care
- Aboriginal Health

Vocational Years
RURAL GENERALIST LEVEL 1 – FELLOW
Senior Registrar

Fellowship

(Completion of all assessment requirements of GP Specialist College of choice)

- FACRRM
- FRACGP-RG



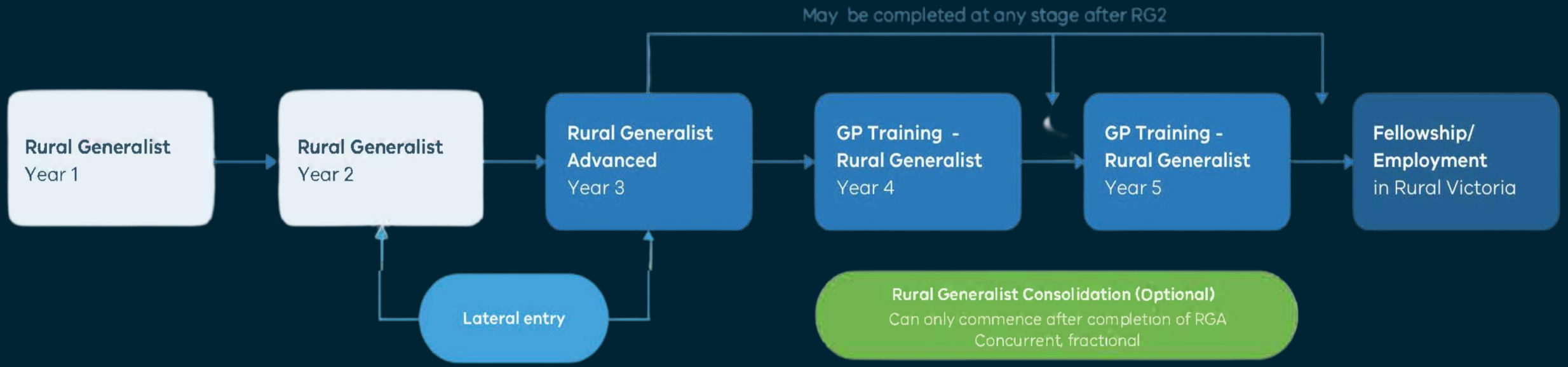
Victorian Rural Generalist Program

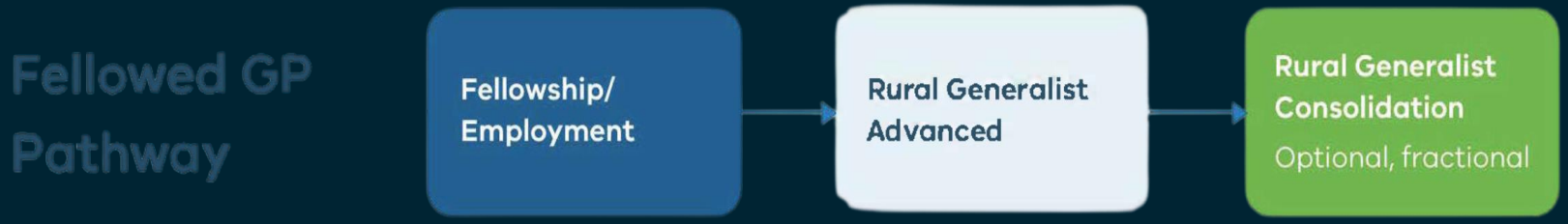
Statewide Coordinator- Merryn Lodding
coordinator@vicruralgeneralist.com.au

Statewide Clinical Lead- Dr Susan Thomas
clinical.lead@vicruralgeneralist.com.au

VICTORIA
State Government

VRGP Pathway





VRGP Support

Clinical Leads

The VRGP has Clinical Leads to provide trainees with career and training advice to progress through their RG journey.

The VRGP has experienced Clinical Leads for Anaesthetics, Emergency Medicine, Obstetrics and Paediatrics.

The Statewide Clinical Lead will support trainees in all other disciplines.

Regional Coordinators

The VRGP has Regional Coordinators to provide case management support to:

Help trainees choose the right RG training pathway.

Assist trainees in navigating their way through the training requirements and career opportunities.

Link trainees with RG role models and mentors

Identify RG training and career opportunities

Regional Networks

The VRGP Regional Networks support the development of RG training to meet the workforce needs of the regions.

Regional Networks have collaborative representation from all health services in the region, GP training organisations, Primary Health Networks, Regional Training Hubs, RG's, RG trainees and medical students.

Innovation

Rural Generalist Training & Education Grant (RGTEG)

Rural Generalist Advanced (RGA) Education Program

Rural Generalist Consolidation

Road-Map for Jurisdictional Rural Generalist Program

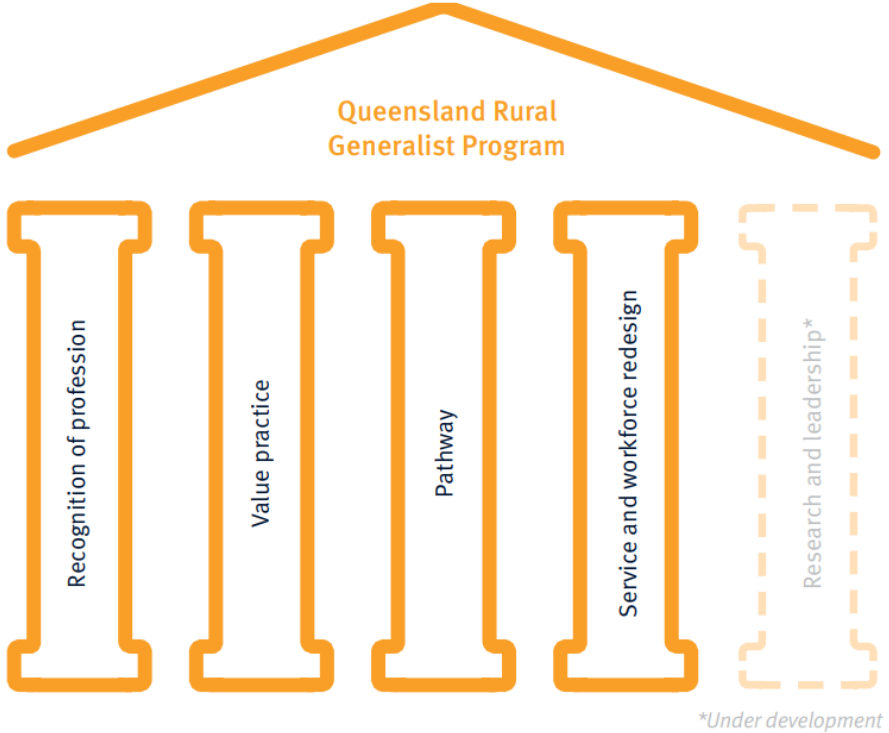
Contact details:
Queensland Rural Generalist Pathway
rural_generalist@health.qld.gov.au
1800 680 291

Queensland framework

Student engagement → Prevocational Training → Advanced Skills Training → Vocational Training → Post fellowship

Core components

- Case management: career navigation, training issues, family considerations.
- Recruitment and placement: internship, AST, vocational training.
- Education: context and training stage specific (prevocational, AST discipline, rural preparation, leadership).
- Relationships: training sites, rural facilities, training partners.



Take home messages

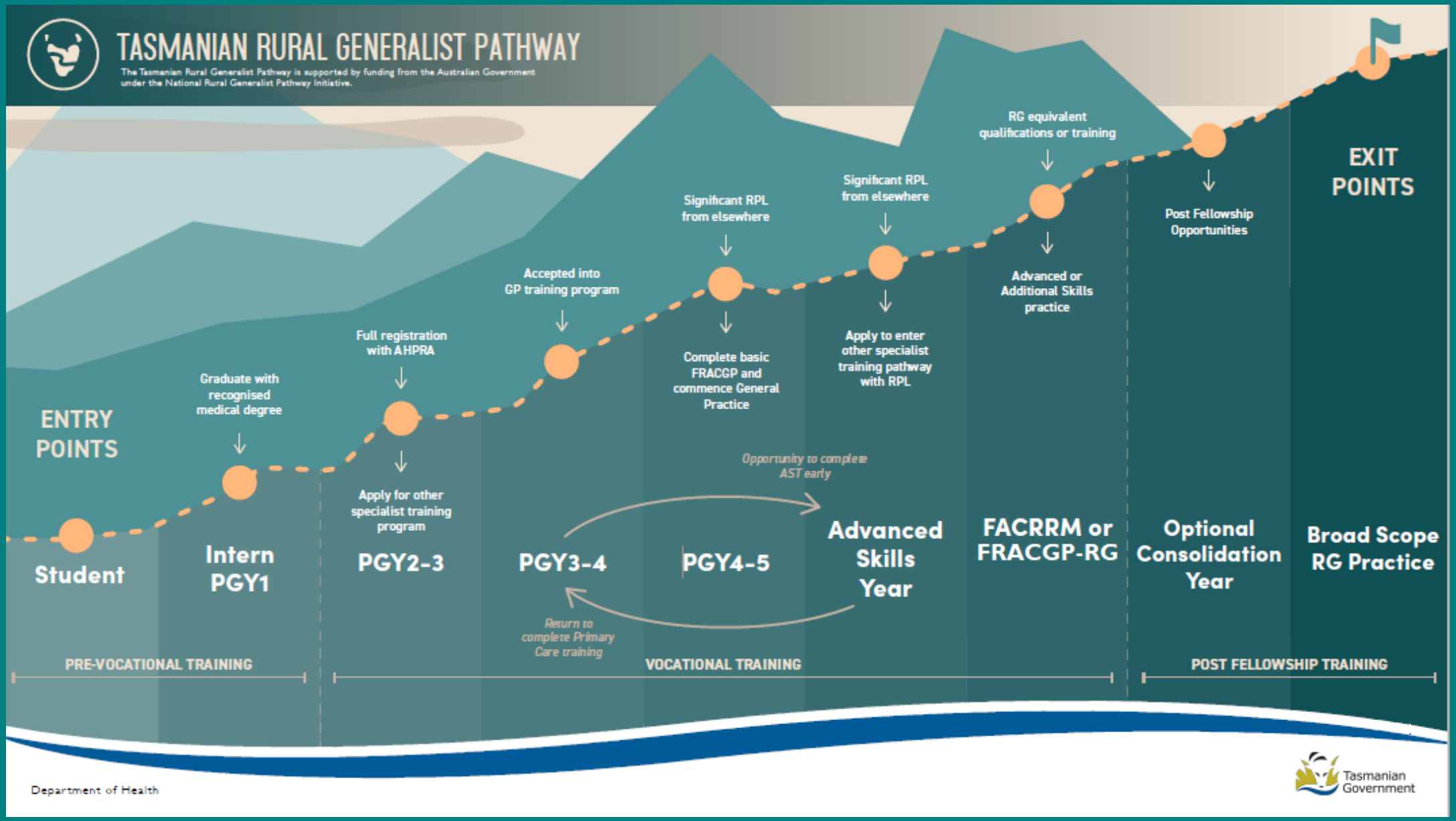
- Collaboration and regular communication is vital
- Investing in a fit for purpose case management and data collection system is key to enabling good case management, reporting, research and evaluation
- Solving primary care workforce issues requires collective interest and accountability – there's a difference between funding mechanisms and enablers.

Roadmap for Tasmanian Rural Generalist Program

Contact details:
Prof Lizzi Shires, Director Rural Pathways
Dr Sally Street, Director Rural Generalist Training and Development
Ashley Galvin, Project Support Officer
Email: tasrural.pathways@health.tas.gov.au

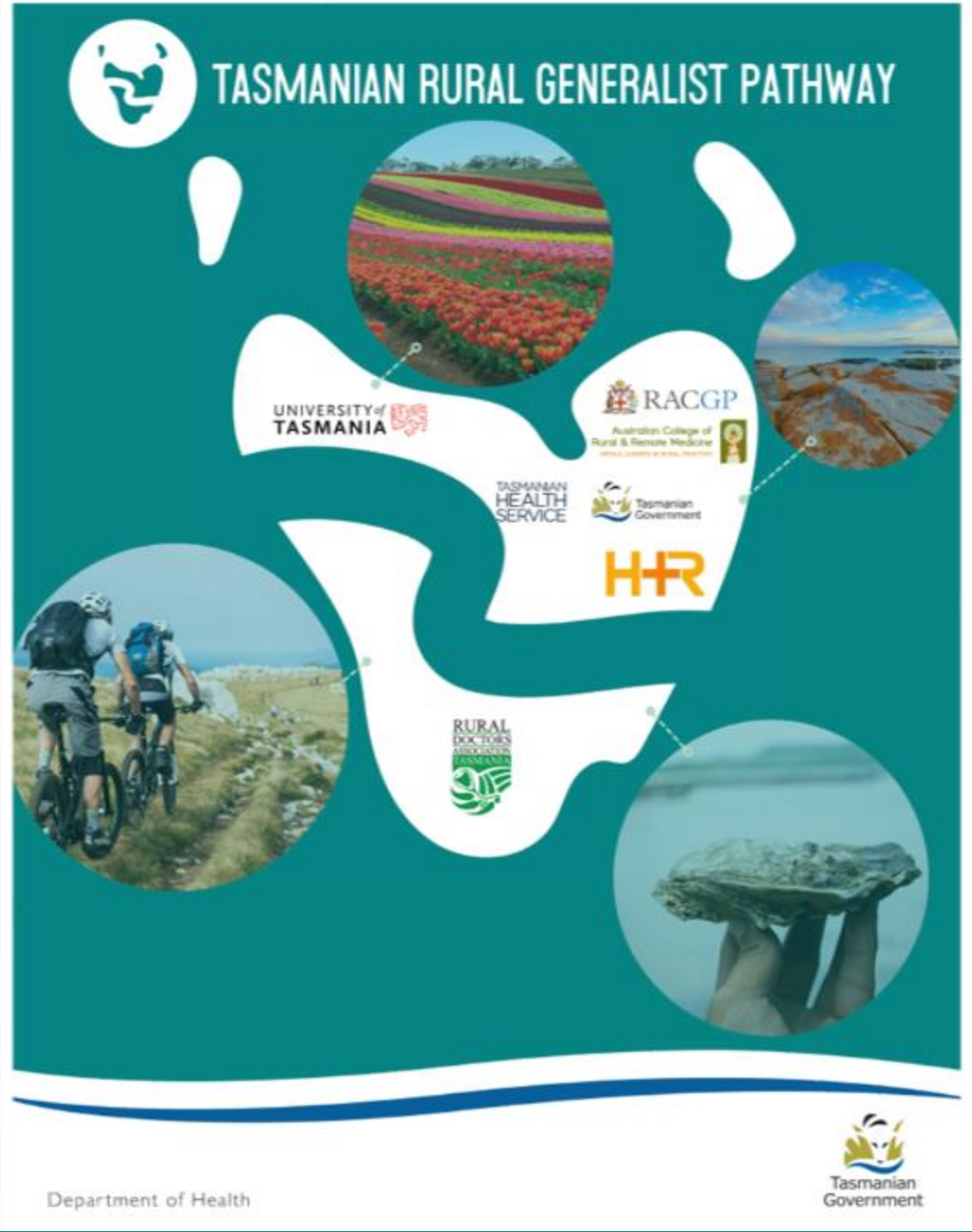
Flinders Island Credit: Adam Gibson

Elevator Pitch



Take Home

- RG in Tasmania is different – unique geography and community needs
- Need for 'Non procedural' advanced skills Palliative Care, Mental health, Aged care
- Need for Emergency Skills in more rural areas
- Collaborative working – with workforce agency, THS, PMCT, University, Colleges
- Links with OCHRE – private company that runs most of the rural and remote practices in Tasmania
- Pathway support through bursaries, mentors, job opportunities, educational opportunities
- Importance of early pathway links with community and university to get Rural students
- Director of Rural Pathways also Director of Rural Clinical School



Attachment 2.1 Jurisdictional Rural Generalist Programs Road Maps

Road-Map for Jurisdictional Rural Generalist Program

Rural Generalist Pathway WA Coordination Unit
Curtin University, Building 418, Koorliny Way, BENTLEY WA 6102
PO Box 6680, East Perth Business Centre WA 6892
T: (08) 6553 0873
E: RGPWA@health.wa.gov.au
W: https://ruralgeneralist.health.wa.gov.au/

Elevator Pitch

*For illustrative purposes only. Each journey will be unique.

Take Home

- Flexible entry to pathway
  - From penultimate year of medical school onwards
  - Open intake
- Case managers in all seven regions
  - Directors of Clinical Training (Rural Generalists) ± Medical Education Officers
- Access to Office 365 for all RGPWA participants (not just WACHS employees)
  - MS Teams, WACHS library including UpToDate
- Further innovation is reliant on securing funding for AST posts

Attachment 2.2

RURAL AND REMOTE HOSPITAL AND HEALTH SERVICES MEDICAL AND DENTAL CREDENTIALING AND SCOPE OF CLINICAL PRACTICE COMMITTEE

TERMS OF REFERENCE

1. Name of Committee

Rural and Remote Hospital and Health Services Medical and Dental Credentialing and Scope of Clinical Practice Committee (the Committee).

2. Purpose

The purpose of the Committee is to:

- review applications for credentialing and make appropriate recommendations on a defined scope of clinical practice (SoCP) for:
  - Medical Practitioners and Dentists, including practitioners engaged by Non-Government Organisations (NGOs), practising in Torres and Cape, North West, Central West and South West Hospital and Health Services (Rural and Remote HHSs)
  - Medical Practitioners engaged by the Flying Specialist Service (based in South West Hospital and Health Service) and providing services to South West Hospital and Health Service, Central West Hospital and Health Service, and Darling Downs Hospital and Health Service
  - Medical Practitioners engaged by the Royal Flying Doctor Service to provide General Practice services in Queensland public health facilities
  - Medical Practitioners engaged by Queensland Country Practice – Senior Reliever Program
- review and make appropriate recommendations regarding supervision imposed on a practitioner's SoCP
- review and make appropriate recommendations regarding conditions imposed on a practitioner's SoCP
- facilitate the formal review of a practitioner's SoCP in response to a request from the practitioner, an HHS, or other authorised individuals or bodies.

3. Reporting

The Committee makes recommendations to:

- The relevant Health Service Chief Executives (HSCEs) as to a Medical Practitioner's or Dentist's credentials and defined scope of clinical practice within a particular Hospital and Health Service (HHS) or health care facility.
- The South West HSCE regarding multi-HHS SoCP for Medical Practitioners engaged by the Flying Specialist Service.

Queensland Government

- The Torres and Cape HSCE regarding statewide SoCP for Medical Practitioners engaged by the Royal Flying Doctor Service (RFDS) to provide General Practice services in Queensland public health facilities.[1]
- The Torres and Cape HSCE regarding statewide SoCP for Medical Practitioners engaged by Queensland Country Practice – Senior Reliever Program.[2]

The HSCEs are responsible to approve, amend or refuse a practitioner's SOCP on the advice of the respective HHS Executive Director of Medical Services (EDMS) after consideration by the EDMS of the Committee's recommendations.

4. Membership of the Committee

The Committee will comprise the following:

Core Membership

- Chair – an EDMS from one of the four (4) rural and remote HHSs
- The EDMS from each of the four (4) rural and remote HHSs
- A Director of Nursing from a rural and remote HHS
- A Director of Oral Health or Principal Dentist
- A nominee from the Royal Australian College of General Practitioners (RACGP)
- A nominee from the Australian College of Rural and Remote Medicine (ACRRM)
- A nominee from the Australian and New Zealand College of Anaesthetists (ANZCA)
- A nominee from the Royal Australian and New Zealand College of Obstetrics and Gynaecologists (RANZCOG)
- A nominee from the Royal Australasian College of Medical Administrators (RACMA)
- Medical representative of the RFDS
- Medical representative of Apunipima - Cape York Health Council

Co-opted Membership

- A nominee of a relevant professional Specialist College or association as accredited by the Australian Medical Council (AMC);
- Medical representative of any NGOs

Proxies

- Persons officially acting and briefed in a Members' position and approved proxies are expected to attend the meeting on behalf of the member, participate in committee deliberations and contribute to committee recommendations according to the principles outlined in these terms of reference.

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[1] The Torres and Cape HSCE has delegation to approve statewide SoCP only in general practice for RFDS medical officers. RFDS medical officers providing retrieval services receive a statewide SoCP processed by the Department of Health Credentialing and SoCP Committee.

[2] The Torres and Cape HSCE has delegation to approve statewide SoCP for medical practitioners engaged by the Queensland Country Practice Senior Reliever program.

At least one committee member is to be familiar with the requirements of the Queensland Health recruitment and selection process in accordance with the provisions of *Human Resource Policy B1 (QHPOL-212), Recruitment and Selection (July 2016)*[3]. The committee is empowered to access senior human resource advice, as appropriate.

The Committee must access medical practitioners and dentists with the specific clinical skills and experience relevant to the SoCP being requested.

The Committee may co-opt additional practitioners with specific clinical skills and experience relevant to a specific SoCP being requested, or to provide expert advice when required. Such advice may be provided in person at the meeting or in writing prior to the meeting.

If a nominee is not able to attend the meeting, the Chair will request their input/opinion in writing prior to the meeting.

5. Quorum

A quorum will comprise of at least five (5) core members (including the Chair). This should include at least one (1) Medical Practitioner with rural and remote experience.

If a quorum cannot be formed, applications requiring urgent consideration may be electronically circulated and endorsed with Flying Minutes.

6. Out of Session Applications

Urgent applications for credentialing and SoCP may be considered by the Committee via Flying Minute. Endorsement of the Flying Minute requires endorsement by a minimum of five (5) core members. At least one of the four (4) EDMSs of the rural and remote HHSs must endorse the Flying Minute.

7. Length of appointments to the Committee

Membership of the Committee will be for a term of three (3) years with reappointment in ex-officio roles. Other appointments are three (3) years.

8. Role and Function

The Committee will at all times conduct itself in accordance with the *Code of Conduct for the Queensland Public Service*[4], relevant legislation including but not limited to legislation relating to privacy, trade practices, equal opportunity and defamation.

The Committee will:

- follow the established terms of reference, written protocols, procedures and guidelines for the evaluation of credentials and defining the scope of clinical practice as stipulated in the Credentialing and defining the scope of clinical practice for medical practitioners and dentists; a best practice guideline[5] and local HHS procedures

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[3] https://www.health.qld.gov.au/__data/assets/pdf_file/0034/635893/qh-pol-212.pdf

[4] https://www.qld.gov.au/gov/code-conduct-queensland-public-service

[5] https://www.health.qld.gov.au/__data/assets/pdf_file/0035/670976/qh-gdl-390-1-1.pdf

- assess and review credentials and recommend appropriate SoCP for each applicant to the HSCE
- observe confidentiality throughout its processes

9. Requirement to comply with principles of natural justice and procedural fairness

The Committee's determinations and deliberations must at all times be carried out in accordance with the principles of natural justice and procedural fairness. The Committee must act fairly, in good faith and without bias or perception of bias.

Practitioners are entitled to a hearing free of prejudice before any decision is made or implemented, which limits SoCP in a way which affects their practice or employment.

The Committee must ensure that practitioners know what allegations/claims are made against them and that all relevant documents which are being considered by the Committee are disclosed in a timely manner to the parties concerned. Practitioners are given sufficient opportunity to prepare their response and adequately state their case.

10. Managing declarations of interest

All members of the Committee must *ab initio* declare any interests, and if potential or actual conflicts are identified these conflicts be appropriately managed, in consultation with the Chair in accordance with the *Code of Conduct for the Queensland Public Service* [6]. Appropriate management may include, but not limited to, declaring the interest, recusal from the meeting, or resignation from the Committee.

When a member is recused from deliberations at a meeting:

- he/she must physically leave the meeting, and must not take any action to influence the Committee's deliberations
- the reason for that recusal should be documented in the meeting minutes

11. Documentation / written procedures

The committee, in consultation with the relevant HHS, must develop written procedures for dealing with the process of assessment of credentials and delineation of SoCP for medical practitioners and dentists. Any documents obtained or created by the Committee will be accessible under Right to Information Act 2009 (subject to the exemptions specified in that Act) and other court processes, for example, subpoena. The outcome of the credentialing processes, including deliberations and minutes and the credentialed status of the practitioner, will be stored and maintained for at least 40 years and must be accessible as per the provisions of the *Health Sector (Corporate Records) Retention and Disposal Schedule*[7].

12. Education and training

Prior to appointment, core committee members must be provided with education and training to assist them in their role on the Committee. Members must be informed it is their responsibility to bring to the Committee their professional clinical experience and expertise, rather than to act in a way that represents their own personal interests or that of any nominating organisation.

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[6] https://www.qld.gov.au/gov/code-conduct-queensland-public-service

[7] *Health Sector (Corporate Records) Retention and Disposal Schedule, 'Specialised Training and Accreditation, Credentialing and scope of clinical practice'*
https://qheps.health.qld.gov.au/csd/business/records-and-information-management/disposing-of-records/general-retention-and-disposal-schedulem

13. Credentialing of Chair and committee members

Where the credentials and SoCP of any member of the Committee are being considered, that member shall recuse themselves from participation in those deliberations.

When the credentials of the Chair are being reviewed, the Chair will recuse himself/herself from the meeting and an EDMS from one of the other rural and remote HHSs will assume the role of Chair.

14. Indemnity of committee members

Members of committee are indemnified in accordance Queensland Health indemnity arrangements[8].

15. Secretariat

Rural and Remote Clinical Support Unit staff undertake the Secretariat functions for the Committee.

16. Frequency of Meetings

The Committee will meet every month or more frequently if necessary. The dates of all regular meetings will be set and distributed to members at least six (6) months in advance.

17. Method of Meeting

The meetings will be conducted in person or via tele-conference/video conference.

18. Agenda

Agenda items are to be received by the Secretariat at least ten (10) business days prior to the meeting. The Agenda will be distributed at least five (5) business days prior to the meeting.

19. Minutes

Minutes will be endorsed by the Chair within two (2) business days of the meeting.

Minutes will be distributed to HHSs with draft letters within four (4) business days of the meeting.

Minutes will be tabled at the next Committee meeting for endorsement.

Meetings will be recorded via Teams for minute taking purposes. Once the minutes have been confirmed at the following meeting, these recordings will be deleted.

20. Performance Monitoring and Evaluation

The performance of the Committee will be evaluated using the following criteria:

- Annual review of the Terms of Reference
- Annual performance evaluation of the committee and its core members
- An independent audit of the Committee processes will be conducted every two (2) years.

21. Review Period:

12 months from the initial approval, March 2010

Reviewed: June 2010

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[8] Indemnity for Queensland Health employees, HHS employees and other persons covered under Queensland Health or HHS Indemnity policies will be covered by the terms of those policies. Where this member is a non-Queensland Health employee, an application for indemnity would be considered on a case-by-case basis, subject to the same eligibility considerations that apply to a Queensland Health employee. http://qheps.health.qld.gov.au/hr/employment-conditions/policies/i-other.htm

Endorsed: July 2010

Reviewed: July 2011

Endorsed: August 2011

Reviewed: August 2012

Reviewed: September 2012

Endorsed: October 2012

Reviewed: July 2013

Endorsed: September 2013

Reviewed: August 2016

Reviewed: September 2016

Reviewed: December 2016

Committee endorsement: January 2017

Reviewed HSCEs: February 2017

Reviewed EDMSs: March 2017

Reviewed HSCEs: May 2018

Reviewed EDMSs: May 2018

Committee endorsement: May 2018

Reviewed EDMSs: May 2019

Committee endorsement: July 2019

Reviewed HSCEs: July 2019

Reviewed EDMSs: June 2020

Committee endorsement: July 2020

HSCEs: August 2020

Reviewed EDMSs: August 2021

Endorsement:

	Date	Signature
Beverley Hamerton Health Service Chief Executive Torres and Cape HHS		
Jane Hancock Health Service Chief Executive Central West HHS		
Karen Murphy Health Service Chief Executive North West HHS		
Anthony Brown Health Service Chief Executive South West HHS		

RG RECOGNITION TASKFORCE STATEMENT ON THE MOD MED FINAL REPORT FOR POSTGRADUATE STANDARDS, CURRICULJM AND ASSESMENT FRAEMWORK WORKING GROUP OF THE NATIONAL RURAL GENERALIST PATHWAY TASKFORCE

This Report was commissioned by the National Rural Health Commissioner as part of the broad range of consultation and scoping activities that informed the National Rural Generalist Taskforce Advice tabled with the Parliament of Australia in 2019.

Permission has been obtained from the Department of Health to include this Report with our Application to the Australian Medical Council.

The essential purpose of the Report was to assess the feasibility of the two colleges' curricula providing a national educational standard which would become the basis for a nationally consistent, quality-assured pathway for a Rural Generalist workforce. Notably, the document recognises the capacity of the two different educational approaches to contribute to a consistent educational standard for Rural Generalist practitioners.

The two general practice colleges were involved with the development of the paper through their representatives on relevant Taskforce working groups and committees. The document has been reviewed by the Specialist Recognition Taskforce members in 2022 and in the light of this more recent review, continue to support the general principles of the document.

With this general support, the RG Recognition Taskforce would like to make the following points of clarification regarding changes to their respective curricula that have occurred since the publication of this Report.

The following changes related to the ACRRM curriculum have occurred since the Report's publication:

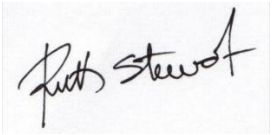
- The Primary Curriculum and Advanced Specialised Training Curricula have been combined into a single curriculum, the ACRRM Rural Generalist Fellowship Curriculum. This has been reviewed through the AMC accreditation processes.
- 'Table 1: Curriculum Framework Structures' refers to terms used in ACRRM curriculum. Two of these are not accurate. "Abilities" are now referred to as "Competencies"; the term "Advanced Skills" is not used, rather "Advanced Specialised - knowledge, skills or attributes")
- 'Table 3: Approximate mapping of Domains of RACGP, ACRRM, and Rural Generalism curricula' - refers to the ACRRM Primary Curriculum which has been superseded by the ACRRM Rural Generalist Curriculum (which incorporates the primary curriculum and the AST curricula). The eight domains are:
  1. Provide expert medical care in all rural contexts
  2. Provide primary care
  3. Provide secondary medical care
  4. Respond to medical emergencies
  5. Apply a population health approach
  6. Work with Aboriginal, Torres Strait Islander, and other culturally diverse communities to improve health and wellbeing
  7. Practise medicine within an ethical, intellectual, and professional framework
  8. Provide safe medical care while working in geographic and professional isolation

The following changes related to the RACGP curriculum have occurred since the Report's publication:

- The Fellowship in Advanced General Practice (FARGP) has been replaced by the RACGP Rural Generalist Fellowship (FRACGP-RG) which has been designed to align with the National Rural Generalist Pathway.
- The Advanced Rural Skills were renamed Additional Rural Skills Training (ARST) and the curricula were revised and updated.
- The strengthened Core–Emergency Medicine Training was introduced as a mandatory component of the RACGP Rural Generalist Fellowship in 2021 to replace the FARGP's Emergency Medicine Module.
- The new Rural Generalist curricula have a progressive assessment approach and a suite of workplace-based assessments.
- The RACGP Curriculum and Syllabus have also been updated and recently published on the RACGP website
- Our current definition and purpose of rural generalist training is aligned with the Collingrove agreement which defines a Rural Generalist as:

> *"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 specialist care in hospital and community settings as part of a rural healthcare team. Rural generalists work to the full scope of their practice with skill sets that are informed by the needs of the community they serve."*

The Rural Generalist Recognition Taskforce is a representative forum chaired by the National Rural Health Commissioner to provide oversight of the joint application to the Medical Board for Recognition of Rural Generalist Medicine as specialist field of general practice. It includes senior representatives of the two general practice colleges.



Adj. Prof Ruth Stewart
Chair
Rural Generalist Recognition Taskforce

Dr Mike Beckoff

Dr Michael Clements

Ms Marita Cowie

A/Prof Ewen McPhee

Dr Ken Wanguhu

Mr Paul Wappett

MODERNISING LEARNING YOUR WAY MOD MED

FINAL Report

For the Postgraduate Standards, Curriculum and Assessment Framework (PSCAF) working group.

To support the development of a National Rural Generalist Pathway

CONFIDENTIAL

INDEX

CONTIBUTORS

Name	Position	Project Role
Professor Lambert Schuwirth	Professor of Medical Education Director Prideaux Research Centre Health Professions Education at Flinders University	Lead consultant Standards Assessment
Professor Richard Hays	Professor, Remote Health and Medicine Adjunct Professor at James Cook University	Curriculum
Associate Professor Jill Benson AO	Senior Medical Educator ModMed Limited	EPAs
Dr Nyoli Valentine	Senior Medical Educator ModMed Limited	EPAs
Ms Stephanie Clota	CEO ModMed Limited	Project Manager

CONFIDENTIAL

INTRODUCTION

The Taskforce for the development of a National Rural Generalist Pathway has been established to oversee and coordinate the results of various working groups. One of these is the Postgraduate Standards, Curriculum and Assessment Framework (PSCAF) working group co-chaired by Associate Professor David Campbell from ACRRM and Mr Mark Rowe from the RACGP. The task set out for this working group has been defined as:

Define nationally consistent Rural Generalist educational standards and identify a relevant curriculum and assessment framework applicable for the qualifications required to support the Pathway.

With the key outcome of:

Framework documents for use by Colleges and Jurisdictions to guide their training policies.

As consultants to the PSCAF working group we have been engaged to produce *this report in order to provide the key principles to inform the design and development of the following:*

- *Nationally consistent rural generalist post graduate educational standards applicable to the qualifications required to support the National Rural Generalist Pathway*
- *Curriculum framework applicable to the qualifications required to support the National Rural Generalist Pathway*
- *Assessment framework that covers contemporary methods of work based assessment such as programmatic assessment for learning, incorporating Entrustable professional activities applicable to the qualifications required to support the National Rural Generalist Pathway*

The consultancy group are clear that the final decision making and responsibility for the documents that will be provided to the Task Force lies with the PSCAF working group and Taskforce.

Therefore the deliverable for the consulting is intended to be supportive to this remit, it is not intended to be prescriptive or interfering to the responsibilities of the PSCAF working group, Taskforce or Colleges.

The following principles are based on best evidence in medical education and need to be applied within the rural generalist context.

Following the delivery of this FINAL report (and subsequent versions), the consultancy group are available to provide support and expertise as required by the PSCAF working group in the advancement of these objectives.

KEY PRINCIPLES

STANDARDS

Key principles to support the development of a standards definition for a National Rural Generalist Pathway

Preamble

'Standard' can mean two things, standards for the quality of the curriculum including the assessment program or standards for performance of the registrars. The latter is part of the discussion about the assessment program and therefore this document will pertain to standards for the quality of education.

Introduction

The Australian Medical Council (AMC) has assessed and accredited specialist medical education and training and professional development programs since 2002. The AMC develops accreditation standards, and assesses programs against those standards. The Medical Board of Australia approves accredited programs of study for the purposes of registration.

The Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) are the two specialist medical colleges accredited by the AMC to provide specialist training for general practice in Australia and are responsible for setting and arbitrating the standards for general practice in Australia. Both Colleges have specialist medical training standards that meet the standards as determined by the AMC. General practice training in Australia is delivered by training providers. These are the Regional Training Organisations (RTOs) funded by Commonwealth Department of Health and the independently funded Remote Vocational Training Scheme.

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The RTOs deliver training according to the Colleges' standards and assess supervisors and teaching posts against the RACGP and ACRRM standards.

In order to deliver this training, RTOs must be accredited by the Colleges against the Colleges' standards.

Background for educational standards

Quality standards can be set in two ways: regulating the quality of the process or regulating the quality of the outcome. [1]

Modern educational views around standards regulating the quality of the outcome takes precedence. This implies logically that the educational and assessment processes in the curriculum should be fit-for-purpose and best-evidence based. The recurring question in quality control is therefore: how will the educational processes lead to an optimal development of competence and what is the best available evidence for this?

Quality and its standards are not unidimensional and aspects are all related to each other. A helpful framework for standards has been developed for assessment programs but it is completely translatable to educational standards[2]. It consists of five dimensions and three boundary conditions.

Boundary conditions

1 Goal orientation

A program has to have clearly defined goals or outcomes. These can originally be phrased in a generic and rather abstract way: for instance: "safe independent practitioner" but in the development of the program this overarching goal will have to be continually operationalised to deeper levels, to the level of EPA or modular learning outcomes.

2 Infrastructure

The infrastructure defines the so-called affordances of the educational program; it defines what the stakeholders (the users of the program – educational designers, education specialists, administrative staff, supervisors and registrars-) are allowed/supported to do and what they are not allowed/supported to do. The infrastructure has to be such that it fully and intuitively supports the educational and assessment goals as well as the educational and assessment philosophy.

[1] An illustration of both views is how quality of the provision of feedback is seen. From a process point of view a quality criterion could be that it has to be a dialogue or that it has to start with 2 positive points. From an outcome point of view the quality criterion would be that it optimally supports learning (so it can be a one-way street in some situations or you can start with negative points)

[2] Dijkstra J, Van der Vleuten C, Schuwirth L. A new framework for designing programmes of assessment. *Advances in health sciences education* 2010;15. :379–93. doi: 10.1007/s10459-009-9205-z

3 Stakeholders

The stakeholders define the so-called effectivities; what the stakeholders of the program are able to do and what not. Typically, this pertains to the quality of staff development and allotted time and resources for the stakeholders to work within the program.

Dimensions

1 Program in action

This part of the standards defines the quality of the individual education processes and how they are aligned to each other. For instance, a training curriculum focusing at competencies that require continuous development but which is modular (individual time-based modules) is not aligned with its purpose, even when the individual modules are each of outstanding quality. A curriculum that wants to recognize prior learning activities or employs a programmatic assessment for learning approach but is not flexible in time or content cannot succeed. All elements of the program in action need to be in constructive alignment and purposeful with regard to the overall generic outcomes.

2 Support for the program

Education happens through interaction (or reflection as an interaction with oneself) and therefore the focus of the stakeholders need to be on the on the interaction. Therefore, the organisation of the curriculum needs to be such that it optimally supports the learning interaction. This pertains to technical support (learning management system, e-portfolio), capacity building but also to legal support. Finally, knowledge brokerage needs to be included to ensure that the curriculum remains up-to-date and best-evidence based.

3 Documenting the program

Transparency is essential for optimisation of quality standards. Clear documentation and well-organised communication between the stakeholders is part of standards in this domain. But so are the rules and regulations. Especially, here the rules and regulations have to show integrity in that they communicate the boundaries within which the goals of the curriculum will be met. Integrity of that 'message' is essential. Overly controlling rules and regulations will for instance stifle assessment for learning as they never transfer the agency for self-regulation of learning and assessment to the registrar and thus do not prepare the registrar for safe **independent** practice.

4 Improving the program

A good curriculum needs to improve on a continuous basis and therefore the organisation needs to have a quality control program and a quality improvement process. These in itself need to be evidence-based and designed according to best practice. The standard questionnaire for instance no longer suffices as the single quality control instrument in education, but the information needs to be triangulated with a multitude of other sources. Just measuring/evaluating the quality and design QI plans of action will not work unless change management strategies are in place as well.

These strategies need to be adapted to the magnitude of change – small changes that do not disrupt the organisational culture are easy to implement, whereas larger changes that do disrupt the organisational culture require careful planning.

5 Accounting of the program

Like any good business conducts fundamental and applied research to continually improve its product, so does a curriculum (or the organisation which hosts the curriculum). This does not only entail scientific research but also scholarly audits of the curriculum, economic evaluations (is the program still optimally cost-effective) and evaluations of political and legal acceptability.

General

In all these domains each decision needs to be accountable in that there has to be a clear rationale with respect to the following questions:

Is the educational activity the most effective?

- Is it based on the literature instead of on opinion or tradition?
- Is the best evidence-based?

Is the educational activity the most efficient?

- Is it most cost- efficient?
- Is it most time efficient?

What were the reasons for any adaptations to the local contexts?
How does the educational activity contribute to the achievement of the overall goals of the curriculum?
How does it align with adjacent educational activities?

Discussion points

Does the working group agree with a fit-for-purpose approach to standards development?
How to adapt these guidelines from the literature – which were for assessment programs – to the curriculum standards.
Which of the standards from both Colleges can be used, adapted or combined with those from the literature…

APPENDIX A:

Guidelines for the development of quality standards (for assessment programs) as an illustration for guidelines for the development of quality standards for an RG program

GENERAL GUIDELINES

I Decisions (and their consequences) should be proportionate to the quality of the information on which they are based.

II Every decision in the design process should be underpinned preferably supported by scientific evidence or evidence of best practice. If evidence is unavailable to support the choices made when designing the programme of assessment, the decisions should be identified as high priority for research.

III Specific expertise should be available (or sought) to perform the activities in the programme of assessment.

PURPOSE OF THE PROGRAMME

A1 One principal purpose of the assessment programme should be formulated.

A2 Long-term and short-term purposes should be formulated. But the number of purposes should be limited.

A3 An overarching structure which projects the domain onto the assessment programme should be constructed.

INFRASTRUCTURE

A4 Opportunities as well as restrictions for the assessment programme should be identified at an early stage and taken into account in the design process.

A5 Design decisions should be checked against consequences for the infrastructure. If necessary compromises should be made, either adjusting the purpose(s) of the assessment programme or adapting the infrastructure.

STAKEHOLDERS

A6 Stakeholders of the assessment programme should be identified and a rationale provided for including the expertise of different stakeholders (or not) and the specific role(s) which they should fulfil.

A7 The level at which various stakeholders participate in the design process should be based on the purpose of the programme as well as the needs of the stakeholders themselves.

PROGRAMME IN ACTION

Collecting Information

B1 When selecting an assessment component for the programme, the extent to which it contributes to the purpose(s) of the assessment programme should be the guiding principle.

B2 When selecting an assessment (component or combination), consideration of the content (stimulus) should take precedence over the response format.

B3 The assessment should sample the intended cognitive, behavioural or affective processes at the intended level.

B4 The information collected should be sufficiently informative (enough detail) to contribute to the purpose of the assessment programme.

B5 The assessment should be able to provide sufficient information to reach the desired level of certainty about the contingent action.

B6 The effect of the instruments on assessee behaviour should be taken into account.

B7 The relation between different assessment components should be taken into account

B8 The overt and covert costs of the assessment components should be taken into account and compared to alternatives.

B9 Assessment approaches that work well in a specific context (setting) should first be re-evaluated before use in another context (setting) before implementation.

B10 A programme of assessment should deal with error and bias in the collection of information. Error (random) is unpredictable and should be reduced by sampling (strategies). Bias (Systematic) should be analysed and its influence should be reduced by appropriate measures.

B11 Any performance categorisation system should be as simple as possible.

B12 When administering an assessment (component), the conditions (time, place, etc.) and the tasks (difficulty, complexity, authenticity, etc) should support the purpose of the specific assessment component.

B13 When scheduling assessment, the planning should support instruction and provide sufficient opportunity for learning.

Combining Information

B14 Combination of the information obtained by different assessment components should be justified based on meaningful entities either defined by purpose, content, or data patterns.

B15 The measurement level of the information should not be changed.

B16 The consequences of combining information obtained by different assessment components, for all stakeholders, should be checked.

Valuing Information

B17 The amount and quality of information on which a decision is based should be in proportion to the stakes.

B18 A rationale should be provided for the standard setting procedures.

Taking Action

B19 Consequences should be proportionally and conceptually related to the purpose of the assessment and justification for the consequences should be provided.

B20 The accessibility of information (feedback) to stakeholders involved should be defined.

B21 Information should be provided optimally in relation to the purpose of the assessment to the relevant stakeholders.

SUPPORTING THE PROGRAMME

Construction Support

C1 Appropriate central governance of the programme of assessment should be in place to align different assessment components and activities.

C2 Assessment development should be supported by quality review to optimise the current situation (Programme in Action), appropriate to the importance of the assessment.

C3 The current assessment (Programme in Action) should be routinely monitored on quality criteria.

C4 Support for constructing the assessment components requires domain expertise and assessment expertise.

C5 Support tasks should be well-defined and responsibilities should lie with the right persons.

Political and Legal Support

C6 The higher the stakes, the more robust the procedures should be.

C7 Procedures should be made transparent to all stakeholders.

C8 Acceptance of the programme should be widely sought.

C9 Protocols and procedures should be in place to support appeal and second opinion.

C10 A body of appeal should be in place

C11 Safety net procedures should be in place to protect both assessor and assessee.

C12 Protocols should be in place to check (the programme in action) on proportionality of actions taken and carefulness of assessment activities.

DOCUMENTING THE PROGRAMME

Rules and Regulations (R&R)

D1 Rules and regulations should be documented.

D2 Rules and regulations should support the purposes of the programme of assessment.

D3 The impact of rules and regulations should be checked against managerial, educational, and legal consequences.

D4 In drawing up rules and regulations one should be pragmatic and concise, to keep them manageable and avoid complexity.

D5 R&R should be based on routine practices and not on incidents or occasional problems.

D6 There should be an organisational body in place to uphold the rules and regulations and take decisions in unforeseen circumstances.

Learning Environment

D7 The environment or context in which the assessment programme has to function should be described.

D8 The relation between educational system and assessment programme should be specified.

Domain Mapping

D9 A domain map should be the optimal representation of the domain in the programme of assessment.

D10 A domain map should not be too detailed.

D11 Starting point for a domain map should be the domain or content and not the assessment component.

D12 A domain map should be a dynamic tool, and as a result should be revised periodically.

IMPROVING THE PROGRAMME

R&D

E1 A regular and recurrent process of evaluation and improvement should be in place, closing the feedback loop.

E2 If there is uncertainty about the evaluation, more information about the programme should be collected.

E3 In developing the programme (re-design) again improvements should be supported by scientific evidence or evidence of best practice.

Change Management

E4 Momentum for change has to be seized or has to be created by providing the necessary priority or external pressure.

E5 Underlying needs of stakeholders should be made explicit.

E6 Sufficient expertise about change management and about the local context should be sought.

E7 Faculty should be supported to cope with the change by providing adequate training

JUSTIFYING THE PROGRAMME

Effectiveness

Scientific Research

F1 Before the programme of assessment is designed, evidence should to be reviewed.

F2 New initiatives (developments) should be accompanied by evaluation, preferably scientific research.

External Review

F3 The programme of assessment should be reviewed periodically by a panel of experts.

F4 Benchmarking against similar assessment programmes (or institutes with similar purposes) should be conducted to judge the quality of the programme.

Efficiency: *cost-effectiveness*

F5 In order to be able to justify the resources used for the assessment programme, all costs (in terms of resources) should be made explicit.

F6 A cost-benefit analysis should be made regularly in light of the purposes of the programme. In the long term, a proactive approach to search for more resource-efficient alternatives should be adopted.

Acceptability: *political-legal justification*

F7 Open and transparent governance of the assessment programme should be in place and can be held accountable

F8 In order to establish a defensible programme of assessment there should be one vision (on assessment) communicated to external parties.

F9 The assessment programme should take into account superseding legal frameworks.

F10 Confidentiality and security of information should be guaranteed at an appropriate level.

KEY PRINCIPLES

CURRICULUM

Key principles underpinning the development of a national curriculum framework for a Rural Generalist Pathway

A shared and agreed understanding is essential of the definition and scope of practice of positions with the title 'Rural Generalist' (RG) within the medical profession.

This document begins with definition provided in the 'Collingrove Agreement' of February 2018 [1]:

A Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care 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 specialist care in hospital and community settings as part of a rural healthcare team.

It is important to note that, while this definition is general enough to be meaningful across Australia, there may be substantial variations by region and/or State in the precise roles played by RGs in the local health care system. More details are provided below.

RG Training should be implemented through existing College training pathways.

The two current pathways are those of the Royal Australian College of General Practitioners (RACGP) Fellowship in Advanced Rural general Practice (FARGP) and the Australian College of Rural and Remote Medicine (ACRRM) [2, 3]. These pathways include an additional 12 months of training in an approved Advanced Skill specialty. Both pathways allow trainees to achieve the requirements of Rural generalist roles, although the additional urgent care/emergency skills are not mandatory in the FARGP. It is unlikely that any other College training program

could provide the breadth of training routinely provided by the two Colleges approved to award qualifications that confer eligibility for recognition as a general practitioner. Establishing a new training pathway, independent of the two relevant Colleges, is likely to represent inefficient use of scarce health system funding. Instead, both Colleges should have the opportunity to ensure equivalence of opportunity for registrars to achieve agreed RG learning outcomes.

All necessary curriculum components are likely to be currently available.

The most likely sources are the RACGP/FARGP and ACRRM training programs' curricula [4-6]. Several Advanced Skill specialty components have been developed jointly by one or both of these Colleges with the collaboration of several other specialist Colleges, and some have Australian Medical Council (AMC) accreditation. Therefore, advanced skills training may result in qualifications that are recognised jointly two or three Colleges and the AMC and have post-certification professional support pathways. . Although only 6 months experience may be required in some disciplines, particularly as 'secondary' advanced skills, 12 months is the usual period because of hospital employment arrangements, and advanced skills training in surgery requires 24 months. Not all potential advanced skills training options have yet achieved this status. Some outstanding issues require resolution regarding content, training responsibility and certification of attainment.

Combine rural medical education strategies, wherever possible.

The longitudinal cohort study of James Cook University medical graduates has demonstrated the impact of combining undergraduate strategies such as selection of rural background students, ruralised curriculum and assessment, rural role models and mentors and longer rural placements [7]. Further, evaluation of RG training in Queensland has shown that a similar range of factors correlate with enhanced rural workforce outcomes [8]. These includes: early (undergraduate) identification as a likely RG; strong mentorship by more senior RGs, mandatory emergency medicine training with additional courses/certification; and opportunities for a 'secondary' period of advanced skills training in a relevant and approved specialty. However, any RG program must be capable of training medical graduates from any undergraduate medical program and provide the appropriate curriculum framework and assessment that prepares RG graduates for their future roles.

The Curriculum Framework must be adaptable to the health care systems of all States and Territories.

Current RG developments have been driven primarily by and within State Health departments, initially Queensland Health, to address specific workforce needs. Queensland employs a substantial 'public' full-and part-time medical workforce in many small hospitals in relatively remote communities. Other States have different models of rural health care delivery, often relying on Visiting Medical Officers and federal funding via Medicare agreements. This may have introduced 'health system bias' into current models. A successful national Curriculum Framework must have meaningful application to all State and Territory Health systems.

RG training and career positions should reflect community health care needs.

Currently, training positions that fit the RG pathways are more available in popular, generally procedurally oriented, disciplines, such as Obstetrics, Anaesthesia and Emergency Medicine. However, a majority of graduates with advanced skills in these procedural disciplines do not continue to practice those skills. The most common reasons are that the communities where RG graduates live and work either do not have health service configurations that require those skills or have no vacant positions. In many communities, needs may be greater in several disciplines that are currently less popular, such as mental health, palliative care, adult medicine, and addiction medicine. Specific needs may vary between communities and allocation of RG training opportunities should be linked to local community needs analyses. A case for this has been made for the Tasmanian RG training pathway, based on consultation with health professionals and community leaders. While there may be 'core' advanced skills that all RGS should acquire, emphasis should be placed on developing *teams* of RGs with complementary Advanced Skills specialty expertise that could be available by referral within the teams. Ideally more than one RG in some specialties should be present to provide professional support and cover during leave. It may be prudent to plan training with a particular community and timeframe in mind, particularly where service gaps may be predictable due to expected changes in workforce and/or service configuration.

RG advanced skills training and career positions should be available in both hospital and community-based, rural contexts.

Only a minority of patient journeys require contact with hospitals, even in smaller communities. "Hospitalist' models of RG training risk producing RGs with limited GP experience, confidence and competence. RG training should include substantial community-based experiences and RG positions should be part of community-based services in a range of Advanced Skill specialties. The intention should be to enhance local community and hospital services that minimise the need for referral to distant, narrower specialist services. In combination with telehealth consultations and visiting services, local sources of greater expertise in a wide range of Advanced Skill disciplines has the potential to improve local medical care.

The entire RG program should be experienced in regional, rural and remote communities.

Regional hospitals often provide more appropriate experiences than large teaching hospitals. Until Advanced Skill training posts are more widely available across the country, RG trainees may benefit from moving to take up a training position elsewhere. This should not require a change of Training Provider or College Training Program. Ideally, all primary care training should be provided in rural and remote communities, as this anchors training in the relevant context of future practice. A recent report from New Mexico showed that combining undergraduate and specialty training in that State double the retention of medical graduates, when compared to undergraduate alone [9]. While rural programs have not been running long enough or in sufficient numbers to demonstrate this in Australia, the power of combining strategies may be similar, and strengthens the need for close collaboration with regional training hubs.

Curriculum learning outcomes should be expressed as Entrustable Professional Activities (EPAs) to align learning with proposed assessment.

Learning outcomes and assessment objectives should be aligned, as in all education programs. Consistent with the proposal to utilize an EPA approach in assessment of RG pathway registrars, the curriculum framework should align with EPAs expected of graduates. EPAs are a form of 'meta-competency' that includes all of the competencies required to perform a particular task.

A proposal for a national Curriculum Framework for Rural Generalism in medicine.

In this section an attempt is made to develop a curriculum framework that matches closely the existing curriculum frameworks of the RACGP and ACRRM, with RG training components emphasized and identified. The two curriculum framework approaches are quite different, making more difficult the task of comparing and mapping content. The RACGP curriculum structure follows a more traditional framework, with five Domains that follow more closely the knowledge, skills, attitudes, populations and context model that is common for medical programs. The terms 'rural' and 'remote' are used infrequently, usually when referring to preparing GPs for multiple contexts, including rural and remote contexts. The FARGP curriculum is an additional component that blends content across all five Domains. The terms 'rural' and 'remote' are present frequently, demonstrating that preparation for practice in rural and remote locations is focused on this additional year and additional Fellowship certification. Nevertheless, general practice without a special interest, additional skills training and/or the FARGP extension still provides eligibility for recognition as a non-RG GP in rural and remote communities. ACRRM bases most of the seven curriculum Domains primarily on context and populations, specifically mentioning the contexts 'rural and 'remote' frequently and throughout the document in all Domains. This demonstrates the integration of this thinking and content throughout the whole ACRRM training program.

The RG curriculum may be expressed best using a different structure, allowing ACRRM and the RACGP to maintain their current curriculum frameworks. Table 1 summarises the curriculum structures of both Colleges and suggests that the national RG pathway have a different, yet to be agreed, structure. Each model has several levels, commencing with a 'purpose' that has been gleaned from College websites and the Collingrove Agreement. These are summarised in Table 2, demonstrating an 'approximate' attempt to map the Domains to each other. Beneath the purpose there are Principles, Domains, Learning Outcomes and then more detailed syllabus, including details of advanced skills training. The principles for RG training have been provided above.

Development of the RG curriculum framework will require substantial effort from engaged stakeholders to agree on the content of the curriculum, based on a common program outcome. The current structures of the RACGP/FARGP and ACRRM curricula are summarised in Table 3, along with a blank column for the RG Domain structure. An example of potential models include a 'roles' based structure, pioneered by the Royal College of Physicians and Surgeons in Canada, known as CANMEDS [10]. Other examples include those of the Royal Australian College of Physicians and the Australian College of Emergency Medicine [11, 12]. These three models are summarized in Table 4, but there are many other models which use different headings to cover a similar range of content and achieve the same curriculum

outcomes. These suggestions are purely to facilitate discussion about the available curriculum frameworks and is not advocating for any particular models. There may be different names and numbers of Domains, so long as it is possible to map all three to the definition of Rural Generalism contained within the Collingrove Agreement.

The third level of a curriculum document is at the level of Learning Outcomes (LOs). Both ACRRM and RACGP/FARGP curriculum documents include explicit LOs/'Abilities' organized by Domains. The proposed RG curriculum would have the same content, expressed a little differently, mapped to roles and EPAs, and located within a differently expressed Domain. Some examples of EPAs already being used in GP training are provided in Appendix 2. Detailed mapping of the three curriculum approaches at learning outcome level will be a substantial task, but is necessary to demonstrate to stakeholders that the relevant and required RG training is possible through both College pathways.

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Table 1. Curriculum Framework structures.

RACGP/FARGP	ACRRM	Rural Generalism
Purpose	Purpose	Purpose
Refers to AGTP documents	Principles	Principles
Domains	Domains	Domains
Competency Outcomes	Abilities	Graduate Outcomes
Advanced skills	Advanced skills	Advanced skills

Table 2. The purpose of training is to produce rural doctors who.....

RACGP/FARGP [2]	ACRRM [r3]	Rural Generalism [1]
'provide first point of contact care; coordinate care and refer patients to other specialists; follow a whole of person approach; see patients of all ages, both sexes, with all disease categories; over a period of patients' lifetime; provide health advice and education; provide legal roles' AND "develop advanced general practice skills specific to rural life in Australia'	*'achieve a broad range of knowledge, skills and abilities needed to be a safe and independent rural general medical practitioner'*	*'meet the specific current and future health care 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 specialist care in hospital and community settings as part of a rural healthcare team.*

Table 3. Approximate mapping of Domains of RACGP, ACRRM and Rural Generalism curricula

RACGP Core Skills Unit Curriculum [5]	**ACRRM Primary Curriculum**[4]	**Rural Generalism (TBC)**
Communication and the doctor-patient relationship	Provide care in the ambulatory and community setting	
Applied professional knowledge and skills	Provide care in the hospital settings	
Population health and the context of general practice	Respond to medical emergencies	
Professional and ethical role	Apply a population health approach	
Organisational and legal dimensions	Address the health needs of culturally diverse and disadvantaged groups	
FARGP: advanced skills in a selected specialty area during an additional training year;	Practise medicine within an ethical, intellectual and professional framework	
	Practise medicine in the rural and remote medicine context	

Table 4. Examples of other curriculum Domain structures for consideration

CANMeds [9]	**RACP** [10]	**ACEM** [11]
Medical expert	Communication	Medical expertise
Communicator	Quality and safety	Prioritisation and decision-making
Collaborator	Teaching and learning	Communication
Professional	Cultural competency	Teamwork and collaboration
Leader	Ethics	Leadership and management
Scholar	Clinical decision making	Scholarship and teaching
	Leadership and management	Professionalism
	Health advocacy	
	Broader context of health	

KEY PRINCIPLES

ASSESSMENT

Key principles underpinning the design of a programmatic assessment for and of learning program for Rural Generalist training

Introduction

Currently many education and training programs are changing their assessment approaches from a traditional end-of-course testing to a programmatic one. The main reason for this is that programmatic assessment is a method that produces more information-rich outcomes and therefore a more rigorous and less arbitrary decision making process. It is often associated with assessment *for* learning which is a way to make assessment an integral part of learning and prepares the learner – in this case the registrar – better for future self-regulation of their assessment and learning.

Programmatic assessment is an approach to collecting and collating information in a more integrated and meaningful way than traditional assessment programs. Although programmatic assessment and assessment for learning are often used in conjunction they are actually different principles.

Elements that are innate to programmatic assessment:

Collection of information about the registrar's performance and progress is done through the use of various assessment instruments.

Collation of information about the registrar and their progress does not happen simply within one assessment instrument.

Information from multiple different assessments and multiple different assessment instruments are triangulated to provide information about how a registrar is performing. For example, poor performance on an abdominal examination OSCE station is compared with information from other assessment instruments – for instance multiple-choice or ECTVs - to better understand why the performance on the abdominal examination station was poor.

This could be because of, for example, lack of practice /poor technique or because of an inability to correlate the clinical symptoms with the right examination to be done. Collection and collation of information happens on a longitudinal and continuous basis to allow better prediction and prognosis of a registrar.

Information is collected and collated, for example in a portfolio, which is periodically discussed between the learner and their supervisor/mentor/coach. The registrar would prepare for these discussions through short written self-reflections.

The principle of proportionality governs decision-making in that limited information about a registrar's performance and progress can only lead to low stakes decisions and for high-stakes decisions rich longitudinal information is needed.

Assessments are typically assessed according to reliability and validity. However, reliability and validity are not purely governed by traditional psychometric methods but are also achieved by organisational measures, such as transparency, documentation, member checking and saturation of information.

In order to successfully implement and sustain programmatic assessment supervisor development must occur. Much of the assessment and decision making in workplace based training, such as the rural generalist program relies on human judgement. It is important that the supervisors who are involved in that assessment and decision-making are sufficiently "assessment – literate" to ensure the rigour in the process. Therefore, the most critical aspect in a successful implementation of programmatic assessment is the aligning staff development and capacity building.

Discussion Points:

- How could programmatic assessment principles be used in a Rural Generalist Training Program?
- What information about the registrar should be collected and how should this be collated and understand in a meaningful way?
- How will decisions about which assessments to be used be made?
- What supervisor development should occur?

Elements that are innate to assessment for learning:

The focus needs to be on providing sufficient and useful feedback to registrar. This is not a natural ability and has to be learnt, so as mentioned above, investment in supervisor training, including in providing feedback is important to teach this skill. This is also an investment in effectiveness and efficiency, because as in any human domain of expertise increase in expertise is associated with an increase of efficiency and effectiveness.

Feedback is not about being nice, but about optimally supporting the learner's development. Feedback is only helpful if it successfully lands in the memory of the learner. So in assessment for learning, measures are taken to ensure that the feedback has been received. This is through the registrar being able to translate this feedback into actionable learning

goals. The supervisor / mentor / coach has a role in teaching the registrar how to do this and make sure that learning goals are not just good intentions.

A combination of summative and formative assessment is difficult to manage. In a highly punitive summative assessment context, formative feedback tends to be ignored by the registrar. Therefore, when trying to design an assessment for learning programme it is essential that the philosophy of development and support for learning informs every design decision in the program. For instance, if mini CEX is used and the scores are used summatively then the feedback and learning goals tend to not be taken seriously by the registrars. In an assessment for learning context the scores would be made formative, and the uptake of feedback and the quality of the actions associated with the learning goals would be the summative aspect of the mini CEX. Such design decisions are essential because they convey the 'hidden curriculum' side of the assessment program to the registrars.

Assessment for learning is therefore not to be confused with purely formative assessment, but instead of using the (numerical) outcomes of assessments, it is the (narrative) quality of the learning activities that form the summative assessments. Of course, this never negates the necessity to make a final decision as to whether a sufficient level of competence has been reached at decision points, but this is based on an accumulation of judgements about the appropriateness and effectiveness of the learning processes.

Discussion Points:

- How can the assessment program ensure there is opportunities for learning?
- How will these opportunities be integrated by the learner?
- How do opportunities for learning complement rather than compete with summative assessment?

General principles around the design of programmatic assessment for learning

Integration

Ideally assessment tasks should require multiple competencies/domains to be performed at the same time for the assessment to be completed successfully. It is therefore important to avoid as much as possible using single-role methods; that is an assessment instrument which is aimed at assessing only one of the competencies/domains. This is important to prevent competition between domains/competencies and to keep registrars from prioritising strategically their activities. The reason for this is that in such 'competitive' programs the 'softer' competencies/domains often receive less attention, and the registrars will not develop them as well as the 'harder' aspects. Given the importance that both the RACGP and ACRRM place on communication, patient-doctor relationship, professional and ethical role, etc. integration of 'soft' and 'hard' skills is essential.

Distinction between modular and longitudinal aspects

Traditionally, assessment programmes have been modular with barrier exams at the end of a course. Now, there has been a tendency to create assessment programs which are only longitudinal. In general, and particularly for a Rural Generalist Pathway, this may not be optimal for a comprehensive assessment program. Any curriculum or development of competence consists of a combination of longitudinal and modular elements.

Typical examples of more longitudinal elements are development of professionalism, communication, cultural awareness and competency, clinical reasoning and resilience. Many of the knowledge and skills based aspects have a more modular character; at some point in time the learner will have to understand the contraindications for medications or intubate an unconscious patient for instance. So, an assessment program which is comprehensive will make a clear distinction between modular aspects and longitudinal aspects but will ensure that clear alignment between both. In a work integrated learning situation, such as the Rural Generalist Pathway, entrustable professional activities are therefore helpful descriptors/criteria to determine both the attainment of modular and longitudinal aspects.

Conjunction

All competencies/domains are equally important and so allowing compensation between competencies/domains would have a negative impact on the credibility of the programme as a whole and should be minimised. It is difficult, for example, to defend that the assessment programme allows a graduate to have poor clinical knowledge but an excellent communicator or vice versa. Therefore, compensation in assessment programs should be used sparsely. This applies not only to compensation between the competencies/domains but also between topics and clinical problems. An assessment programme that allows poor performance in one clinical discipline to be compensated for by good performance in another discipline is therefore also less credible and will not instil the feeling of safety to the public. In summary, conjunction is generally more convincing to stakeholders as an assessment strategy that compensation.

Remediation

Conjunction requires opportunities for remediation so that if a registrar is unable to demonstrate competence in one part of the assessment programme they should be given opportunity to remediate and demonstrate competence after remediation. This is slightly different from the traditional testing approach with single assessment leading to a pass or fail decision. In these cases, the typical consequence of failing is for candidates to resit the whole examination. Resits, however, are weak, fallible and they predicate on false positive decisions (one sided regression to the mean). Low performance needs to be associated with targeted remediation until the issue is mastered. A clinical analogy of this is that a resit is repeating a whole battery of lab tests because one result was abnormal, but targeted remediation is treating the patient and only repeating the specific lab test to see whether the therapy was useful.

Proportionality

Assessment programs should have proportional consequences. The risk of disproportional consequences to minor offences is that such penalties often become paper tigers and are seldom fully imposed. Failing a term because the registrar was two days late in doing their multi-source feedback looks very 'strong' on paper but when it is not imposed (because it is too draconic or would not hold up in court) it is therefore a waste of time, money and paper. Another example of where disproportionality works (but is more generally accepted) is the registrar who fails a test but would have passed if s/he had answered one extra item correctly (so the near misses). Proportional consequences are easier to impose and therefore are stronger. Small issues should results in 'nuisances', larger in 'unpleasant tasks', and patterns or serious offences in high-stakes consequences.

Self-responsibility with accountability

Responsibility for the successful completion of the curriculum and the assessment programme should reside with the registrar and not entirely with the organisation. Rules and regulations should therefore (with proportionality) be such that the registrar is the one who is made to assume responsibility for poor development or performance and who takes accountability for it.

Unpredictability

Assessment needs to be fair, the rules and regulations and quality assurance processes need to be transparent but assessment does not need to be predictable. There is little reason to let the candidate know beforehand what the content - even if only at the level of blueprint or matrix domains - or what the pass mark should be. The goal of the curriculum is to make every registrar the best possible rural generalist that they can be, and assessment should support this and not stimulate strategic study behaviour.

Credibility

Outcomes of education and assessment are very hard to define, much like the outcome of the healthcare process. 'Health' cannot be defined and neither can 'safety' or 'competence'. That does not mean that it cannot be assessed, because just as 'health' can be evaluated (and improved), competence and safety can be evaluated and improved. However, the concept of 'health' has changed over time, and the concept of a 'safe' and 'competent' doctor has similarly changed[3]. Assessment must therefore be such that it convinces people and is demonstrated to be credible. This comes partly from psychometric procedures (such as reliability, construct validity) but also from the credibility of the processes and procedures. The same applies for an assessment program, sometimes sheer psychometric data sometimes through due process and transparency.

[3] Hodges B. (2006). Medical education and the maintenance of incompetence. Medical Teacher, 28(8), 690-696.

Learning focused

It is a generally held belief that assessment drives learning, but when reviewing the literature it seems to be mostly focused at how assessment drives study ***behaviour***[4]. Up until recently, the theoretical models used to study this were strongly influence by behaviourist theories. Behaviourist theories assume that the behaviour is shaped by external influences (such as assessment) and not a response to internal thoughts or feelings of the registrar (such as an interest in the topic). However this, is conflicting with other educational theories which are mainly constructivist. Constructivist theories assume the registrar "constructs" their own knowledge on the basis of what they already know, making judgements about when and how to modify their knowledge. What this means is that modern education is more aimed at instilling *learning* for the registrar instead of *teaching* of the teacher. However we traditionally use assessment to drive *studying behaviour* instead of *learning*.

Modern assessment programs are designed to optimise their influence on the learning of the trainee rather than just driving study behaviour[5]. They are strongly based on evidence about developing registrars into experts as it emerges from the cognitive psychological literature. In addition, educational theories such as transformative learning theory are applied. Where the former explains better how people gather knowledge, skills, problem solving ability, communication skills, etc., the latter focuses more on how people mature and develop from learners who are able to function and feel comfortable when they are uncertain.

Discussion Points:

- Which if these principles need to be included in the design of the assessment program

Design of the program

There are several starting points that can be used to define quality of an assessment program, some may be based on conviction, values and beliefs and thus define quality as the extent to which the program supports those values. For the design of the program for a Rural Generalist Pathway, a pragmatic or utilitarian definition of quality should be used such as the extent to which the program achieves its stated purposes or optimises learning and ensures readiness for practice as a rural generalist.

The literature identifies five dimensions for the design and quality evaluation of programmatic assessment programmes[6]

[4] Cilliers FJ, Schuwirth LWT, Adendorff HJ, et al. The mechanisms of impact of summative assessment on medical students' learning. *advances in health sciences education* 2010;15:695-715. doi: 10.1007/s10459-010-9232-9

[5] Shepard L. The role of assessment in a learning culture. *Educational Researcher* 2009;29(7):4-14.

[6] Dijkstra J, Van der Vleuten CPM, & Schuwirth LWT. (2010). A new framework for designing programmes of assessment. Advances in health sciences education, 15. , 379–393. doi: 10.1007/s10459-009-9205-z.

1 The first dimension is designing the ***program in action***. This includes all the methods of collecting information about a registrar's competence and development, the way this information is collated and how it is used to come to a decision and influence the registrar's learning.

2 The second dimension contains all the aspects in the organisation that contribute to ***supporting the program.*** In this dimension two subdomains are identified: firstly, aspects that are needed to ensure the program in action can be delivered such as infrastructure, expertise of assessors etc; and secondly support for the program by the stakeholders.

3 This support is contingent on the ***documentation of the program*** including the way the program is described and made known to all stakeholders. Examples are the blueprinting, clear rules and regulations, and the approach to informing stakeholders about the assessment program.

4 All these parts need to be in a process of quality assurance and improvement, ***improving the program***, which ensures that the assessment program can be kept up-to-date and thus ensures the assessment program is fit for purpose. Research and development and Plan-Do-Act approaches are examples of this, as is keeping up with the current research findings and developments in the literature.

5 The final layer concerns the ***accountability of the program*** which is the way it is combined with a scientific research program, the program's transparency and making the program subject to external review.

Discussion points

Which layers will be included in the total design and implementation plan?

Evidence from the literature guiding programmatic assessment for learning

Role of meaningfulness and being active for learning in strengthening storage, retention and retrieval in memory.

Unlike a computer, human memory works best if new information can be attached to pre-existing information; in other words when we can link what we learn to things we already know. Such links do not always come naturally and often have to be actively constructed by the learner. For example, a registrar will find it easier to understand the medications used in secondary prevention of cardiovascular disease if they understand how cardiovascular disease occurs. The registrar will often have to actively forge a memory link between what they already know and what they need to learn.

What people know and what their prior experiences are is highly individual and therefore the specific connections between what they know and what they need to learn varies from person to person.[7 8] In an assessment program, the assessment tasks therefore require the registrar to create individual links between what they has seen during a patient consultation, identify individualised learning goals and actively connect experiences to pre-existing knowledge to build new knowledge and understanding. Such learning is most effective if it can be focussed on the learning tasks and is not interfered with by so-called 'extraneous cognitive load', or distractions. Therefore, assessment assignments should be short and the required analyses, learning goals and outcomes should be kept as simple, short and focussed as possible [9 10]

Role of transfer and domain specificity

It is very doubtful whether generic clinical problem solving skills exist; the literature suggest that the ability to solve problems is highly dependent on having well-organised knowledge on the subject[11]. This presents a problem to education and assessment, namely the issue of domain specificity. Domain specificity means that the performance of a registrar on one problem is a poor indicator for how s/he would solve any other problem, even within the same discipline. For assessment this typically means that short tests or limited assessment information is never enough to draw a reliable conclusion about somebody's competence.

A factor that contributes to the occurrence of domain specificity is that, in solving problems, people often are influenced by so-called surface features of the problem and we fail to understand the deep structure of the problem. Due to this, we may be able to solve a certain problem very well but may fail to recognise that another presentation in fact means the same problem[12]. A typical example of this would be the TV repair man who always checks whether the power cord is not unplugged before checking other possible faults, but who then does not think of checking whether there is still fuel in the tank when his car won't start. The link between experience and background (and often basic science) knowledge is important to help the learner understand the deep nature (e.g., seeing Kussmaul breathing and hyperventilation during an anxiety attack both as acid-base balance disturbances rather than completely separate entities).

[7] Schmidt, H. G. (1993). Foundations of problem-based learning: some explanatory notes. Medical Education, 27(5), 422-432.
[8] Schmidt, H. G., & Boshuizen, H. P. (1993). On acquiring expertise in medicine. Special Issue: European educational psychology. Educational Psychology Review, 5(3), 205-221.
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[12] Eva, K. (2003). On the generality of specificity. Medical Education, 37, 587-588.

An assessment program that require the registrar to forge links between the present case (in a work integrated learning context) and subsequent cases - by requiring him/her to demonstrate in future cases how the learning goals have been achieved and introduced in their clinical practice supports this transfer and thus mitigates the influence of domain specificity[13] [14].

Deliberate practice and self-regulated learning

Reflection-on-action or analysis of one's own performance in combination with targeted remedial or learning activities is found to have a positive effect on the speed of developing expertise and ultimately affects the levels of expertise reached. Typically, this analysis is performed by the registrars themselves in combination with the analyses done by their supervisors. Of course, this is not completely new, as athletes, musicians, artists, etc. all train and develop this way[15]. Yet, being able to analyse one's own performance well and having an active attitude towards seeking and using external information (such as test results, feedback from others, and analyses by others) does not come naturally as humans are not born as natural good self-assessors[16]. Therefore, an assessment program should require such self-assessment in conjunction with external information on a continual basis. The registrar will receive not only feedback about their expertise development as a GP but also in their development as a self-regulated learner[17]

Situativity of education

All educational activities and therefore also all assessment activities are situative. This means that the value of such activities is determined by what the activities allows the registrar and their supervisors/mentors/coaches to do (the traditional validity of the assessment instrument); this is called the affordances of the activity.

[13] Eva, K. W., Neville, A. J., & G.R., N. (1998). Exploring the aetiology of content specificity: Factors influencing analogic transfer and problem solving. Academic Medicine, 73(10), s1-5.
[14] Regehr, G., & Norman, G. R. (1996). Issues in cognitive psychology: Implications for professional education. Academic Medicine, 71(9), 988 - 1001.
[15] Ericsson KA. (2007). An expert-performance perspective of research on medical expertise: the study of clinical performance. Medical Education, 41, 1124-1130. doi: 10.1111/j.1365-2923.2007.02946.x)
[16] Eva KW, Cunnington JPW, Reiter HI, Keane D, & G, N. (2004). How can I know what I don't know? Poor self assessment in a well-defined domain. Advances in Health Sciences Education, 9, 211-224.
[17] Pintrich P. (2004). A Conceptual Framework for Assessing Motivation and Self-Regulated Learning in College Students. Educational Psychology Review,, 16(4), 385-407. doi: 1040-726X/04/1200-0385/0
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[17] Eva KW, Cunnington JPW, Reiter HI, Keane D, & G, N. (2004). How can I know what I don't know? Poor self assessment in a well-defined domain. Advances in Health Sciences Education, 9, 211-224.
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The second factor is the capacity of the registrars to use the affordances of the activity, the so-called effectivities and the purposefulness of the activities. A surgical knife can be used to illustrate this: a knife in itself does not cure any patient; it requires the effectivities of the surgeon. An effective surgeon would however still not be able to perform optimally with a dull surgical knife as that knife does not have the necessary affordances, but even a sharp knife in the hands of a skilful surgeon does harm if it is used for the wrong indication.

So, the designed assessment program contains the affordances, the stakeholders' expertise and assessment literacy define the effectivities in the system and the definition of the expected outcomes (standards and curriculum framework) define the purposefulness of the system.

So, as a final point; what we have learned in the past about programmatic assessment for learning is that the implementation strategy and the support underneath the designed program are essential (and probably most difficult). Therefore, a detailed plan and set of activities for the implementation and staff development are crucial to the project.

KEY PRINCIPLES

EPAs

Key principles to support the development of workable Entrustable Professional Activities for a Rural Generalist Pathway

Introduction to EPAs: What are they and why were they developed?

Entrustable Professional Activities (EPAs), first conceptualised more than a decade ago,(1) were proposed as a solution to address concerns about how, as medical training shifted towards competency-based medical education(2, 3), competencies could be assessed and how they relate to or capture the actual performance of caring for patients(4). Training programs define a curriculum with competencies and training standards. These competencies are complex, integrated and are unable to be assessed by a check box assessment. Many supervisors struggle with the ambiguity of the competency assessment and therefore EPAs were proposed to bridge the gap between clinical practice and competency based training standards.

EPAs are defined as the "professional activities that together constitute the mass of critical elements that operationally define a profession"(1). Breaking down the name EPA also helps: EPAs are Entrustable; that is "how much do I trust this registrar to care for patient x with condition y"; they are Professional, that is they are the core activities that constitute a profession; and they are Activities, that is activities which can be observed.
In contrast to competencies, activities are observable and measurable(5). The concept of entrustment decision-making, that is deciding how far to trust a registrar to care for a patient, is an attempt to align the daily workplace clinical activities with assessment(6). Supervisors are able to observe, assess and entrust a registrar to perform a particular activity as the

registrar develops competency. Full level of entrustment occurs once they have obtained and demonstrated adequate competency(2).
EPAs have been utilised around the world in many different countries. They assist in aligning assessments with programmatic assessment principles and a culture of assessment for learning.

Guidelines for Designing EPAs for the Rural Generalist Pathway:

Prerequisites for EPA Development

Defined Competencies and Curriculum

Competencies for the Rural Generalist Pathway need to be defined as EPAs provide a meaningful way of assessing competencies. Similarly, a curriculum needs to have been developed so the EPAs can assess these.

Understanding of the defined work based activities of a rural generalist

The defined work-based activities of a rural generalist will inform the development of EPAs. Whilst this will have local context there are core activities which are essential for all Rural Generalists, such as being able to formulate differential diagnoses, or lead and work within professional teams.

Discussion Points:

- What are the competencies of the Rural Generalist Pathway?
- What is the curricula of the Rural Generalist Pathway?
- What are the core activities of a Rural Generalist?
- Which elements are developmental and longitudinal and which are modular?
- How will these be reflected in EPAs or will there be different outcomes for the modular aspects?

Design Decisions

Defining EPAs Content Headings: A holistic or detailed approach

It is our recommendation that EPAs be considered from a holistic perspective. The Dundee's definition of competence as the "ability to repeatedly do the right things at the right time in the right way and to the right person"(7) could be useful in considering the role of EPAs in the Rural Generalist Pathway. This approach aligns with the principles of integration described in the assessment framework, whereby assessment tasks require multiple competencies to be performed at the same time for the assessment to be completed successfully to prevent competition between competencies and to keep registrars from prioritising strategically their activities.

This concept of integration of competencies is also important when considering the number of EPAs to develop. Recalling that competence is multiple specific competencies applied repeatedly at the same time(7), the recommendation to ensure EPAs involved broad-based responsibilities and be limited in number should be adhered to(8).

Although registrars have a very diverse set of responsibilities working within the community, most, if not all, patient presentations and non-clinical responsibilities can be covered by a limited number of EPAs. Limiting the number of EPAs to 10-15 ensures they remain workable for both supervisors and registrars while still providing opportunities for detailed, specific feedback. EPAs should be able to provide individual pieces of information which, when combined, would still provide a clear picture of a registrar's progress.

Role of EPAs within the assessment framework for the Rural Generalist Pathway

EPAs should be considered from a systems-based perspective, reviewing where entrustment decisions will fit within the assessment framework and the aim of EPAs within the program. The Rural Generalist Pathway competencies, how these relate to the core activities of a rural generalist, and then how these may be able to be assessed by EPAs should be considered, hence bridging the gap between these competencies and activities. A literature review looking for other EPAs developed for rural generalism or general practice should be undertaken as part of the planning and implementation processes.

Discussion Points:

- How will EPAs fit within the Rural Generalist Program Assessment Framework?
- What high level EPA Content Headings would encompass activities of the Rural Generalist?
- Do these EPAs relate to the competencies of the Rural Generalist Pathway?
- Is there at least two or more competencies required to achieve each EPA?
- Are all competencies mapped to at least two EPAs?

Synthesis of EPAs

The published guidelines for "Full Entrustable Professional Activities Descriptions"(8) provide a useful framework for the development of EPAs. This includes the EPA title, a justification of why this is included, a description of tasks, mapping to college domains and competencies, suggested assessment tools (sources of information to assessment progress) and when unsupervised practice is expected. See Appendix A for an example of this.

Entrustment Levels

In consideration of the entrustment scale to be used, evidence from literature suggested that allowing supervisors to use language which fits their expertise had a positive impact on the psychometric characteristics of the assessment(9). In this example, an entrustment level for anaesthetic supervisors was developed as: supervision required within the theatre suite, supervision required outside the theatre suite but within the hospital and supervision not required. This resonated with supervisors as they often made decisions about where they

were required to be when they were supervising their registrar (i.e. at home, in the tea room, in theatre) and there was far more agreement between supervisors about the level of entrustment of the registrar.(9) Therefore, the entrustment scale, and indeed all of the EPA should be written by clinicians in clinical jargon familiar to supervisors rather than generic educational narrative.

An example of an Entrustment scale for GP training is shown below:

Levels of Entrustment
Need frequent direct in room review by supervisor
Need onsite supervisor available in the practice most of the time
Safe to practice with phone access from supervisor
Safe to practice unsupervised

Registrar Self Assessment

In line with the discussion document about assessment for learning, we recommend that registrars complete a self assessment using the EPAs. This allows for registrars to critically reflect on their trust of themselves and assists in identifying an opportunity for learning. This can be compared with supervisor ratings (see evaluation below) to help identify registrars who may rate their level of entrustment higher than their supervisor.

Opportunities for Learning

EPAs have been noted in the literature to have an impact on learning and provide a roadmap for the trainee to identify where to improve.(10-12) EPAs developed for General Practice training had opportunities for feedback from the supervisor after each EPA. This did provide narrative rich information for the registrar (see evaluation below).

Discussion Questions

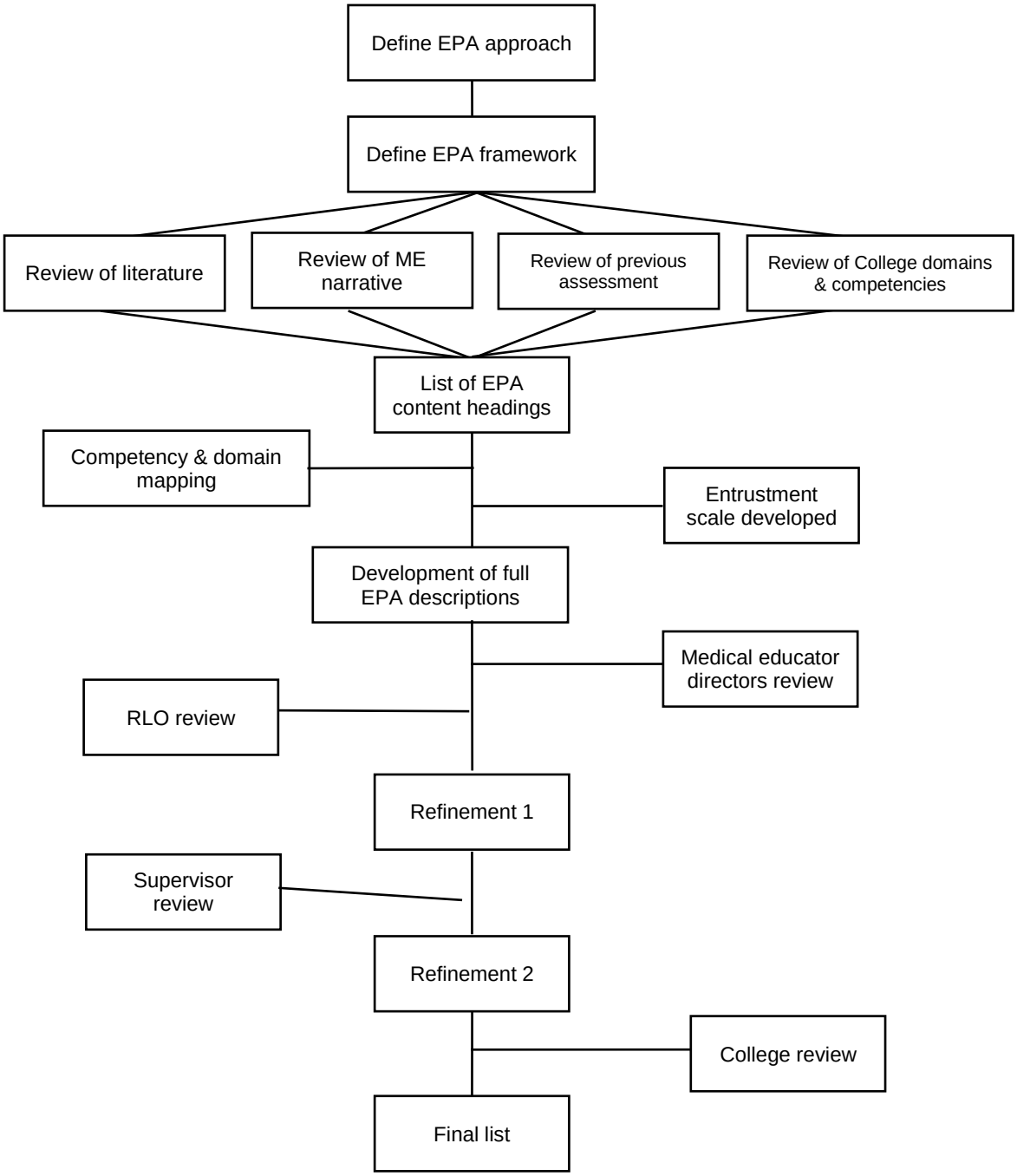
- What levels of entrustment would be suitable for the Rural Generalist Program?
    - Is entrustment aligned with levels of supervision?
- What opportunities for learning could EPAs include: i.e. registrar self, assessment, opportunities for narrative feedback from supervisors?

Validation of EPA content

Chen et al. describe the standards for content-related validity as the process for specifying assessment content should be described and justified according to the intended population

and the construct the assessment is intended to measure(13). The development process should involve key stakeholders in at least two different ways and at least one of these in the form of in-depth discussion. This may include supervisors, medical educators, appropriate working groups, and the registrars themselves. Qualitative rather than quantitative feedback should be sought as it allows a greater understanding and exploration of the issues raised and suggestions for additional content, as well as opportunities to discuss proposed resolutions.

An example of the development process and validation of content of the development of EPAs for Australian general practice is shown below:



Discussion points:

- What stakeholders should be involved in the EPA development?
- How will the content be validated?

Guidelines for the implementation of EPAs

Critical to the successful adoption of the EPAs as a new form of assessment is a change management approach. A systematic approach to implementation should be adopted to ensure increased uptake and engagement with the EPA processes. A framework should be developed was based on the congruence model of organisational alignment which very simply is the greater the congruence of organisational elements such as work, people, structure, and culture the higher the performance.

It is imperative to incorporate the behavioural and cultural elements in a co-ordinated and transparent manner to bring about lasting change. This can be achieved by focusing on the intrinsic nature of EPAs as part of the new programmatic assessment framework and alignment with an '*assessment for learning*' culture.

The intrinsic quality of EPAs can be harnessed to build the confidence of supervisors and educators, with key messages centred on the development of a tool that reflects what many are already doing in practice i.e. modifying their supervision for various activities based on their trust of the registrar. Videos around the concept of EPAs can be utilised as part of an initial awareness campaign.

Co-design principles which are used in the validation of content can also encourage stakeholder participation, quality (through improvements to the EPAs), engagement and desire to change. A case for change can be built through comparing the EPA tool's ability to increase feedback opportunities and demonstrate registrar competencies, flag registrars with professional or clinical issues early, and demonstrate progress effectively.

Change is assisted if all the leadership team are supportive of the change and a strong group of influencers and champions for the EPAs are created. This should be coupled with regular, personalised and transparent communication to achieving negligible resistance and lasting change.

EPA Evaluation

Undertaking evaluation of assessment is an important component of ensuring quality and validity of a training program.

The key evaluation findings:

- *EPAs demonstrate growth in levels of entrustment in both junior and senior trainees*
- *EPAs promote registrar and patient safety*
- *EPAs promote learning, feedback opportunities and self-reflection*
- *EPAs are able to identify struggling registrars*
- *EPAs demonstrate differences between junior and senior trainees*
- *EPAs are acceptable and useful for supervisors and registrars*
- *EPAs identify where there is not concordance of entrustment between the supervisor and trainee in specific activities (highlighting the overconfident/ under-confident trainee)*

Lessons learned in the development, implementation and evaluation of EPAs for general practice training:

- *EPAs are a valuable assessment tool which can be used in postgraduate training.*
- *EPA design is critical –follow a robust process to ensure EPAs developed are successful in providing individual pixels of information which when combined provide a clear picture of a registrar's progress.*
- *It is important to think about delivery – you need a system to make it easy for people to complete the assessment.*
- *Stakeholder engagement and communication is critical to the successful adoption of a new form assessment.*

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Appendix 1: EPAs for General Practice Training merely as an illustration of what some of the EPAs for the RG training could look like

	End of Training EPA	Description and Tasks	Suggested Assessment Methods and tools	Competencies (RACGP) and Domains (ACRRM)
1	Take a comprehensive history and perform an examination in all patients	Prior to entering unsupervised general practice, registrars need to be able to take a comprehensive history and perform an appropriate examination. This includes: • Uses a structure in order to elicit as much information as necessary from history and examination • Assesses biopsychosocial factors • Identifies red flags • Demonstrates prioritisation of symptoms • Asks questions to confirm or exclude a particular hypothesis or diagnosis • Assesses in context of other continuing medical problems	Direct observation Video review Critical case analysis	*RACGP:* CS1.1 CS2.2 CS3.1 *ACRRM:* D1 D2 D3 D4
2	Identify common working diagnoses and prioritise a list of differential diagnoses	Prior to entering unsupervised general practice, registrars need to be able to make an appropriate diagnosis. This includes: • Is able to recognise patterns of disease and presentations • Is able to recognise the most likely diagnosis as well as the most important diagnosis to exclude • Demonstrates an ability to think beyond the obvious presentation • Demonstrates an appropriate balance between clinical diagnosis and the use of investigations • Is able to deal with uncertainty of diagnosis and can appropriately implement safety nets for patients	Direct observation Video review Case based discussions Critical case analysis	*RACGP:* CS2.1, CS2.2 CS3.1 *ACRRM:* D1 D2 D3 D5
3	Manage the care of patients with acute common symptoms and diseases across multiple care settings	Prior to entering unsupervised general practice, registrars need to be able to diagnose and manage common acute medical symptoms and conditions in the community and in hospital settings (if relevant). This includes: • Handle medical emergencies • Obtains accurate and complete information sufficient to develop differential diagnosis and inform management plan • Demonstrates knowledge of diseases common to general practice	KCA discussions Registrar run tutorials Direct observations Video observations Case based discussions	*RACGP:* CS1.1 CS2.1, CS2.2, CS2.3, CS2.4 CS3.1 CS4.1 CS5.1, CS5.2 *ACRRM:*

		• Performs procedures as needed (e.g. suturing wound) • Appropriately investigates and prescribes as needed (e.g. avoiding unnecessary tests and medications) • Communicates plans of care to patients, families and care givers (e.g. handouts)	Critical case analysis Chart audits Feedback from patients	D1 D2 D3 D5 D6 D7
4	Manage the care of patients with common chronic disease and multiple morbidities	Prior to entering unsupervised general practice, registrars need to be able to diagnose and manage common chronic diseases and multiple morbidities. This includes: • Diagnoses chronic diseases according to current criteria • Manages chronic diseases according to current guidelines • Manage an older patient with multiple morbidity • Is aware of drug interactions in patients with multiple morbidity • Uses chronic disease Medicare item numbers appropriately • Uses recalls • Follow ups appropriately	KCA discussions Registrar run tutorials Direct observations Video observations Case based discussions Critical case analysis Chart audits Feedback from patients	*RACGP:* CS1.1, CS1.2 CS2.1, CS2.2, CS2.3, CS2.4 CS3.1 CS4.1 CS5.1, CS5.2 *ACRRM:* D1 D2 D4 D5 D6 D7
5	Manage gender related health issues	Prior to entering unsupervised general practice, registrars need to be able to diagnose and manage health issues that specifically relate to women. This includes: • Provides appropriate contraception advice • Provides pre pregnancy counselling • Manages first antenatal consult • Manages menstrual abnormalities • Advices of appropriate screening • Manages menopause • Manage erectile issues • Manage prostate issues and screening	KCA discussions Registrar run tutorials Direct observations Video observations Case based discussions Critical case analysis Chart audits Feedback from patients	*RACGP:* CS1.1, CS1.2 CS2.1, CS2.2, CS2.3, CS2.4 CS3.1, CS3.2 CS4.1 CS5.1, CS5.2 *ACRRM:* D1 D4 D5 D6 D7

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6	Manage mental health issues	Prior to entering unsupervised general practice, registrars need to be able to manage mental health issues. This includes: • Be aware of and manage the somatic presentations of mental health issues • Manages the interaction of physical and mental health • Assess the safety of a patient with mental health issues • Refers appropriately • Manages drug and alcohol issues	KCA discussions Registrar run tutorials Direct observations Video observations Case based discussions Critical case analysis Chart audits Feedback from patients	*RACGP:* CS1.1, CS1.2 CS2.1, CS2.2, CS2.3, CS2.4 CS3.1 CS4.1 CS5.2 *ACRRM:* D1 D3 D4 D5 D6 D7
7	Manage the care of children and adolescents	Prior to entering unsupervised general practice, registrars need to be able to manage the care of children and adolescent. This includes: • Is capable of managing an ill child • Can recognise and ask for assistance in the management of a seriously ill child • Understands the development of a normal child and adolescent • Knowledge of age appropriate immunisations	KCA discussions Registrar run tutorials Direct observations Video observations Case based discussions Critical case analysis Chart audits Feedback from patients / parents Paediatric log book	*RACGP:* CS1.1, CS1.2 CS2.1, CS2.2, CS2.3, CS2.4 CS3.1 CS4.1 CS5.1, CS5.2 *ACRRM:* D1 D2 D3 D4 D5 D6 D7
8	Follow screening protocols and primary prevention guidelines	Prior to entering unsupervised general practice, registrars need to be able to follow and implement primary prevention and screening protocols. This includes: • Incorporating prevention and screening questions into history taking • Explaining and implementing primary prevention and screening protocols in patients • Appling screening guidelines to individual patient scenarios	KCA discussions Registrar run tutorials Direct observations Video observations	*RACGP:* CS1.1 CS2.2, CS2.3 CS3.1 CS5.2

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			Case based discussions Chart audits	*ACRRM:* D1 D4 D5
9	Lead and work within professional teams	Prior to entering unsupervised general practice, registrars need to be able to lead and work with other doctors, nurses and allied health staff to improve patient care through coordination and collaboration. This includes: • Coordinate care between different health care providers • Act and engage in collaborative communication • Manage diverse opinions and beliefs with the goals of optimising care • Writes appropriate referral letters • Works professionally with other practice staff	Direct observations Multi source feedback Feedback from patients Registrar run tutorials	*RACGP:* CS1.1 CS2.4 CS3.2 CS4.1 CS5.1, CS5.2 *ACRRM:* D1 D2 D3 D4 D5 D6 D7
10	Communicate effectively and develop partnerships with patients, carers and families	Prior to entering unsupervised general practice, registrars need to be able to communicate effectively with patients, carers and families. This includes: • Avoids the use of jargon • Uses handouts and resources • Clearly articulates management to patients • Develops rapport with patients • Manages consults with patients and family members • Able to manage difficult patients and consults	Direct observation Video observations Feedback from patients	*RACGP:* CS1.1, CS1.2 CS2.4 CS4.1 CS5.2 *ACRRM:* D1 D2 D5 D6
11	Demonstrate time management and practice management skills	Prior to entering unsupervised general practice, registrars need to be able to manage their time effectively. This includes: • Management of multi-issue consults • Completes adequate medical notes, reports and assignments in a timely manner • Punctuality • Demonstrates reliability in non-clinical tasks (including infection control, mandatory notification, confidentiality, informed consent)	Direct observation Multi sources feedback Submission of assignments Submission of KCAs	*RACGP:* CS4.1 CS5.1, CS5.2 *ACRRM:* D2 D4

		• Utilises recalls, alerts and patient registration to maximise patient care		D6
12	Demonstrate attributes which are expected of a GP	Prior to entering unsupervised general practice, registrars need to be able to demonstrate attributes which are expected of a GP. This includes: • A non-judgmental attitude • Demonstrates cultural awareness • Displays personal habits of lifelong learning • Is self-reflective • Is aware of limitations • Receives feedback appropriate • Demonstrates ethical practice	Direct observation Video observation Multi source feedback Registrar run tutorials Learning plans Relationship with supervisor	*RACGP:* CS1.1, CS1.2 CS2.1 CS4.1, CS4.2, CS4.3 *ACRRM:* D1 D5 D6 D7
13	RURAL ONLY: Demonstrates an ability to manage emergency on call and inpatient care	Prior to entering unsupervised general practice, registrars need to be able to manage rural hospital inpatients and emergency on call. This includes: • Manage care of patients in hospital • Recognise and respond early to a deteriorating patient • Maintain accurate patient hospital records • Undertake initial assessment and tirage of patients • Stabilise critically ill patients and provide definitive emergency resuscitation • Communicate effectively at a distance with other health care providers • Arrange retrieval when appropriate		*RACGP:* CS1.1 CS2.1, CS2.2. CS2.3, CS2.4 CS3.2 CS5.1, CS5.2 *ACRRM:* D1 D2 D3 D5 D7

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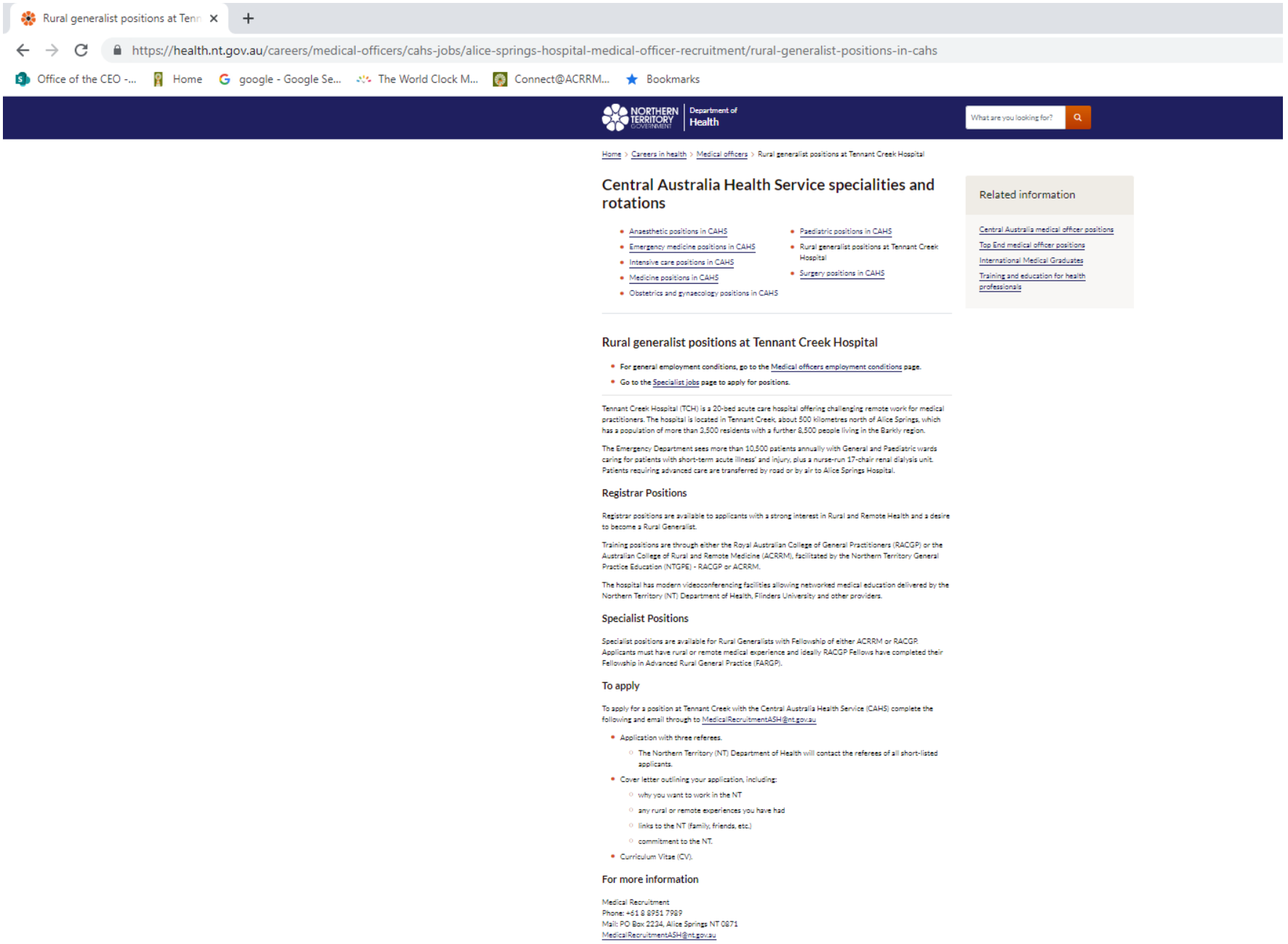
Attachment 3.2 Sample Rural Generalist Job Advertisements



Rural generalist positions at Tenn

https://health.nt.gov.au/careers/medical-officers/cahs-jobs/alice-springs-hospital-medical-officer-recruitment/rural-generalist-positions-in-cahs

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NORTHERN TERRITORY GOVERNMENT | Department of Health

What are you looking for?

Home > Careers in health > Medical officers > Rural generalist positions at Tennant Creek Hospital

Central Australia Health Service specialities and rotations

- Anaesthetic positions in CAHS
- Emergency medicine positions in CAHS
- Intensive care positions in CAHS
- Medicine positions in CAHS
- Obstetrics and gynaecology positions in CAHS
- Paediatric positions in CAHS
- Rural generalist positions at Tennant Creek Hospital
- Surgery positions in CAHS

Related information

- Central Australia medical officer positions
- Top End medical officer positions
- International Medical Graduates
- Training and education for health professionals

Rural generalist positions at Tennant Creek Hospital

- For general employment conditions, go to the Medical officers employment conditions page.
- Go to the Specialist jobs page to apply for positions.

Tennant Creek Hospital (TCH) is a 20-bed acute care hospital offering challenging remote work for medical practitioners. The hospital is located in Tennant Creek, about 500 kilometres north of Alice Springs, which has a population of more than 3,500 residents with a further 8,500 people living in the Barkly region.

The Emergency Department sees more than 10,500 patients annually with General and Paediatric wards caring for patients with short-term acute illness' and injury, plus a nurse-run 17-chair renal dialysis unit. Patients requiring advanced care are transferred by road or by air to Alice Springs Hospital.

Registrar Positions

Registrar positions are available to applicants with a strong interest in Rural and Remote Health and a desire to become a Rural Generalist.

Training positions are through either the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM), facilitated by the Northern Territory General Practice Education (NTGPE) - RACGP or ACRRM.

The hospital has modern videoconferencing facilities allowing networked medical education delivered by the Northern Territory (NT) Department of Health, Flinders University and other providers.

Specialist Positions

Specialist positions are available for Rural Generalists with Fellowship of either ACRRM or RACGP. Applicants must have rural or remote medical experience and ideally RACGP Fellows have completed their Fellowship in Advanced Rural General Practice (FARGP).

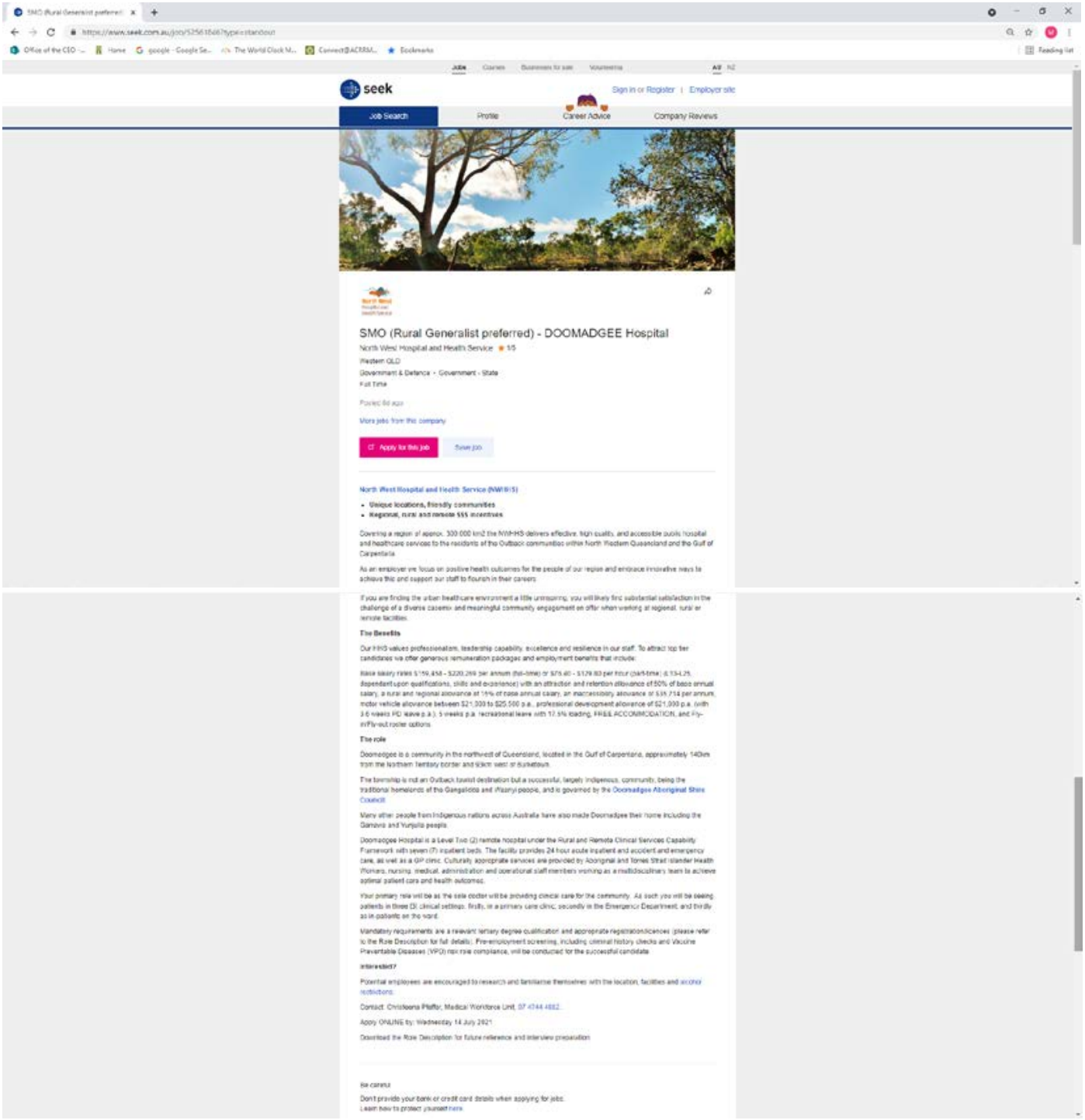
To apply

To apply for a position at Tennant Creek with the Central Australia Health Service (CAHS) complete the following and email through to MedicalRecruitmentASH@nt.gov.au

- Application with three referees.
  - The Northern Territory (NT) Department of Health will contact the referees of all short-listed applicants.
- Cover letter outlining your application, including:
  - why you want to work in the NT
  - any rural or remote experiences you have had
  - links to the NT (family, friends, etc.)
  - commitment to the NT.
- Curriculum Vitae (CV).

For more information

Medical Recruitment
Phone: +61 8 8951 7989
Mail: PO Box 2234, Alice Springs NT 0871
MedicalRecruitmentASH@nt.gov.au



seek

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SMO (Rural Generalist preferred) - DOOMADGEE Hospital

North West Hospital and Health Service ★ 5/5

Western QLD

Government & Defence - Government - State

Full Time

Posted 6d ago

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North West Hospital and Health Service (NWHHS)

- **Unique locations, friendly communities**
- **Regional, rural and remote $$$ incentives**

Covering a region of approx. 300 000 km2 the NWHHS delivers effective, high quality, and accessible public hospital and healthcare services to the residents of the Outback communities within North Western Queensland and the Gulf of Carpentaria.

As an employer we focus on positive health outcomes for the people of our region and embrace innovative ways to achieve this and support our staff to flourish in their careers.

If you are finding the urban healthcare environment a little unrewarding, you will likely find substantial satisfaction in the challenge of a diverse casemix and meaningful community engagement on offer when working at regional, rural or remote facilities.

The Benefits

Our HHS values professionalism, leadership capability, excellence and resilience in our staff. To attract top tier candidates we offer generous remuneration packages and employment benefits that include:

Base salary rates $159,458 - $220,269 per annum (full-time) or $75.40 - $129.80 per hour (part-time) (L1S4-L2S5, dependant upon qualifications, skills and experience) with an attraction and retention allowance of 50% of base annual salary, a rural and regional allowance at 15% of base annual salary, an inaccessibility allowance of $35,714 per annum, motor vehicle allowance between $21,000 to $25,500 p.a., professional development allowance of $21,000 p.a. (with 3.6 weeks PD leave p.a.), 5 weeks p.a. recreational leave with 17.5% loading, FREE ACCOMMODATION, and Fly-in/Fly-out roster options.

The role

Doomadgee is a community in the northwest of Queensland, located in the Gulf of Carpentaria, approximately 140km from the Northern Territory border and 958km west of Burketown.

The township is not an Outback tourist destination but a successful, largely Indigenous, community, being the traditional homelands of the Gangalidda and Waanyi people, and is governed by the Doomadgee Aboriginal Shire Council.

Many other people from Indigenous nations across Australia have also made Doomadgee their home including the Ganalvira and Yunjulla people.

Doomadgee Hospital is a Level Two (2) remote hospital under the Rural and Remote Clinical Services Capability Framework with seven (7) inpatient beds. The facility provides 24 hour acute inpatient and accident and emergency care, as well as a GP clinic. Culturally appropriate services are provided by Aboriginal and Torres Strait Islander Health Workers, nursing, medical, administration and operational staff members working as a multidisciplinary team to achieve optimal patient care and health outcomes.

Your primary role will be as the sole doctor will be providing clinical care for the community. As such you will be seeing patients in three (3) clinical settings: firstly, in a primary care clinic, secondly in the Emergency Department, and thirdly as in patients on the ward.

Mandatory requirements are a relevant tertiary degree qualification and appropriate registration/licences (please refer to the Role Description for full details). Pre-employment screening, including criminal history checks and Vaccine Preventable Diseases (VPD) risk role compliance, will be conducted for the successful candidate.

Interested?

Potential employees are encouraged to research and familiarise themselves with the location, facilities and alcohol restrictions.

Contact: Christeena Pfeffer, Medical Workforce Unit, 07 4744 4882.

Apply ONLINE by: Wednesday 14 July 2021

Download the Role Description for future reference and interview preparation.

Be careful

Don't provide your bank or credit card details when applying for jobs.
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