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

College Submission
November 2022

Review of the Accreditation Standards for Primary Medical Programs

College Details

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About ACRRM

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.*** It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

ACRRM has more than 5000 rural doctor members with some 1000 registrars, who live and work in rural, remote, and indigenous communities across Australia. Our members provide expert frontline medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial Comments

The College thanks the AMC for the opportunity to provide comment to this Review. We see the proposed changes as generally positive and welcome their enhanced recognition of the importance of facilitating a workforce skilled in Aboriginal and Torres Strait Islander peoples' healthcare.

Our feedback is provided in the Consultation Table provided by the AMC (below). Comments have only been provided on the items where the College has a specific and priority interest and for which the proposals present issues of particular concern.

1. Graduate outcomes statements

Content of the graduate outcome statements – Questions
1. *Social Accountability* In the area of Social Accountability, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required? Do you have any further comments on this area?
Understanding of rural and remote healthcare context There is opportunity to better emphasise the importance of medical graduates having attained some understanding of the distinctive perspective of rural and remote communities and the impacts of reduced access to medical services and resources that they experience relative to people living in cities. The experience of remoteness and its impacts on Aboriginal and Torres Strait Islander people's health and healthcare should be an area of significant focus. These are key factors in healthcare inequity in Australia and an important principle for future medical workforces to recognise and respect. Unfortunately, the default setting for training medical students tends to be training them for medicine as it is delivered in urban settings with a highly specialised workforce and reasonable access to specialist doctors, allied health professionals, screening and testing services and resources. There are particular skills, attitudes and approaches that become important for doctors when they need to care for patients in situations of relative isolation from urban centres, including community-responsiveness, resourcefulness, and capacity for complex clinical decision making around when and how to refer. These are valuable attributes for all medical practitioners but essential for safe, quality practice in rural and remote settings. Medical graduates should be prepared to practice anywhere in Australia. Even graduates who take on highly specialised careers and never practice in rural and remote areas should be able to understand the perspective of patients who may be based in rural and remote communities. Such doctors should also be able to effectively support these patients' local doctors/healthcare teams to provide the continuity, emergency, and follow-up care that they as a city-based specialist are unable to provide. *Outcome 3.9* We recommend, in particular, that Outcome 3.9 include "accessibility" as a fourth dimension to a systems approach to care (i.e. *Describe a systems approach to improving the quality, safety and sustainability 'and accessibility' of health care).*

2.	*Cultural Safety* In the area of Cultural Safety, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required? Do you have any further comments on this area?
Nil comments	
3.	*Safety and Quality* In the area of Safety and Quality, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required? Do you have any further comments on this area?

Quality and safety in rural and remote contexts

As per (1) above, there is opportunity to better emphasise the importance of medical graduates attaining an understanding of the distinctions of the rural and remote context and its affects on assessments of how to deliver the highest quality and safety of care for patients and their communities. We would consider a minimum standard at the medical graduate level, should be to attain an appreciation that "access to resources and services" can have complex and significant implications for patient management.

Outcome 3.2

Outcome 3.2 alludes to these concepts however it is broad to the point that we would consider it unlikely that it would be linked to consideration of the rural and remote healthcare context, and we would recommend that this be reworded to specify consideration of issues of low resource settings and geographic isolation.

Clinical uncertainty and generalist practice

Working with uncertainty is highlighted as a well-being issue in Outcome 2.5, however there is no explicit recognition in the Standards of the need for medical graduates to attain an understanding of the relationship between clinical judgement and uncertainty in good medical practice. We would like to see Standards included which reflected the need for medical programs to foster this understanding.

This is especially important to practice for primary care providers, rural generalists and other generalists who need to take the most holistic approach to medical diagnoses and management.

For practitioners in rural and remote contexts, especially, clinical guidelines often don't exist which reflect the complexity of their clinical settings in which other specialists, specialist resources, support staff, and patient access to care are all potentially not available options.

The College of Family Physicians of Canada (CFPC) have described the concept of 'specificity' as a core disciplinary competency of all family practice. 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.[1] Similarly, Cooper

[1] Critchton et al (2020) Assessment Objectives for Certification in Family Medicine. College of Family Physicians of Canada.

and associates have described this as working in the 'corridor or uncertainty" and view this as essential general practice.[2]

Understanding the essential principles of when to refer is a critical element to being able to be a safe and functional practitioner in rural and remote areas, with minimal professional specialisation, minimal access to specialist testing and resources and fewer options for referral.[3]

We consider this approach foundational approach to all practice but critical to rural and remote practice. If patient care is not developed at the undergraduate stage which recognises the role of the practitioner as working with uncertainty in a measured and responsible way, students are unlikely to develop the skills they need to work in rural practice and/or generalist practice.

4. *Emerging Technologies*

In the area of Emerging Technologies, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?
Do you have any further comments on this area?

Impacts of emerging technologies of rural and remote community care (positive and negative)

It is important that any exploration of emerging technologies includes consideration of how these can be used effectively to provide services to people in situations of physical isolation from healthcare resources including in rural and remote communities. It is also important that consideration of technology-enabled care includes consideration of what are ethically appropriate and effective technologically-enabled models of medical care. This should recognise the ethical issues associated with replacing in-person, human care and potentially fragmenting doctor-patient continuity of care. This applies particularly in rural and remote communities, but also potentially to the chronically ill and/or incapacitated, who may have restricted capability to access services. Effective models should be considered, which emphasise appropriate systems which can provide additional services while supporting and augmenting in-person, continuous doctor-patient relationships.

We note that these issues are covered somewhat in Outcome 3.8 but would see value in these being strengthened to emphasise:

- appreciating the role and value of human in-person interaction and the importance of patients having access to this in rural and remote settings,
- that the merits of these technologies should be viewed in terms of their potential to be a contributing element within appropriate models of care in these settings.

5. *Partnering with Patients*

In the area of Partnering with Patients, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

[2] Cooper M, Sornalingam S, Jegatheesan M, Fernandes C (2022) The undergraduate 'corridor of uncertainty': teaching core concepts for managing clinical uncertainty as the 'special technique' of general practice. *Educ Prim Care*. 33(2):120-124. doi: 10.1080/14739879.2021.1996276.
[3] Konkin J et al (2020) 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. *BMJ Open* 10(8):e037705.

Nil comments

Structure of the graduate outcome statements – Questions
6. *Specificity of Outcomes* Are the proposed revisions to the outcomes appropriately specified at a high level? If not, what further revisions might be required? Do you have any further comments on this area?
Nil comments
7. Order of Domains Do you agree with the re-ordering of the outcome domains? If not, what else should the AMC consider?
Nil comments

2. Standards for medical schools

Contents of the accreditation standards for medical schools - Questions

8. *Social Accountability*

In the area of Social Accountability, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?
Do you have any further comments on this area?

Engagement, consultation, representation of stakeholders from rural and remote areas

We would see opportunity for more clearly articulating the accountability of the medical program to actively engage with and reflect the needs of communities beyond the major cities in which they are predominantly based. This is necessary if they are to develop and teach programs which reflect the healthcare needs and health service structures for people from these locations.

Standard 1.2.2

For example, we would recommend that Standard 1.2.2 be altered to specify that partnerships with the various listed stakeholders should include stakeholders and stakeholder organisations based in regional, rural, and remote locations.

Student selection reflects patient population

There are substantive and growing distortions in the geographic maldistribution of our workforce and its skew toward the highest remunerated areas of practice. These are translating to people in rural and remote areas with relatively low socio-economic status and especially people in remote Aboriginal and Torres Strait Islander communities recording lower access to services, lower use of services, and lower health status across all metrics.[4,5,6] We consider that this reflects an historic failure of AMC Standards to uphold social accountability that needs to be corrected.

The College supports many of the proposed changes in the Standards toward increased numbers of students in medical schools likely to meet the major areas of unmet patient needs in our emerging medical workforce but does not consider these sufficient.

Standards 4.1.2-4.1.5

1. We would see opportunity for these Standards to specify not just recruitment targets but also that these are supported by measured and reported targets in terms of graduation and ultimately workforce outcomes. These should be able to demonstrate some degree of parity with each medical school's graduate outcomes and the community's medical service needs. In particular, there should be targets in key areas of unmet community need including:
    - Rural practice

[4] AIHW (2019) Rural and Remote Health. Cat. no. PHE 255. https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health
[5] O'Sullivan B et al (2019) Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence *Hum Resour Health* 17: 8.
[6] 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

- Remote practice
- Rural Generalist practice
- General practice
- Aboriginal and Torres Strait Islander health service based practice
- Mental health

2. We see need for clarity around the term 'rural' origin which is inconsistently applied - to ensure students from a diversity of rural backgrounds are represented especially people from the more remote locations that experience the most significant workforce shortages.
3. We would like to see Selection processes encouraged through these Standards which include a measure of applicants' expected proficiency to become a patient-oriented, community-oriented, caring, medical professional - noting that these aptitudes are strongly predictive of working in areas of highest workforce need.[7]
4. We would see opportunity for the standards to encourage Universities to be proactive in meeting rural recruitment targets particularly in terms of their engagement with schools in rural, remote communities including remote Aboriginal and Torres Strait Islander communities. There is clear need for some proactivity by medical schools to achieve these goals and address inherent inequities. Year 12 completion rates decrease with remoteness from 75% in urban areas to 55% in remote and very remote areas[8] and the rate of bachelor degree completions drops from 37% in cities to 20% in outer-regional, remote and very remote areas.[9]

Standard 6.2.4

The College supports the introduction of this standard to improve representation of under-represented communication and particularly its specification of evaluation of outcomes in graduates who are Aboriginal and Torres Strait Islander peoples. We would however recommend that this Standard or alternatively a separate additional Standard, identify other key under-represented communities in particular people from rural and remote areas (including Aboriginal and Torres Strait Islander people from these areas).

We would further like to see this Standard or an additional separate Standard, identify the need to evaluate program outcomes in terms of fostering a medical workforce that can meet national priority areas of medical specialist service. This should specify evaluating outcomes in terms of graduation demographics, intentions and actual workforce recruitment and retention especially in the key areas given at point (1) above in relation to Standards 4.1.2-5.

It should be noted that these outcomes - should they point to medical programs' contributing to current workforce distortions, may point to flaws not only in the selection policies but also potentially in the curriculum, teaching program delivery, and governance structures which should be explored and addressed.

9. *Cultural Safety*

In the area of Cultural Safety, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

[7] Strasser RP (2022) Beyond rural clinical schools to "by rural, in rural, for rural": Immersive community engaged rural education and training pathways. Med J Aust; 216 (11): doi: 10.5694/mja2.51525
[8] ABS (2019) Education and work, Australia, May 2019. ABS cat. no. 6227.0. Canberra.
[9] AIHW (2019) *Australia's Health 2018* Australia's health series no. 16. AUS 221. Canberra.

Do you have any further comments on this area?
Nil comments
10. Student Wellbeing In the area of Student Wellbeing, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required? Do you have any further comments on this area?
Wellbeing of students in rural and remote placements It is recognised that rural and remote communities are likely to have fewer resources in terms of staff support and facilities and there are likely to be issues of geographical isolation from support mechanisms for many students undertaking these placements. We would like to see the Standards specifically address the need for students being able to access psychological support as and when required irrespective of their location but especially for those in rural and remote locations. We would like also to see reference in the Standards to sufficient day-to-day staff support which would hopefully minimise the escalation of minor issues into issues of psychological distress. Standard 4.2.2 We support the changes to this standard which reference the requirement to offer "accessible services" but would like to see these extended to clearly specify the need for their accessibility in rural and remote contexts where this could be potentially most important and most problematic.
11. Transition to Practice In the area of Transition to Practice, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required? Do you have any further comments on this area?
Readiness for rural and remote practice There is considerable discussion about compulsory rural rotations as part of internship and specialist training. This highlights the importance of ensuring there is adequate breadth of exposure to regional, rural, and remote contexts (noting the important distinctions between these) at the undergraduate level. There is considerable scholarship demonstrating that sending doctors to rural placements who are poorly prepared for these experiences typically has the perverse outcome of not only making them unlikely to pursue rural careers but also to lead to these students and junior doctors contributing to prevailing negative perceptions among their colleagues, that rural work is both undesirable and professionally frightening. For these reasons we would like to see the standards under this domain specify the need to ensure education for, and exposure to, regional, rural, remote clinical practice.

Evidence has shown that the most effective exposure in terms of quality of learning and recruitment and retention outcomes however is longitudinal placements.[10] We would like to see the Standards acknowledge the value of these in developing doctors ready for rural and remote practice.

Readiness for practice in Aboriginal and Torres Strait Islander healthcare settings

We would see similar arguments applying to the provision of placement with a particular focus on longitudinal placement in Aboriginal and Torres Strait Islander healthcare settings and would like to see the Standards reflect the importance of this.

Readiness for general practice

We see exposure to general practice as critical to building a future general practice workforce. We also consider the opportunity to experience continuity of care requires as lengthy exposure as practicable to a single practice. We would also like to see the Standards reflect the importance of time in general practice settings to career readiness. This is particularly important given the relative lack of exposure to general practice and especially rural general practice provided through the prevocational training framework.

12. Governance, Leadership and Resources

In the area of Governance, Leadership and Resources, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?
Do you have any further comments on this area?

Rural and remote perspectives representation at all levels of governance

The College welcomes the introduction of Standard 1.3.5 which specifies representation of Aboriginal and Torres Strait Islander peoples in representation and sees this as an important mechanism to ensure that these interests are represented at all levels of governance and decision making.

Given that nearly all Australian universities are based in major cities it has been a recurring issue that many medical programs particularly at the highest levels of governance do not reflect the perspectives or priorities of people living in rural and remote areas. We consider that this is an important contributing factor to the continued maldistribution of our medical workforce and the associated lower health status of people in these areas.

For these reasons we would recommend inclusion of a new Standard or inclusion in the wording of an existing standard to the effect that people who can reflect the perspectives of rural and remote communities should be included at all levels of the medical program's governance and decision-making structures.

13. Outcomes, the Curriculum and Assessment

In the area of Outcomes, the Curriculum and Assessment, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

[10] Woolley T et al. (2021) A return-on-investment analysis of impacts on James Cook University medical students and rural workforce resulting from participation in extended rural placements. *Rural Remote Health*. 21(4):6597.

Standard 2.1.2

The College strongly supports the introduction of Standard 2.1.2 which enables fit-for-purpose training in rural and remote and other sites outside of urban campuses and tertiary hospitals.

We would recommend that additionally this Standard should reference the need for training in all locations to receive sufficient resourcing and support to enable it to be taught to the same quality standard.

Standard 2.3.8

The College supports this Standard but would recommend the following two amendments:

- This should reference experiential learning which gives students exposure to continuity of care (noting longitudinal community and rural/remote placements would be an effective mechanism for achieving this)
- Point iv: *"Situated across metropolitan and rural health settings"* should be changed to read "*Situated across metropolitan, **regional, rural and remote settings***". There are important distinctions between these geographical classifications for health service delivery with some being much simpler administratively to manage than others for urban based medical schools. These schools should however offer the possibility of working in all of these settings where the medical workforce will be expected to practice.

Standard 3.3.2

The College supports this Standard but would recommend that it also include reference to the need to for assessment to be supported and resourced to be able to be delivered to the same standard irrespective of location.

14. Emerging Technologies

Do the proposed revisions to the standards identify the requirements on education programs that graduate safe and competent medical practitioners in the area of Emerging Technologies? If not, what further revisions might be required?
Do you have any further comments on this area?

Nil comments

15. Innovation

Do the proposed revisions ensure that the standards are able to continue to support innovation within medical schools?
Are any further revisions required?

Nil comments

16. International Frameworks

Do the proposed revisions to the standards meet the requirements under relevant international frameworks? If not, what further revisions might be required?
Do you have any further comments on this area?

Nil comments

Summary questions
17. In your view, are there any areas of change which might be challenging for medical schools to implement effectively? If so, please explain what areas might be challenging and why.
Nil comments
18. Are there any **further significant areas** in which the AMC should consider revisions to the graduate outcomes and the standards for medical schools?

There are a number of areas of key importance to ensuring our emergent medical workforce will meet Australians' medical care needs that are either not covered or insufficiently covered.

Where possible within the context of the specific questions the AMC have asked above, this submission has offered specific suggestions.

We consider these issues however should be given consideration in terms of the adequacy of their representation and prominence across the entire Standards and Outcomes frameworks. This prominence of itself will influence the perceptions of medical programs about the AMC priorities and will in turn influence their strategic priorities and developments going forward.

Some of the key areas we consider need strengthening include the following:

- *Engagement with, and representation of rural and remote perspectives across all areas of medical programs structures, curricula, and delivery*.

  Historically this has not been achieved within most Australian medical schools. The AMC standards should provide a basis for accountability in this area, noting the significant and persisting workforce maldistribution and associated gap in relative health status between urban and rural and remote Australians.

- *Building students' capacity in, and orientation toward primary care, rural medicine and generalist approaches to medicine.*

  There Is a strong overlap between generalist medicine and rural medicine, noting that the latter occurs in locations where highly specialised approaches are not practically feasible. The graduate outcomes and standards should thus emphasise competencies such as working in in conditions of uncertainty, with self-reliance, capacity for resourcefulness and to work in low-resource environments. These issues should be reflected in curricula and assessment.

- *Selection for and promoting community-oriented students*

  The Outcomes and Standards should emphasise, selecting for and promoting attributes in students such as compassion, commitment to community, community-responsiveness, and altruism. In Australian geography, there is a clear and growing inverse relationship between level of healthcare need and accessibility of doctors. This points strongly to a need for cultural shifts in our medical education systems.

- *Connectedness to the profession in key workforce areas*

  Due to the relative administrative simplicity there is a default tendency of medical schools to focus learning activities on tertiary teaching hospitals. And it is the doctors in these institutions predominantly with whom medical students engage and learn. Thus students' exposure to the profession is skewed toward urban, highly specialised practice. This in turn is the area of our medical workforce most over-supplied while rural generalist practice and rural general practice are facing critical workforce shortages.

  There is a need for medical schools to ensure all students are exposed to rural generalists, rural general practitioners and general practitioners more broadly. This is necessary in order that they can visualise what a career in these areas of medicine would entail. These doctors may take the form of teachers, supervisors, mentors, or administrators, but importantly they will also provide positive and aspirational role models.

  Rural placements and especially longitudinal placements are clearly a key mechanism by which this would be achieved.

- *Longitudinal Placements*

  The Outcomes and Standards are essentially silent on the value of providing short or long-term rural and remote placements even though these are well-evidenced as being one of the strongest predictors of a rural workforce outcome within rural medical education.[11,12] We would like to see considerably more prominence given to these such that Universities doing well in this area should receive special commendation through AMC processes.

- *Measuring outcomes against workforce priorities*

  We would like to see the AMC standards ensure that medical schools are measuring their outcomes against key workforce priorities most predominantly in the key areas in contributing to the building of essential workforces for people in rural and remote areas including remote Aboriginal and Torres Strait Islander communities.

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live, and pay respect to their Elders past present and future.

[11] Campbell DG et al (2019) Outcomes of a 1-year longitudinal integrated medical clerkship in small rural Victorian communities. *Rural Remote Health*. 19(2):4987.
[12] Worley PS et al (2019) From locum-led outposts to locally led continuous rural training networks: the National Rural Generalist Pathway. *Med J Aust*. 211(2):57-59.e1.