



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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Paul Wappett, RACGP 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 speciality 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 doctorsⁱ 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 Canada⁶, New Zealand⁷, the United States^{8,9}, Africa^{10,11} and Asia¹².

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 physicians¹⁶

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 disadvantage¹⁸
- 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 speciality²⁰. 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	<ul style="list-style-type: none"> • 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 (<i>'always one doctor away from a crisis'</i>)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	<ul style="list-style-type: none"> • 52% of rural doctors provide afterhours care, compared with 20% of metropolitan doctors²²

	<ul style="list-style-type: none"> • Negligible deputising services • Perform secondary care services after hours – anaesthetics, surgery, emergency care, or inpatient hospital care
Hospital care	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 3-4 times more likely to die in road accidents²³, • Twice as likely to be hospitalised, and twice as likely to die, from injury²⁴ • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 Australians²⁸ • Rural doctors need advanced skills in cross cultural communication and an understanding of Aboriginal history, culture, health, and community-controlled health systems
Public Health	<ul style="list-style-type: none"> • Rural and remote people have worse health status than their metropolitan counterparts and higher rates of lifestyle related illness²⁹ • 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 credentialing 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., Oncology⁴²). 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 identify 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 skills⁴⁶
- Tennett et al. (2020) Access and outcomes of general practitioner obstetrician (Rural Generalist)-supported birthing units in Queensland⁴⁷
- Bond and Chong (2020) Investing in Queensland's rural medical leaders: Lessons from the Queensland Rural Generalist Program⁴⁸

- 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 students⁵⁰

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 Career⁵⁹

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 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 al⁶⁰ 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:

Region	Included
Asia pacific	4
Australia/New Zealand	46
North America	36
Africa	11
Europe	4
International (WHO)	1
Total	102

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
<ul style="list-style-type: none"> • 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 health, 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 skills (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
<p>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.</p>
<p>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).</p>
<p>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.</p>
<p>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.</p>
<p>Prof Jill Konkin, BA(Hons), MCISc, 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.</p>
<p>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.</p>
<p>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.</p>

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	<p>There are 18 University Medical Schools supporting 89 Rural Clinical Schools.</p> <p>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.</p> <p>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.</p>
Rurally oriented undergraduate medicine (MBBS) and Masters and Postgraduate Diploma of Rural and Remote Medicine, JCU, Australia	<p>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.</p> <p>At the postgraduate level the Rural Health Department offers several courses to rural GPs and Rural Generalist doctors:</p> <ul style="list-style-type: none"> • Postgraduate Diploma of Rural and Remote Medicine • Masters of Rural and Remote Medicine <p>These are postgraduate programs for rural clinicians wishing to expand their capacity as educators and researchers in issues related to rural and remote medicine.</p>

Table 1.7 Flagship Rural Generalist Training Curricula and Programs	
State/Territory led Rural Generalist Programs, Australia	<p>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.</p> <p>The programs include:</p> <ul style="list-style-type: none"> • 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	<p>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.</p> <p>Pathway includes:</p> <ul style="list-style-type: none"> • 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	<p>Graduate-entry medical program to medical degree (MD). Includes:</p> <ul style="list-style-type: none"> • 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	<p>Assessment Objectives for Certification in Family Medicine, including:</p> <p>Priority Topics and Key Features for Rural and Remote Family Medicine (See Appendix 1)</p> <p>Advanced Skills curricula:</p> <ul style="list-style-type: none"> • Obstetric Surgical Skills • Advanced Family Practice Anaesthesia • Enhanced Surgical Skills • Palliative Care • Care of the Elderly • Addiction Medicine <p>The Advanced Skills programs are delivered through medical schools including:</p> <ul style="list-style-type: none"> • University of Toronto • University of Alberta • Northern Ontario Medical School

Table 1.7 Flagship Rural Generalist Training Curricula and Programs	
	<ul style="list-style-type: none"> • 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	<p>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</p> <p>Program includes:</p> <ul style="list-style-type: none"> • 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 <p>The WWAMI Rural Integrated Training Experience incorporates 31 rural family residency programs across those states.</p>
Rural Pipeline Programs, United States	<p>There are around 40 rural training pipeline medical schools in the United States offering broad scope Rural Generalist type curriculum options. Key programs include:</p> <ul style="list-style-type: none"> • Physician Shortage Area Program (PSAP) of Jefferson Medical College, Thomas Jefferson University⁶⁸ • 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	<p>Postgraduate Diploma in Rural Medicine</p> <p>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:</p> <ul style="list-style-type: none"> • 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. <p>Four modules:</p>

Table 1.7 Flagship Rural Generalist Training Curricula and Programs	
	<ul style="list-style-type: none"> • 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	<p>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.</p> <p>Additionally, University of Otago offers:</p> <ul style="list-style-type: none"> • 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	<p>Rural Generalist postgraduate training program based on ACRRM curriculum, based in rural and remote islands of Japan, includes. Training comprises:</p> <ul style="list-style-type: none"> • 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	<p>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.</p>

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 one 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 recognised 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 2022⁷⁸
- Joint position paper on rural surgery and operative delivery, 2015.⁷⁹
- Joint position paper on training for rural family physicians in anaesthesia, 2001⁸⁰
- 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.

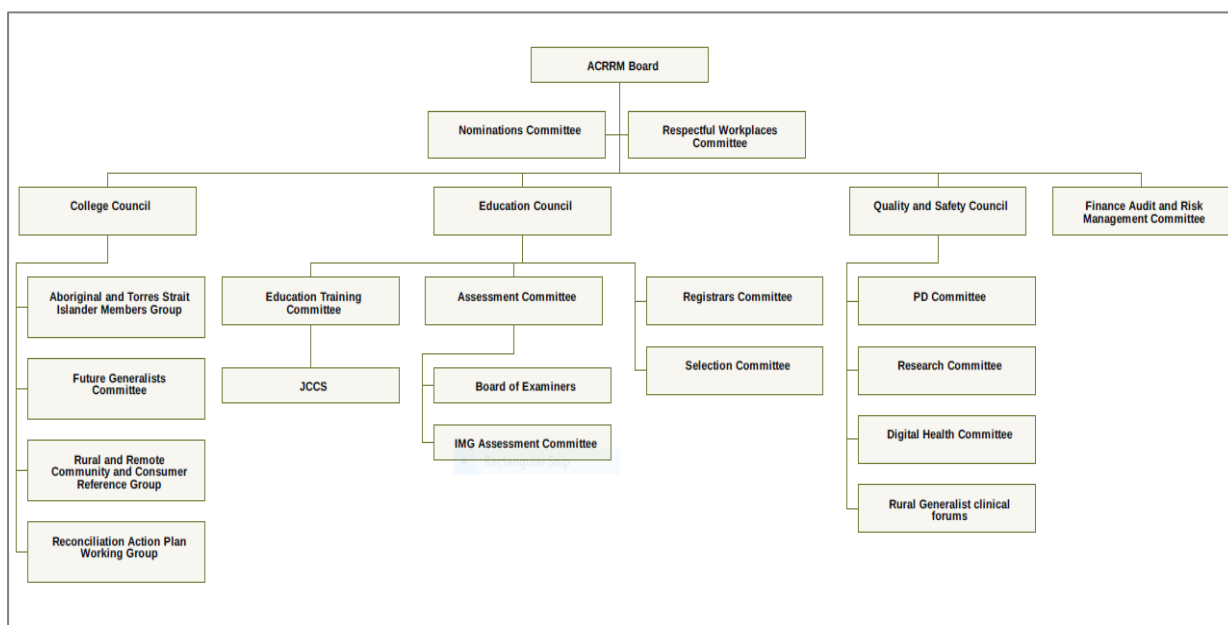
Colleges' Internal Governance

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 of 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 Anaesthetists (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 its 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	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • NT Health Workforce Stakeholder Group • NT RGP Reference Committee (RG CU Governance Body)
Queensland	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Committee of College Chairs, South Australia Health South Australian Rural Generalist Program – Steering Committee (RG CU Governance Body)
Tasmania	<ul style="list-style-type: none"> Rural Medical Generalist Coordinating Council (RG CU Governance Body) Voluntary Assisted Dying Stakeholder Reference Group, Tasmanian Government
Victoria	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 credentialing 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 Eundem 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

Practising 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 Felloved 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 learning 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 enrolls 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	<p>Fellowship of The Royal Australian College of General Practitioners (FRACGP)</p> <p>FRACGP + RACGP Rural Generalist Fellowship (FRACGP-RG)*</p> <p>*FRACGP-RG has replaced the Fellowship of Advanced Rural General Practice (FARGP)</p>	Fellowship of the Australian College of Rural and Remote Medicine (FACRRM)
Duration	<p>3 years – FRACGP</p> <p>4 years – FRACGP+FARGP</p>	<p>4 years*</p> <p>*5 years for Fellowship with AST in surgery</p>
Program Structure	<p>For FRACGP:</p> <p>12 months Hospital Training Time</p> <p>24 months in RACGP accredited facilities/training practices:</p> <ul style="list-style-type: none"> • 3 x 6-month terms in general practice (GPT1-3) • 6 months Extended Skills <p>For FRACGP-RG:</p> <ul style="list-style-type: none"> • 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) 	<p>36 months Core Generalist Training</p> <p>Commence at postgraduate year (PGY) 2 or above.</p> <p>Train in regional, rural and remote General Practices, hospitals, Aboriginal and Torres Strait Islander health services and retrieval services.</p> <p>Complete the minimum full-time equivalent training in the following:</p> <ul style="list-style-type: none"> • 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.

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 health 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 health 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 cities¹⁰²
- The inequitable and unacceptably poor access to quality healthcare services for both acute and continuing care of these same people relative to people in cities¹⁰³
- The persisting issues of attracting and retaining sufficient doctors to meet the breadth of services required in rural and remote areas¹⁰⁴

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 States¹⁰⁹ and Canada¹¹⁰. (Further detailed at [Section 3.A.5](#))

Figure 3.1 General practitioners FTE per 1,000 pop, by MM and GP type 2015 and 2019¹¹

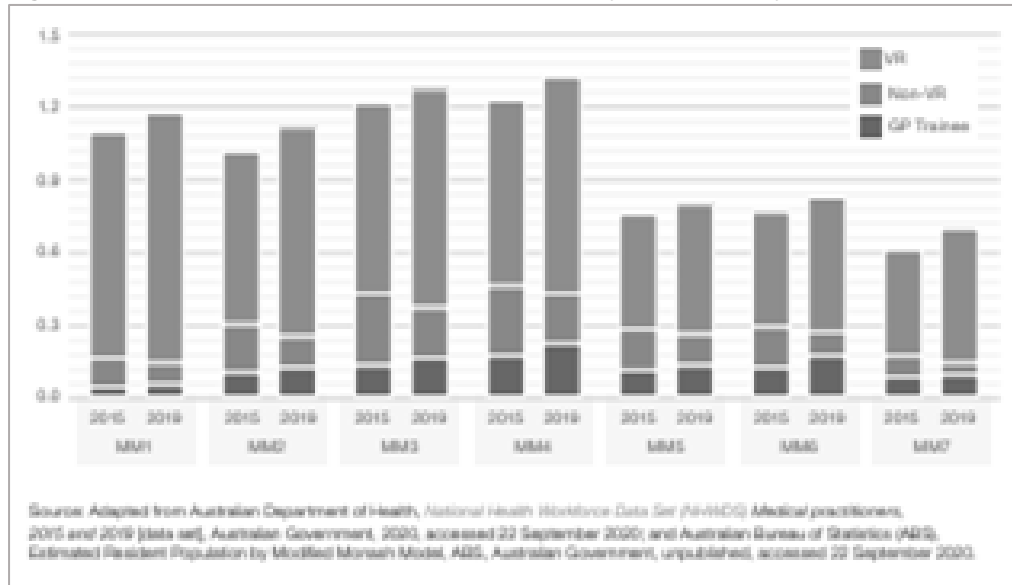
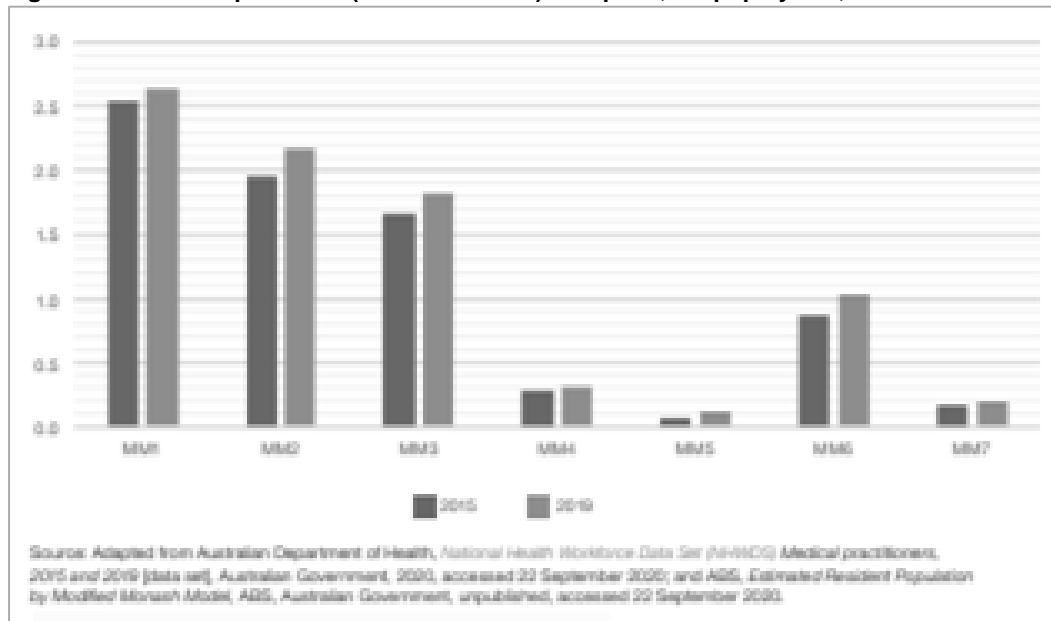
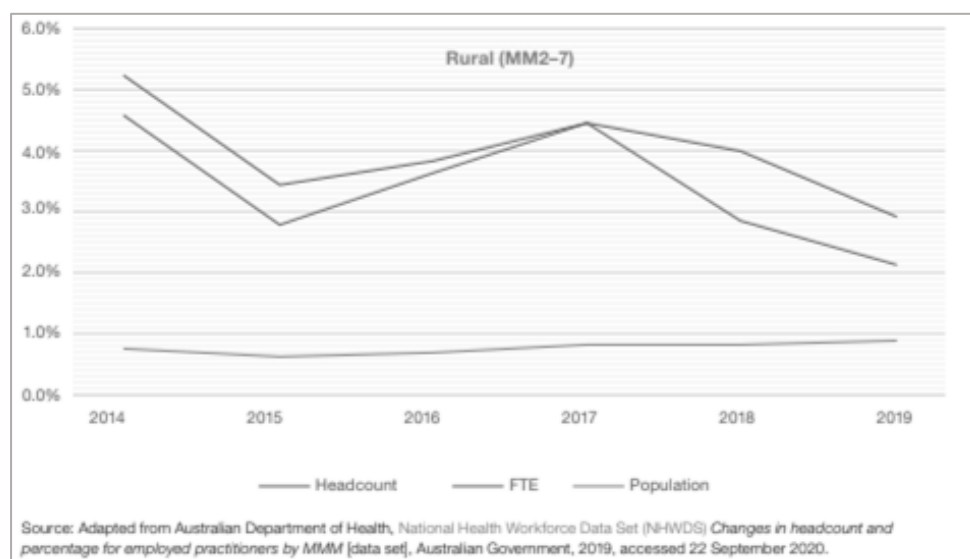


Figure 3.2 Medical specialists (GP and non-GP) FTE per 1,000 pop by MM, 2015 and 2019¹²



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, MM2-7¹¹³



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 are 10% 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:
<p>Need better access to medical care (insufficient rural and remote doctors)</p> <p><i>Evidence:</i> Rural and remote people's lower health status, workforce shortages, patient wait-times.¹³⁴ patient testimonies¹³⁵, Rural Generalist's long working hours.¹³⁶</p>	<ul style="list-style-type: none"> • 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}
<p>Need stronger coordination of care (primary, referred, emergency)</p> <p><i>Evidence:</i> GPs typically uninformed of outcomes of consultant specialist visits but required to provide follow up and emergency care.</p>	<ul style="list-style-type: none"> • 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
<p>Need local access to care in medical emergencies</p> <p><i>Evidence:</i> Higher death rates, deaths by accidents, road toll etc.¹⁴⁰</p>	<ul style="list-style-type: none"> • 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
<p>Need as much access as possible to the spectrum of advanced care/specialised services</p> <p>(To provide access and to avoid the inequity of forcing the cost of travel to access care on to rural and remote people)</p> <p><i>Evidence:</i> Rural and remote patients not receiving specialist care and having poorer health status across most categories (See Section 3.A.1)</p>	<ul style="list-style-type: none"> • 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
<p>Need specialised care but cannot support business model for a locally-based consultant specialist</p> <p><i>Evidence:</i> Very low representation of specialists in rural and remote areas.¹⁴¹</p>	<ul style="list-style-type: none"> • 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 QRG 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 cities¹⁵⁹ 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	<p>A single national standard which is associated with AMC accredited Fellowships, enabling:</p> <ul style="list-style-type: none"> • 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	<p>Recognition will provide protected title which will be associated with an AMC accredited Fellowship</p> <ul style="list-style-type: none"> • 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’	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 QRGF and its associated Rural Generalist specialist title and the James Cook University (JCU) medical school. JCU graduates represent almost half of all QRGF trainees (41% of all trainees and fellows).¹⁸⁰

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

Medical School	Student intake 2018 ¹⁸¹	Total trainees and fellows in/completed the QRGF 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
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*Support for Mental Health Emergencies training introduced in 2020

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

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.

	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

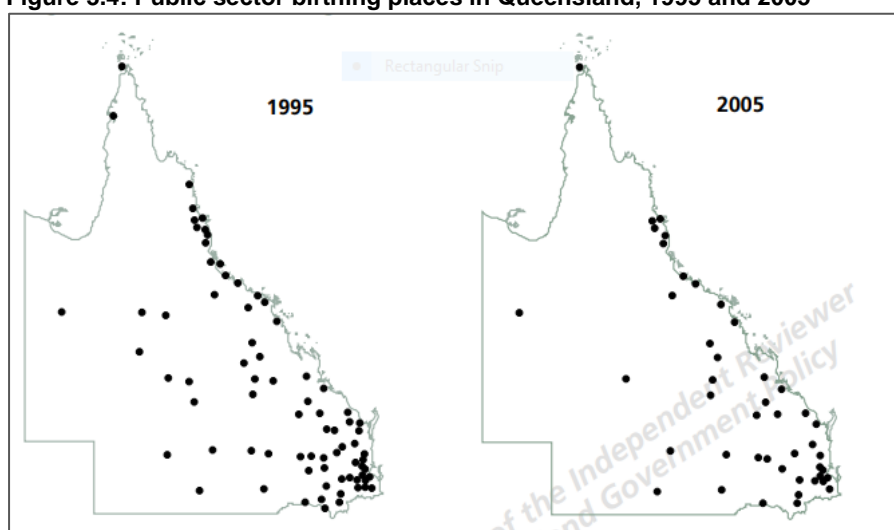
Indicative evidence of the positive workforce outcomes associated with strong support for Rural Generalist training and some degree of recognition of specialist title for Rural Generalists are given below.

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 underserved 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 RGM²¹⁰ 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 practice²¹²

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. Its 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 there is considerable evidence of the prevalence of the Rural Generalist scope of practice elsewhere including from Canada²²², New Zealand²²³, the United States^{224, 225} and, Africa^{226, 227} and Asia²²⁸.

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 Recommendations²³⁵ 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 Australians²⁴² 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 Australia²⁴⁷ 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 Australia²⁶⁴ and New South Wales²⁶⁵. 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.

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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 scarce 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 underserved 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	<p>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.</p> <p>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.</p> <p>MMM classifications are based on the Australian Statistical Geography Standard - Remoteness Areas (ASGS-RA) framework.</p>
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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