# *The rural–city dispute of the 1990s and beyond*

Max Kamien, MD, FRACP, FRACGP, FACRRM



Gundabooka National Park, Far-West NSW
Photo Max Kamien 2017

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# *Acronyms and abbreviations*

| | |
|---|---|
| ACRRM | Australian College of Rural and Remote Medicine |
| AGPT | Australian General Practice Training |
| AM | Adelaide Mafia – the North Queensland RACGP faction's name for their South Australian opponents |
| AMA | Australian Medical Association |
| ASC | Annual Scientific Convention |
| BEACH | Bettering the Evaluation and Care of Health |
| FMP | Family Medicine Program |
| FARGP | Fellowship in Advanced Rural General Practice |
| FRM | Fellowship in Rural Medicine |
| FRACGP RM | Fellowship of the RACGP – Rural Medicine |
| GP | General practitioner |
| GPET | General Practice Education Training |
| JCCs | joint consultative committees |
| JVB | Joint Venture Board |
| MSRPP | Medical Superintendents with the Right of Private Practice |
| NCGPET | National Council for General Practice Education and Training |
| NQRNs | North Queensland Rednecks – the South Australian RACGP faction's name for their Queensland opponents |
| NRF | National Rural Faculty |
| QIRC | Queensland Industrial Relations Commission |
| RTP | regional training provider |
| RACGP | Royal Australian College of General Practitioners |
| RDAA | Rural Doctors Association of Australia |
| RDANSW | Rural Doctors Association of New South Wales |
| RDAQ | Rural Doctors Association of Queensland |
| RHSET | Rural Health Support Education and Training |
| RMCC | Rural Medicine Committee of Council |
| SPSFQ | State Public Services Federation of Queensland |

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Most particularly, I thank all the participants in these events who agreed to be interviewed. I knew all of them from previous meetings and rural medicine endeavours. All were generous with their time and their hospitality.

Some participants in these events will learn things about the rural–city dispute that they did not know at the time. Some will not agree with my interpretation of events. That is the nature of writing (fearlessly) about history.

Before writing this history, I held my informants in high esteem. After writing it, I still do. I would be happy to have every single one of them as my personal GP and as a trusted friend.

## Biographical note

Max Kamien was born and educated in Perth, Western Australia. He has postgraduate qualifications in internal medicine, psychiatry and child health but his main interest has been in primary health care. In the early 1970s he was a doctor in the Far West of New South Wales where he wrote the book ‘The Dark People of Bourke’, exploring the concept of a doctor acting as an agent of social change. In 1976, he was appointed the first professor of General Practice in Australia.

He has had a 42 year association with the RACGP and has served as Provost of the WA Faculty and as Chair of the National Archives Committee. The RACGP awarded him Life Fellowship in 2004 and in 2015 its highest accolade, the Rose – Hunt Award.

He has also been an Academic Director and Board Member of the Australian College of Rural and Remote Medicine and was granted Honorary Fellowship in 2007.

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# *Introduction*

This history deals with two critical issues that continue to plague medical practice and education; health services in remote and rural areas and the institutional dissonance of urban versus rural.

In 2012, the National Rural Faculty (NRF) (now RACGP Rural) of The Royal Australian College of General Practitioners (RACGP) commissioned Fay Woodhouse, a freelance historian, to write an institutional history in celebration of their 20th anniversary. The NRF executive wished to record a holistic picture of the challenges, changes and initiatives that had occurred within the rural general practice setting since the 1970s.[1]

Fay Woodhouse started to write a celebratory essay but found that all was not well with the world of rural practice. She pointed out that an examination of the upheavals of the 1990s were fundamental to any examination of the history and development of the NRF and could not be ignored or minimised.[2] Fay Woodhouse made a brave attempt to complete her task but had difficulty in obtaining interviews with most of the protagonists of the 1990–2000 'rural–city dispute'.

John Kramer, the NSW representative on the NRF Board, suggested that I, Max Kamien, the new chair of the RACGP Archives Committee, and a rural medicine advocate, should interview the main doctors involved in the events that led to some leading rural doctors splitting from the RACGP to form a second general practice college – the Australian College of Rural and Remote Medicine (ACRRM).

My motivation in agreeing to research and write about this saga was that the major role of the RACGP Archives Committee is to document significant historical events in a manner that is as accurate as possible, by recording and understanding the contemporaneous views that determined the actions of all the players in major events involving the RACGP.

The formation of ACRRM and the loss of the Family Medicine Program (FMP) are two of the most important events in the recent history of the RACGP. My ultimate aim is for current and future office holders to know of and learn from past successes – and more importantly, from past failures and follies.

## Method

My method combined oral history and a search of pertinent RACGP archives and back issues of the weekly medical newspaper, *Australian Doctor*. Many of my interviewees also gave me access to their personal papers, minutes of meetings and newspaper cuttings from that fractious time.

Between June and September 2014, I sent emails to most of the main participants in the rural–city dispute (1991–2000), whom I identified through my initial search of the literature and from my personal knowledge of the event. These emails described my aims and the method that I was proposing to use. All but three of these doctors agreed to be interviewed. Two were happy to dine with me but only on the condition that we talked of other matters. The third was willing to talk on the phone but only to correct 'matters of fact'. Their reasons for declining a full interview were: 'the fickle, self-serving frailties of memory', not wanting to participate in an RACGP/NRF 'self-serving rewrite of history', and 'not wanting to revisit traumatic and unhappy events'.

My intention of recording oral histories was thwarted by the inadequacy of my recording equipment. My other intention of sending transcripts of the interviews, together with my insights, back to the participants for correction and comment also went by the board. The main reason was my realisation that this was a further imposition on the time of my participants, whom I was loath to badger any further. However, when I was unsure about a date, an event or about the accuracy of my interpretation, I emailed my informants, who all provided timely and courteous replies.

# The setting

A shortage of adequately trained and well-supported doctors in rural and remote areas has been a constant problem in Australia.[3] Despite this situation, in 1987, the federal government reduced after-hours payment for all general practitioners (GPs). This measure was aimed at curbing the activities of entrepreneurial 24-hour city clinics, but it also led to the emergency after-hours work of country doctors being paid at less than a tenth of that of the nurses and ambulance drivers involved in the same emergency. This led to the NSW Rural Doctors' Dispute.[4]

The RACGP offered to assist the rural GPs in their negotiations with the NSW Minister for Health. The GPs declined this offer because they were worried that the RACGP 'would sell them down the river'.[5]

The Rural Doctors' Dispute resulted in rural GPs developing a strong sense of camaraderie. This was assisted by their leaders' ingenious modifications to the facsimile (fax) communication technology of that time that enabled quick communication with their colleagues. This newfound solidarity was the genesis of the Rural Doctors Associations of NSW (RDANSW) and Queensland (RDAQ) and shortly after, the Rural Doctors Association of Australia (RDAA).

In Western Australia, the shortage of country GPs had become an election issue, especially in four of the six swinging seats that would decide the upcoming 1985 state election. The Labor government tried to defuse an electoral backlash by promising an investigation into the problems of recruitment and retention of country doctors. The subsequent report, known as 'The Kamien Report', was submitted to the state Minister for Health at the end of 1987. It provided an evidence base for the political actions of the various Rural Doctors' Associations.[6] South Australia held a similar inquiry, with similar findings.[7]

Between 1988 and 1992 there was increasing activity aimed at addressing the shortage of well-trained country doctors (see Timeline).

# RACGP involvement

The RACGP had been an early pathfinder in seeking solutions to the provision of medical services to rural and remote areas. In 1977, the Medical Education Committee of the RACGP Council formed a sub-committee on rural practice. It recommended that a national conference be held to address the issue of rural practice. The Victoria Faculty of the RACGP and the Victorian Academy of General Practice organised and held the conference in Melbourne over five days in November 1978. The conference title was 'Country Towns, Country Doctors' and the theme was 'Better healthcare for rural Australia'.

The conference drew together 205 people representing 42 organisations involved in rural healthcare from all over Australia. Participants included doctors, health personnel and concerned citizens. The conference embraced all communities, including Aboriginal and Torres Strait Islander participants.

Dr Eric Fisher told me: 'I particularly remember the indigenous contribution emphasising the need to understand Aboriginal culture in order to manage Aboriginal health. I learnt more about understanding indigenous needs then than I have heard expounded since'.[5]

The meeting was opened by the then Minister for Health, the Hon Ralph J Hunt. He stated that 'the rural community provides much of the real wealth of Australia and it has therefore earned the right to have access to high quality healthcare'.[8] He reminded his audience that his government had only recently brought in the Isolated Patients' Travel and Accommodation Assistance Scheme to provide financial help for country patients who had to travel long distances for specialist consultations.

Minister Hunt displayed a good grasp of the problems of rural people, rural doctors and the failure of undergraduate and vocational medical training, and free market principles, to help solve the shortage of well-trained Australian graduates working in rural and remote populations. He concluded his address by challenging the medical community to 'seriously consider rural general practice as a career every bit as enjoyable and fulfilling as city practice'.[8]

The deliberations of the attendees at the conference were guided by three basic principles:

- Communities should define their own healthcare needs.
- Health professionals should define their initial and continuing education needs.
- Support services must be evaluated both from the point of view of the community and by the health professionals involved with them.

The conference was a resounding success with attendees unanimously passing 44 recommendations that would further their aims of improving rural people's access to appropriate healthcare. Nearly all of those recommendations are as pertinent in 2017 as they were in 1978. The last two recommendations (43, 44) were for the RACGP to be the appropriate network for the coordination and implementation of activities arising from the conference. The organiser, Dr Rex Walpole, a distinguished Fellow, GP, medical educator and editor of *Australian Family Physician* (*AFP*), published the proceedings of the conference.[8]

Some of the attendees' recommendations were actioned rapidly. These were:

- Dr Brian Connor's suggestion of financial assistance for country families visiting relatives at base or teaching hospitals.
- The formation of a committee to address Aboriginal and Torres Strait Islander health issues.
- Specialist supervised general practice registrar training in anaesthetics and obstetrics at country base hospitals.
- A joint diploma in obstetrics and gynaecology that was organised in conjunction with The Royal Australian College of Obstetrics and Gynaecology.

Unfortunately, most of the other recommendations of this conference were not followed up, probably because Dr Walpole died unexpectedly and Council did not set up committees responsible for their implementation.[5] These early rural doctor initiatives remained dormant for 12 years, until the 1990 Annual Scientific Convention (ASC) in Perth, when two resolutions were passed at Convocation requesting Council to consider setting up a rural faculty. After lengthy deliberations, Council ratified the formation of an RACGP Rural Faculty on 26 April 1992. Dr Alan Wallace (QLD) was elected chair, Dr Col Owen the representative on Council, and Dr Mark Craig the censor.

The RACGP Rural Faculty was welcomed and supported by Dr Tony Buhagiar, RACGP President (1990–92). He saw the need to give rural doctors more say within the RACGP and believed that a rural faculty with a seat on Council would help them.[5]

Aboriginal health issues were accented in the FMP curriculum and through registrar attachments to community controlled Aboriginal Medical Services. In 2010, the RACGP formed a National Faculty of Aboriginal and Torres Strait Islander Health. Dr Brad Murphy, a Kamilaroi man from Gunnedah in NSW, was the driving force behind this initiative and he was elected as its first chairman.

# *Solutions to the problem*

As already noted, in 1990 there was a shortage of rural doctors in every state and territory of Australia. Various state-based strategies were devised to address this deficiency.

Queensland has long been the most decentralised state in mainland Australia, with more than half of its population living outside of the Brisbane Statistical Division (see also South Australia, Victoria and Western Australia, where three out of every four persons lived in Adelaide, Melbourne or Perth).[9]

Queensland Health 'solved' its rural medical workforce problem by providing scholarships to medical students in return for an equivalent time of rural medical service. After completing their intern year these bonded doctors were sent to rural and remote towns where they were 'thrown in at the deep end before they had learned to swim – most left the anxieties of rural practice as soon as they could'.[10] Those who satisfactorily completed their rural service were not encouraged to stay in the bush. They were rewarded with preferential entry into city hospital-based specialty training positions.

Those who did choose a career in rural medicine wanted to protect the next generation of rural doctors, and their patients, from suffering the same traumatic learning experiences. They wanted doctors going to practise in remote and rural locations to be able to provide a safe level of care by being properly trained as procedural rural generalists.

The RDAA argued that rural and remote populations provided much of Australia's wealth and deserved a high-class medical service. This required procedural GPs who could deliver babies, administer anaesthetics and cope with emergencies. The RDAA activists maintained that the RACGP Family Medicine Program (FMP) neglected this area of vocational training leaving young doctors without sufficient procedural skills training for safe rural practice. This became an RDAA catchcry, even when or where it was not true. One such example concerned Dr Susan Griffiths who was the FMP Director in South Australia from 1987 to 1995. She had been a remote area GP in Port Hedland and was well aware of the procedural needs of future rural doctors. A majority of her graduating FRACGPs acquired procedural skills and 40% became rural GPs. Despite this success some South Australian RDAA activists kept up an unfair attack on her that she found personally distressing.[11]

Another RDAA grievance was the bureaucratic intransigence of the RACGP and the FMP in denying competency assessment or recognition for prior experience and learning unless this had been pre-approved. For example, a young doctor could obtain three years of first class GP experience in the UK or Canada but this would not count for the purposes of completing their FMP training and sitting the FRACGP unless they had applied for pre-approval of those postings before they left Australia.[12,13]

The RDAA wanted a dedicated training program for future rural doctors. They wanted the end point of this four-year program to be a Fellowship in Rural Medicine (FRM), awarded by a rural faculty within the RACGP responsible for the education, training and assessment of rural generalists and with the same level of infrastructure support that was provided to a state faculty.

# *The antagonists*

## The NRF

Most of the early office bearers in the NRF were procedural rural GPs from Queensland whose medico-political experience began with the setting up of the RDAQ and the RDAA. Their motivation was pure: to get good training for the next generation of rural doctors. They had no ulterior or self-aggrandising agendas. Therefore, they found it difficult to understand why the 1994–96 RACGP Councils could not see the inherent logic and virtue behind their quest.

Their spokepersons were plain speakers. The older, more circumspect, city-based and committee-wise Council members regarded them as 'hairy chested fanatics' with a 'feral' negotiating style that on one angry occasion included an episode of table thumping. The NRF spokepersons were 'doers'. Patience was not one of their virtues. They wanted to achieve their ends and move on. To them, the word 'bureaucracy' was a synonym for 'obstruction'.

Passion is a much over-used word. But in this case study it does accurately describe the RDAA and NRF leaders' emotional investment in their cause, as the following quotes and exchanges demonstrate:

'My involvement in making things better for rural docs and rural patients became a passion, like a marriage. My involvement cost me my first marriage. I became totally focused on rural needs and neglected my family's needs.'[14]

When Max Kamien asked: 'Why were you so emotional when you lost the vote at the 1995 RACGP Council meeting in Toowoomba?' Dr Bruce Chater replied: 'I had worked very hard, my hair had gone grey. I had convinced the rural doubters that made up 50% of the Rural Doctors Association, that they should go with the RACGP. I felt that I had misled the rural doctors and I had let them down. I was carrying the expectations of the rural doctors. It was the only time I have ever cried about politics.'[15]

Dr Owen, founding president of the RDAA, was older than the 'young Turks' and already a seasoned and

successful medical politician. He was their natural leader. Dr Owen was concerned with issues, not personalities. During negotiations, he would fight hard for his cause. After the meeting, he would happily socialise with his political opponents. RACGP Council members found that difficult to fathom.

## The RACGP Council

Council was, and still is, the apex decision-making body of the RACGP. In the early 1990s it was made up of a representative from each of the state faculties and one from the registrars-in-training. Other members were the censor-in-chief, the honorary secretary, and for one year, the secretary-general. The only members elected by universal college suffrage were the president and the treasurer. Members of Council elected a chairperson who presided over the meetings. The councillors were mindful of their role as decision-makers and proud of their position.

In the 1990s Council meetings were very formal and followed the procedures used in Australian parliaments. Members were addressed as: 'The councillor from Victoria' (etc) and stood when they spoke. One of the younger councillors from that time described this formality as old-fashioned and at variance with the ethos of the country doctors. 'At a time when you could not buy a paperclip without Council permission, Col Owen and Bruce Chater just went and did what they thought was necessary ... Council found them difficult to cope with.'[16]

In 1990, Council and then president, Dr Geoffrey Gates, a long-time procedural GP from Kellerberrin (a two-doctor town in the WA wheatbelt), genuinely wanted to support and advance rural medicine. They were also mindful that a new membership category of 'super' GPs would be likely to antagonise the majority of RACGP members.

Most Council members were already uncomfortable with what they perceived to be the RDAQ's 'caricaturisation' of two sorts of GPs: 'Giants of the bush', who were on call 24/7, administered anaesthetics, performed emergency surgery, delivered babies, planned for disaster management, and who knew their patients from cradle to grave, and 'City GPs', working fixed hours in group practices, seeing patients with coughs and colds, and writing certificates for sick leave.

This categorisation was not accurate and did not fit the experience of some city-based Council members who were still performing minor surgery and delivering 50 babies a year. It was also not true for most rural GPs in provincial towns with resident specialists. These GPs often had expertise in a procedural skill, such as anaesthetics and/or obstetrics, but apart from that, practised in much the same way as most city doctors.

Council also felt that they were being 'stood over' by a small group of single-minded rural doctors, mostly from Queensland, and had concerns that these 'zealous Queenslanders' would damage the RACGP's relationships with the federal government and affect its funding of the Family Medicine Training Program.

What Council failed to understand was the sway GPs in one- or two-doctor towns have with their local MPs, whose extended families are in all likelihood their patients (eg Dr Owen delivered the 2012–15 Queensland Minister for Health, Lawrence Springborg). Healthcare also looms much higher on the political priorities of rural politicians than it does for those representing city electorates. Also, the RDAA leadership was active in and close to the rurally based National Party, whose leader is usually also the deputy prime minister.

The rural doctors may have been few in number but their political sway was much greater than that of the RACGP. In addition, two of the RDAA leaders, Jack Shepherd from South Australia and Brian Williams from Western Australia, were colonels in the Army Reserve and one, now senior public servant, had served under them. This gave the RDAA another line of communication to federal government ministers.

## The debate

*'Elsewhere, professional squabbles, always so unseemly and distressing, are happily becoming rare, and in Great Britain, and on this side of the water, we try at any rate "to wash our dirty linen at home". In the large Australian cities, differences and dissentions seem lamentably common.'*[17]

The organisational, educational and rural Fellowship aims of the RDAA and RDAQ proceeded slowly but in a

positive direction. Four years after the 1990 meeting between RACGP President Dr Gates and RDAA President Dr Owen, the RACGP had formed a National Rural Faculty (NRF), appointed a director of rural education and training, and Council had accepted and ratified the Board of Censors' recommendation to award a Fellow of the RACGP – Rural Medicine (FRACGP RM) to appropriately qualified rural GPs.

However, there were underlying tensions among Council members over the primacy and standing of the FRACGP. Those tensions surfaced at the end of 1994.

Secretary-General, Dr Michael Bollen, drew Council's attention to the legal requirements of the RACGP Constitution. Under its terms of reference, the NRF was a faculty of the RACGP with the same organisational status as a state faculty. It was an integral part of the RACGP and (without changing the constitution) could not legally award a qualification in its own right. This led the censors to revisit the status of the proposed qualification of FRACGP RM.

The executive director of the FMP (Dr Richard Nowotny) was asked for an opinion. He argued that an extra year of study should not result in an award of the status of a Fellowship of a professional college. By university academic standards, an extra year of study was equivalent to a graduate diploma. The Board of Censors accepted this argument, and this resulted in Council rescinding its previous decision to award an FRACGP RM and opting instead for a Graduate Diploma in Rural General Practice. Council also declared that the NRF of the RACGP would now be called the RACGP Rural Faculty.

The following year Council went even further in putting the RACGP Rural Faculty activists in their place. They declared that Fellows of the RACGP with appropriate rural general practice experience and who had attained a Graduate Diploma in Rural General Practice or satisfied other criteria set by the censors, could be elected to Fellowship of the RACGP Rural Faculty and use the post-nominal 'FRACGP (Rural)' and be styled Rural Fellows of the RACGP.

That is, some rural GPs could be named as rural Fellows without undertaking any specific additional training. This was the antithesis of what the rural doctors had been fighting for (see Timeline, October 1995). The RDAA, RDAQ, RDNSW and the NRF board members regarded these provocations as a slap in the face. It is therefore ironic that ACRRM did much the same when they grandfathered and 'pioneered' in their original batch of FACRRMs on the nomination of two of their rural colleagues.[18]

For the first time in the history of the RACGP, in 1994, nine of the 14 members of the Council came from only two states, Queensland and South Australia. Queensland provided the president, treasurer, a faculty representative and a rural faculty representative; South Australia contributed the chair of Council, censor-in-chief, honorary secretary, a faculty representative and the registrar representative. Since those two states' representatives tended to vote as opposing blocs, Council was rendered dysfunctional and unable to exercise its important role as the umpire in RACGP disputes.

A further factor adding fuel to this dysfunction was that the new president, Dr Col Owen, had campaigned on a ticket of improving doctor training and medical services for rural people. He considered that his election gave him a mandate to further the aspirations of the rural lobby.

The debates between the two groups became increasingly acrimonious and each began to distrust the other. Council came to see the Queensland doctors as a 'small group of self-interested activists, intent on serving their own sectional interests'.[19] At one meeting, two of the senior college office holders told the RDAQ lobbyists that: 'You are with us, but not of us', adding later that 'you will not get a bigger, bolder, brighter Fellowship. We will crush you'.[20]

The Queensland rural doctors came to the conclusion that the Melbourne-based RACGP was not committed to their rural members. They stated that they were 'fed up with the broken promises, endless negotiations and back-flips of Council' and that Council had 'dishonourably reneged on their agreement with them'.[21] They blamed the secretary-general and the Adelaide members of Council for this impasse and referred to them as the 'Royal Adelaide College'.

The views and actions of the opposing factions became tribal. The South Australian faction labelled their opponents the 'North Queensland Rednecks' (NQRNs)*. The Queensland faction referred to their South Australian opponents as the 'Adelaide Mafia' (AM). Each group regarded the other as 'treacherous'.[22,23]

Debate was replaced by 'game playing', with the NRF failing to answer correspondence and proposing motions of no confidence, non-negotiable propositions, plebiscites, boycotts of RACGP proposed member surveys, and denying that they had plans to set up an ACRRM. Similarly, the RACGP executive accused their more outspoken opponents of having conflicts of interest and 'inviting' them to resign from the RACGP.[16,23] Disagreements were aired to an ever-eager medical and national press. The words 'intransigent' and 'obdurate' became the catch-cries of the warring parties.

The complete breakdown of civil discourse between the rural doctors and Council occurred over the latter's discovery of a two-year-old in-principle judgement of the Queensland Industrial Relations Commission (QIRC). Alan Wallace had been called as an expert witness and had testified that a Fellowship in rural medicine was about to be established. The QIRC judgement stated that:

*Well-trained rural doctors with a Fellowship in Rural Medicine would have a higher level of skill than doctors who had only an FRACGP. The QIRC recommended that this higher level should be rewarded by increasing their award to two increments above that of an FRACGP. This award could only come into practice when the Fellowship of Rural Medicine received official recognition by the RACGP.*[24]

QIRC went on to explain that:

*Because the qualification is yet to be approved by the RACGP, our decision can only be in-principle. Consequently, we grant leave to the SPSFQ to approach the Commission immediately upon recognition of the Fellowship of Rural Medicine at which time the new clause can be inserted into the Award*.[24]

They added that 'Should a different level of qualification be determined by the RACGP this should be brought to our attention'.[24]

The Adelaide faction on Council interpreted this newfound information as the reason for the RDAQ doctors' insistence on having the post-nominal qualification of FRM. It also explained to them why so many meetings of Council and of the NRF had been so abortive. The AM criticised the NQRNs for putting money and status for themselves above the wellbeing of general practice as a whole. They accused the Queensland representatives on Council of 'double dealing', 'playing dirty', being 'dishonest' and 'wilfully deceptive', and as members of a legally incorporated governing board, of 'acting illegally'.[25]

The Adelaide faction on Council came to the conclusion that it was not possible to negotiate with the NQRNs. Despite their awareness of the risk of creating fractures in the fabric of the Australian general practice community, the Adelaide faction reasoned that the RACGP would be better off ridding itself of these 'deceptive rurals'.[25]

The RACGP executive consulted one of Australia's leading industrial law firms, Tress, Cocks & Maddocks, who agreed that Drs Owen and Chater had breached the provisions of the *Corporations Act*.

Dr Chater (and Dr Wallace) countered by pointing out that they had informed Council about this determination on several occasions in the previous two years. It was a small part of a State Public Services Federation Queensland Union of Employees application to the QIRC for restructuring the medical specialist and medical officers award for medical officers working in the public sector. It applied to full-time medical superintendents without the right of private practice. The NRF Board and Council members were all Medical Superintendents with the Right of Private Practice (MSRPP), so the QIRC determination did not apply to them.

Dr Peter Joseph, the RACGP president-elect, also confirmed that he had known about this in-principle industrial relations decision for some time. Based on this corrected information, Tress, Cocks & Maddocks reversed their original opinion.

* In fact, most of the passionate or angry Queensland activists came from south and central Queensland and regarded the north Queensland doctors and the North Queensland Sub-faculty of the RACGP as too moderate.[13]

In my interviews with rural doctors, the issue of this determination and increased remuneration never arose. I had to ask direct questions about it and do considerable archival research to discover that the 1994 monetary value of two public service increments under the Regional Health Authorities Award was $4200 a year.[26]

The only spontaneous comment about money made in my interviews with the RDAQ doctors was a description of the 1990 meeting they had with the then Minister for Health, Mr Brian Howe. Five minutes into the meeting he asked them how much money they wanted. Dr Chater replied: 'We are not after more money, we are after more training.'[15] Mr Howe then sat up and took notice of what they were saying.

The increment was never awarded. At the next determination, it was applied to doctors who held an FRACGP.[15]

To this day, many of the RDAQ faction believe that the whole saga was 'a malicious beat-up by the Adelaide faction who were more interested in preserving their own power-base than doing what was best for the College!'[21]

My interpretation is that the mind-set of the 'AM' led them to believe that their opponents had committed a breach of the *Corporations Act* and should therefore resign from Council and other positions they held in the RACGP. Some of the doctors I interviewed still hold to this belief.

## *The rural doctors' position*

My understanding of the rural doctors' stance is summarised below.

The RDAA/NRF leadership wanted to ensure that rural doctors were well-trained procedural generalists who could provide a safe level of care for rural and remote populations. This had been a longstanding problem that was in urgent need of a solution.

They reasoned that this could be achieved by providing new graduates with a dedicated, comprehensive, four-year rural training program within the FMP that concluded with a rigorous examination, and if passed would result in the award of an FRM in addition to an FRACGP.

They would not settle for a diploma because they maintained that the recognised currency in clinical medical practice was a Fellowship. They believed it would add status to the profile of rural medicine and attract more well trained procedural generalists to rural practice. They were sure that a Fellowship that accredited doctors' competence to perform procedures in state hospitals was more likely to be recognised by the joint consultative committees (JCCs).

The RDAA/NRF held a Fellowship as an article of faith. When their long-time respected leaders and now RACGP Council members, Dr Owen and Dr Chater, reluctantly agreed to accept the compromise of a graduate diploma of rural general practice, members of the RDAA executive accused them of 'selling out' to the RACGP – some even went so far as to call them 'traitors'.[27]

The RDAA wanted to be part of a faculty of rural medicine within the infrastructure of the RACGP. They wanted that faculty to have independent responsibility for rural training standards, for the examination and the award of the FRM even though they knew this was over and above the powers of an RACGP faculty.[28]

The RDAA/NRF wanted FMP registrars to commit to either a four-year rural training program or to the standard three-year general training program. Those registrars enrolled in the three-year stream were to learn about rural practice by completing a mandatory six-month rural attachment prior to sitting the FRACGP exam.

The rural doctors were aware that Council was reluctant to accept any group of GPs who had a special interest (eg skin cancer). They thought this was a myopic view that 'failed to recognise the diversity of general practice'.[28] They came to the conclusion that, being a minority group, their needs and wants would always be of a secondary consideration to the needs and wants of the urban majority of the RACGP. Then in 1996, an RDAA postal ballot of 1500 rural doctors confirmed that two-thirds of rural doctors reflected this view and wanted an organisation that would represent their needs and aspirations.[28]

# The RACGP Council's position

Council wanted to help advance rural medicine, and although it maintained that the basic FRACGP was a sufficiently encompassing qualification for all GPs, the need for extra procedural training for rural doctors was accepted. Dr Wilson, then Censor-in-Chief, agreed with Dr Nowotny's argument, that based on Australian university standards, an extra year of training was only equivalent to a graduate diploma.[29]

Council was unwilling to devalue the status and primacy of the FRACGP. It was convinced that the proposed FRM would imply that one group of RACGP GPs was better than another group. This would polarise the RACGP membership, whereas a graduate diploma after an extra year of study, would not.

Council did not accept the argument that a rural Fellowship was necessary to have standing with other medical colleges. Moreover, they believed an FRACGP RM would open the door to GPs with special interests wanting to set up their own faculties within the RACGP, and so destroy the whole concept of being a 'general practitioner'.

The RACGP was an incorporated body and had to comply with company and contractual law. Fulfilling the RDAA/NRF wants would involve modifying the college constitution and renegotiating the conditions that applied to its FMP government grant. The secretary-general was aware that the rural doctors saw these legal and fiscal obligations as nothing more than bureaucratic obstruction – particularly since these objections had never surfaced in the previous two years of discussions.[30]

Council worried that mandating a six-month rural attachment as part of the three-year general practice training would be unpopular and would be vehemently resisted. The registrars' families had jobs, attended schools and so on, and all would have their lives disrupted. Council also thought that compulsory rural attachments would be counter-productive and more likely to antagonise registrars against future rural practice than attract them to it. Council tried to compromise by carrying a motion that registrars should spend six months working in any area of need – not just rural need. The RDAA saw this as further evidence of 'anti-rural Council obstructionism'.

Council was not convinced of the wisdom of having first-year registrars commit to either a standard three-year general training program or to a four-year rural training program. Council thought this was likely to reduce opportunities for trainees in the general stream to experience and subsequently develop a liking for rural general practice. They thought that this proposal might well reduce rather than increase the number of future rural GPs.

Council was suspicious of the motives of the rural doctors. They thought that the proposal to split the training program into two separate programs, with a separate director for each, was part of an RDAA stratagem to split from the RACGP and take an established four-year training program with it.

Finally, Council was concerned that setting up a separate rural entity would require an increase in members' annual fees. In the early 1990s Australia was undergoing a financial downturn – Council thought that this was not the time to raise fees and risk provoking a backlash from members.[30]

# Is rural practice different?

*'The rural and city contexts are different. In Sydney, a rainy day is a bad day. In western New South Wales a forecast of rain is a hope for a great day*.' (Paul Collett)[31]

The existence and/or nature of a difference between rural and urban general practice had a major influence on the debate about the need for a special training program and an extra qualification. Council maintained that the work of all GPs was basically the same and the FRACGP was the unifying generalist qualification. Dr Nowotny, Director of General Practice Education, and Dr Wilson, South Australian Censor, used the Bettering the Evaluation and Care of Health (BEACH) data to show that the difference in workload between urban and rural practice was at most 10% (the latter being greater).

The RDAQ and NRF spokespersons agreed that the bread-and-butter of general practice work was the same for all GPs, city, rural, regional or in isolated practice. However, they drew Council's attention to the fact that the BEACH studies measured the content of general practice but not its context.

The contextual difference was what happened at the hospital door. The city and regional GPs handed over to the hospital specialists and their staff. The GP in a town without a hospital and the isolated or single-handed small-town GP could not. He or she was the hospital doctor, and had to know how to cope until backup arrived. That could take many hours. For example, an ectopic pregnancy in a remote rural situation typically took over a doctor's whole day.[32]

That 10% increase in workload over metropolitan practice equated to 36 days a year. It included the white-knuckle stuff that made rural practice scary, unless you were properly trained and had the skills to cope with it.

Dr Joseph, the RACGP president-elect (installed 16 October 1996), agreed. He recognised that front-line rural GPs faced problems rarely dealt with by city doctors. He advocated that rural GPs needed to learn to do procedures in medicine because they – and their patients – were vulnerable without those skills. He supported the creation of the FRACGP RM.

This question of rural/city difference remained an underlying factor in negotiations between the two parties right up to the beginning of the 21st century. In April 1999, in the western NSW town of Gunnedah, the then president of the RACGP, Margaret Kilmartin, told a surprised John Anderson, a future leader of the National Party and Deputy Prime Minister and an equally surprised Minister of Health, Dr Michael Wooldridge, that any difference between urban and rural practice was a myth.[33]

Dr Kilmartin was a GP in an established urban practice less than one kilometre from the Hobart GPO. Dr Kramer, then Honorary Secretary of the RACGP Rural Faculty and their representative on Council, tried to defuse the situation by saying he would work with the president and Council to improve their understanding of rural general practice and to ensure that the RACGP was representative of all GPs. But the damage had been done.

The rural lobby became increasingly frustrated by what they perceived as the inability of the RACGP Council to hear their concerns or respond to their needs and, by extension, to the needs of their patients. Many rural doctors wanted to leave the RACGP and set up a stand-alone rural college.[14] The RDAQ leadership decided to introduce a 'credible threat' as a tactic for progressing the negotiations. That threat was to hive off from the RACGP and start their own rural college.[28] It was only a matter of time before the credible threat became the new reality.

Since the rationale behind the formation of the NRF and then the ACRRM was to ensure that future rural GPs got top-class training that included procedural competence, it was also certain that ACRRM would want their share of the FMP training money that was provided by the federal government and administered by the RACGP.

# *The outcomes*

## RACGP Rural

Twenty years after these disputes came to a head, the RACGP has a national rural faculty called RACGP Rural. Membership is open to all RACGP members, as part of the annual membership fee of $1420. In 2017, RACGP Rural membership exceeded 16,000 members of whom 8000 were in rural or remote general practice.

The RACGP Rural aim is:

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

The RACGP recognises rural general practice, including regional, rural remote and very remote general practice, as a highly skilled practice area, greatly valued by its rural and remote members. It acknowledges that rural general practitioners benefit from specific training and continuing professional development.[34] It supports the ACRRM concept of a new grade of rural doctor, 'the rural generalist'[35] and it has long recognised ACRRM as a body with expertise about rural medicine.[36]

The AMC first accredited the RACGP and its programs in 2003. The last accreditation was in 2013 and a further review is scheduled for 2019. Strangely, the 2013 review made no mention of the Fellowship in Advanced Rural General Practice (FARGP).[36] This was probably because it had previously accredited the Graduate Diploma in Rural General Practice (Grad Dip Rural General Practice) that preceded and merged into the FARGP. The FARGP is awarded, post-FRACGP, after an equivalent time of one year of additional study. It has two pathways, one for registrars and the other for experienced GPs. Studies include extra skills training, such as procedures, cross-cultural understanding and mental health care. It allows FARGP candidates to focus on skills that are specific to their needs and their areas of practice.[37] It aims to increase a doctor's competence and confidence to practise in rural and remote Australia. Some 20% of its candidates are experienced rural doctors who want to extend their knowledge and skills base and wish to obtain a Fellowship that recognises their rural expertise.[37] Nearly all FARGP registrars take training in more than one of the major procedural areas of advanced practice (eg anaesthetics, obstetrics and surgery).[38]

From 2003–17, the Grad Dip Rural General Practice and the FARGP programs have graduated 567 doctors. They have a documented 70% rural retention rate with a procedural retention rate of 66%. This is a testament to their relevance in assisting doctors to prepare for rural practice.[38] In the financial year 2016–17, 167 registrars and 44 experienced GPs have enrolled in the FARGP program.[37,39]

RACGP Rural is represented at the federal government's rural policy table, and administers (with acclaim) the Rural Procedural Grants Program. It produces a bimonthly e-newsletter *Bush Alert*, develops resources to assist rural and remote general practitioners, and interacts with medical students and registrars. Evidence of its vitality can be found at the annual social event that is always fully subscribed and is the most high-energy event at each RACGP ASC.

## The ACRRM

The RDAA established and incorporated ACRRM in 1997 – the initial AMC accreditation of the college and its programs occurred in February 2007.[40] It is now fully accredited to 2018. In 2017 it had a national membership of 4800 of whom 1900 are Fellows and 1000 registrars. The remainder are specialist GPs without FACRRM, non-specialist GPs, junior doctors and medical students.[41]

Some 80% of all the Fellows and registrars are in rural or remote practice.[41] The annual membership fee is $1145. Membership gives access to the highly regarded Rural Remote Medical Education Online (RRMEO) learning modules that provide whole-of-career support for ACRRM trainees and members.

ACRRM's aim is:

*To provide leadership, training and support for rural generalist doctors who promote effective systems of care for their communities.*

ACRRM's registrar training program is of the same four-year period as the RACGP rural registrar plus FARGP. ACRRM maintains that its 'structured training pipeline', Rural Generalist and Independent Pathway program is better integrated, more rigorous and better at producing rural generalists than the FARGP.[28] It predicts that it will have graduated 400 rural generalists by 2018.[42]

ACRRM regards itself as an efficient, 'can-do' group of true believers with a competent educational and political program.[43] They see RACGP Rural as but a pale shadow of themselves.[28] ACRRM is strong in Queensland and NSW. It has a less influential presence in Victoria, South Australia and Western Australia. Its small size and messianic rural enthusiasm enable it to maintain a good connection with its members.

Rural generalists are sorely needed in Queensland. The Health Workforce Queensland's report on *Medical practice in remote, rural and regional Queensland: Minimum data set report at November 2013*, showed that only 170 (8.7%) of the 1951 medical practitioners in remote, rural and regional Queensland provided obstetric, anaesthetic or surgery services.[44]

Both the FRACGP and FACRRM are recognised general practice qualifications in Australia and New Zealand. Both colleges are accredited by the Australian Medical Council, that has complimented each of them for setting high professional standards for training, assessment, certification and continuing professional development, in the specialty of general practice.

## Which pathway?

In 2005, the AMC commissioned two professors of medical education to write an independent report on the rural and remote training curricula of the two colleges. They found broad similarities between the two programs. The main differences were that the RACGP program was conceptually based and the ACRRM program discipline based. The RACGP's model trained for core skills applicable across all general practice contexts and trusted registrars to learn skills specific to the needs of their training practices. The ACRRM curriculum listed all of the skills that were to be acquired. These theoretically different methods of presenting a curriculum accounted for the 35% increase in the curricula content of the ACRRM program. The two professors went on to point out that a qualitative view of the two programs accented their similarities. The two programs shared training providers and supervisors who did not see substantial differences in the training delivered to registrars following the ACRRM or the RACGP pathways. The two investigators thought that any real differences in the two programs would be tested out in the realities of practice.[45]

Data from a longitudinal survey of 610 rural pathway registrars (taken from both programs) who completed their training between 2008 and 2014 showed strong quantitative evidence of the association between rural GP vocational training location and subsequent rural practice location. The association was even stronger when rural origin was taken into account.[46]

This evidence supports the objectives of existing policies that require at least 50% of GP training to occur in rural locations, and that at least 25% of medical students should be of rural origin.[46] But it does not answer the question about differences, if any, between the two colleges' rural pathway programs. Dr Scott Kitchener, a rural medical educator in Queensland, has suggested that Australian General Practice Training (AGPT) providers should be charged with the responsibility of collecting and reporting their rural workforce outcomes particularly with regard to rural retention and the proportion of those doctors who are practising advanced rural skills.[47] These comprehensive measurements have yet to be reported.[47]

However, spokespersons from each college state that their Fellows' rural retention rates are between 70–80% with the continuing practise of advanced skills of between 60 and 70%.[34,41]

The completion of vocational training is an important part of any doctor's career path. But much, if not most, learning occurs, post qualification, in the course of a doctor's practice needs. That is why there have been many competent rural GPs who achieved legendary status in their communities long before the availability of formal vocational or mandatory continuous medical education.

I think it likely that long term evaluation of the graduates from each program will confirm the wisdom of the Chinese proverb: *'There are many paths to the top of the mountain, but the view is always the same.'*

# *The RACGP–ACRRM dispute and the evolution of general practice training*

In the 1990s, one of the arguments against setting up a rural faculty that could award an FRACGP RM, was that it would open the door to GPs with special interests who wanted to set up their own faculties within the RACGP, thus destroying the whole concept of being a 'general' practitioner. At that time, the majority of Council members did not value the idea of general practice being a 'broad church'.[27,28]

Two decades after the official conclusion of the rural–city dispute in 1996, the RACGP has a Faculty of Specific Interests (established 2009) and a Faculty of Aboriginal and Torres Strait Islander Health (established 2010). The former is very broad-based and includes GPs with special interests in important areas such as sexual abuse, family violence, sport and exercise medicine, refugee health and military medicine.

From an RDAA and ACRRM viewpoint, 'the RACGP missed the bus ... [they] had the opportunity to become a world leader in rural education. We offered it to them on a plate.'[28]

Other rural medicine leaders such as 2000–02 ACRRM president, Prof Ian Wronski and 1994–96 RACGP president, Dr Col Owen expressed the same view. 'Practitioners of rural medicine put their trust in the Royal Australian College of General Practitioners but it failed to deliver. This resulted in rural practitioners recognising the fact that they were better off on their own and their decision to form their own college'.[48] 'The RACGP needed to accept the diversity of general practice. This included sports medicine, emergency medicine and public health. The RACGP could have been the embryo for the development of a comprehensive practice of primary care.'[49]

The rural doctors' lobby and the ACRRM were politically active and advocated strongly for a slice of the $24 million per year FMP pie. They accused the FMP of ignoring rural needs and of being 'metrocentric'.[50] That word became the shibboleth and campaign slogan of ACRRM and their National Party supporters. This claim was not true since the FMP had always given priority to registrars who wanted rural attachments. A WA survey of rural registrars who finished their FMP training between 1977 and 1986 showed that all but one registrar was happy with their training even though most would have liked some more instruction and practice in procedural skills.[51] FMP took that complaint on board. At the formation of ACRRM in 1997, FMP was delivering rural training through 17 rural regional nodes, all of which had local medical education staff and administrative support.[31,52]

Proponents of the 'whatever it takes' school of politics[53] would regard the 'metrocentric' claim as clever politics. It did activate National Party MPs to lobby the Minister for Health, Dr Wooldridge, and to demand financial support for the ACRRM training program.[50] This 'clever politics', the failure of ACRRM/RDAA to ever recognise the work that the RACGP did in regionalising training for its rural registrars, and the 'crowing' of its achievements, remain three of the underlying tensions in the relationship that the RACGP has with ACRRM.[34,38,52]

In January 1997, Minister Wooldridge commissioned a review of general practice training. Following this review, the minister decided to set up a government-owned company, General Practice Education and Training Ltd (GPET), to oversee the implementation of a new system of general practice vocational training, the Australian General Practice Training (AGPT) program.[55]

In 2001, after 28 years as the vocational training program of the RACGP, the FMP closed its doors. This was a watershed moment for the RACGP. It became the only Royal College of Medicine in the British Commonwealth that was no longer responsible for training and educating its future members. Many members were, and still are, dismayed at this development:

*'The RACGP-FMP had developed a training program that was regarded as one of the best in the Western world. It was providing rural training through 17 rural regional nodes. Its replacement by regional training providers is but an expensive shadow of the former FMP*.'[31]

No small Australian organisation that lacked major political support could have survived the combined onslaught of the RDAA and the National Party. Nonetheless, in my view, and that of the Bryce Phillips' Committee, FMP could have made more effort to be a catalyst for the vertical integration of general practice education. It did so in north Queensland alongside the medical school at James Cook University.[13] (This vertical integration of all rural education and training is now a major feature of the overall ACRRM program).[43] FMP did not do it elsewhere because of an overly rigid view about its funding conditions. To the credit of its directors, FMP did insist that its general practice trainers fulfilled their contracts. Those who used registrars solely as a pair of medical hands and did not provide adequate supervision and education were removed from its teaching list. So, FMP had some enemies. But its difficulty in filling rural positions was due to the paucity of registrars who wanted to undertake rural terms – not because it was 'metrocentric'.[31]

AGPT built on an innovative, vertically integrated and regionalised model of training that had been established by the RACGP-FMP. It started with 22 regional training providers (RTPs). Some amalgamated, leaving 17.[54]

In 2015, AGPT (under federal government instructions) caused much registrar anxiety by reducing their training regions from 17 to 11 and calling for tenders for their management. Nine organisations currently provide general practice training in those 11 regions.

There are differing opinions about the success of this 16-year educational experiment. In comparison to the centralised RACGP-FMP, it has been an expensive exercise. Even a former GPET Board chairman and its first chief executive officer have posed the question: 'Have the policy outcomes of GPET and the AGPT program justified the resources required to maintain GPET and 17 regional RTP offices?'[54]

In 2017, the federal government looked for ways to offset the costs of general practice registrar training. They agreed to allow the biggest Australian corporate, Primary Health Care Ltd, to co-fund the training of an additional 300 registrars, who were expected to work for that corporate after they had obtained their Fellowship.[56] This was a contentious decision, strongly opposed by the Australian Medical Association (AMA) and by GPs who were critical of corporate medicine and worried about its ability to provide education in the value of continuity of care and other quintessential role modelling credentials.

There is little doubt that the AGPT program is popular with registrars. In 2013, an independent survey of 1942 registrars (74% of all registrars enrolled by AGPT) showed an overall satisfaction rating of 3.9 on a five-point scale. The vast majority of AGPT registrars (87.3%) were participating in FRACGP. A small number were engaged with FACRRM (3.6%) and FARGP (2.2%).[57] Hospital based skills training was being undertaken by 245 (12.6% of the registrars) as a part of their AGPT program.[57] This is a marginal improvement on AGPT data from 2006 to 2010 when there had been an average yearly intake of 21 registrars into anaesthetic training and 42 into obstetrics and gynaecology training – fewer than 10% of the annual intake of registrars.[58]

In 2017 ACRRM had 250 registrars a year training to become FACRRM qualified rural GPs.[41] The RACGP has 167 registrars and another 44 more senior FRACGPs enrolled in the FARGP program.[39]

# *A Shakespearean tragedy*

The split between the city and country members is the biggest calamity to befall the RACGP since its inception in 1958. It has had a much greater and longer-lasting effect on the political profile of the RACGP and general practice as a whole than did the threatened bankruptcy of 2002. Furthermore, any possible re-amalgamation of the two colleges is unlikely to occur within the lifetime of the current generation of ACRRM college leaders.

This split has all the elements of a Shakespearean tragedy. The main characters (the protagonists) were the RACGP Councils. Those Councils were composed of doctors of good will, who devoted much time and energy to the running of the RACGP on behalf of more than the then 15,000 members. They believed that they had to ward off the 'wild rurals' who were threatening the integrity of the RACGP as a whole.

However, those Councils and their secretariats had some fatal flaws. These were a narrowness of vision, indecision, authoritarianism, a failure to check their facts or follow due process, and an inability to set up optimal structures for negotiation and mediation. These flaws became apparent when Council was put under stress by an uncompromising, tenacious, politically savvy group of its rural members who wanted recognition for their special skills and who accused Council of breaking their earlier contract with them. These rural doctors were supported by rural politicians, who wanted a general practice training program that produced procedural GPs who could and would, service the medical needs of their constituents.

The end result for the RACGP was much unnecessary bloodshed, including the death of its training program and the remains of a rural faculty that the chairman described as a 'smouldering ruin'.[59]

These outcomes are wildly disproportionate to the dispute itself – in essence, an argument between different branches of the same family about whether the rural branch could have additional letters after their FRACGP.

The leaders of the city branch were conservative, senior Fellows of the RACGP not used to having their authority challenged and certainly not by their 'country bumpkin' cousins from rural South Australia, New South Wales and especially Queensland. These RACGP leaders had legitimate concerns about weakening the primacy of the FRACGP as the endpoint of general practice training. They grew impatient with the demands of their rural cousins, whose negotiating style they likened to 'having a gun put to their head'.[13]

Council, and the RACGP management, adopted an authoritarian approach to putting their unruly, rural relatives in their place. This centred on refusing to endorse an FRM as an extra qualification for appropriately trained rural GPs.

The reality then, and now, is that the Australian public is not knowledgeable about, nor interested in, post-nominals. The rural Fellows of the RACGP who 'defected' to ACCRM still use the post-nominals FRACGP, FACRRM. Few of their patients, if any, would know the meaning or the significance of these letters. To the public, a GP is a registered medical practitioner whom they expect to be competent.

Even Medicare is not interested in a GP's post-nominals. It classifies GPs as being on, or not on, the vocational register. Clinical privileges for GPs in rural government and private hospitals are influenced by recently acquired qualifications. After that, re-credentialing is not dependent on post-nominals but on competence and attendance at obligatory courses.

In short, the letters following a GP's name do nothing other than record his or her education at the time they were acquired. A GP's reputation and accreditation depends on what he or she has done with those letters.

Had the RACGP endorsed a Fellowship of Rural Medicine, all the aforementioned angst and divisiveness would not have occurred. There would not be a second general practice college, a revamped version of the FMP would exist, and the RACGP would, in all likelihood, be the influential, educational and political umbrella organisation for most forms and modalities of primary care medicine.

The dispute could not be resolved because the Rural Doctor Associations, Council, and the RACGP administration, contained some strong, unbending personalities. Council, succeeding councils and some RACGP presidents had a narrow view of the diversity of Australian general practice. A majority of Council members could not even agree that rural practice was different from city practice, and that rural GPs required an extra level of skill in dealing with sick or injured patients who, in a city, would be immediately taken to the emergency department of a well-staffed hospital.[27]

Between 1992 and 1994 Council and its executive were onside with its new rural faculty. But from the end of 1994 to 1996 they were offside. They made decisions and then back-flipped on them. The RACGP's own history timeline records a litany of dysfunction.[60]

Council repeatedly changed not only the position of the goalposts but the name of the game. They lacked procedural and decision-making competence and broke their contract with their rural members. This turned the rural doctors from colleagues into true believers with a righteous cause, who – if they could not shift an obstacle in their path – found a way past it. That way was to set up a college of their own. They were not moved by Council appeals for them to consider the good of general practice as a whole.

The RACGP is an incorporated business entity. The ethical and legal duty of its board (the Council) is to consider the best interests of the RACGP as a whole. The 1990–2000 Councils carried out that duty according to their thinking at that time. However, when that business entity is also a medical college that accepts government (taxpayers') money to run Australia's only general practice training program, its board must also consider what is best for the whole community that it serves. That includes taking into account what their paymasters (public servants and politicians) consider to be best.

The RACGP Council did make attempts to ruralise the management of the training program and to engage with rural and university stakeholders, but it was too late. The 'metrocentric' label had stuck, and country politicians were all too aware that a shortage of adequately trained GPs was, and still is, a major issue in their electorates.[50]

The consequent changes in general practice training in Australia have been well summarised by Steven Trumble FRACGP, a former director of the Victorian State RACGP Training Program and board member of GPET.

The Darwinian view of evolution is somewhat brutal: a species that is poorly suited to a changed environment needs to make way for one that is better suited. And that newly dominant species had better keep an eye on the weather if it wishes to retain its place. Extinction is only a moment away for those who live in the moment rather than anticipate the future. However, it is wrong to say that evolutionary success has much to do with being 'better' than one's antecedents. Despite Spencer's sociological interpretation of Darwin's theories of natural selection as 'survival of the fittest' – phraseology that Darwin himself eagerly adopted – successful evolution has less to do with strength and merit than the ability to read a changing environment and to effectively change to suit it.[61]

# *Lessons learned*

'There was fault on both sides. Some of the rural doctors were never going to accept any other outcome, but most blame lies with the RACGP, that could have been big enough to allow sensible changes. Instead, the more moderate rural doctors were betrayed and some moved to the extreme side of the separatist movement.'[13]

The history of the College is littered with decisions of Council made without adequate consultation. This has led to unnecessary extraordinary general meetings so that members can have their say or to continuing unrest in faculties.[62]

Hopefully, most of the lessons that can be learned from this decade of rural–city conflict will be taken on board by Council and the administrators of the RACGP. It is hard to imagine that a future president or single member of Council would maintain that any major difference between urban and rural practice is a myth. Nor is it likely that a GP with a special interest will be seen as a threat to the purity of the practice of general primary care medicine. It is also hard to envisage that Council and its secretariat would ever again exhibit such a narrowness of focus or get involved in a prolonged, backtracking dispute of such migraine inducing aggression and bitterness.[63]

Nevertheless, Council will always have the need to gather informed advice from experts within and outside the RACGP membership, consult with its faculties, then make fully considered decisions with the presence of the representatives of all involved parties. The same needs apply to committees such as the Board of Censors whose deliberations carry weight with Council. One of the problems in this case was that members of the Board of Censors were not always fully informed about contentious issues around the FRM and allowed themselves to be directed by Council on how they should vote.[64]

The NRF, the RACGP Council and its secretariat understood each other's agendas and concerns, but they did not have an effective means of negotiation and mediation. Negotiations should be between representatives of each party. It is a different process to the discussion, debate and vote by which decisions are made at Council meetings. Council was not and is not, an appropriate forum for negotiation between emotionally invested, warring factions, especially when members of both parties are on Council.

Private negotiation with representatives of the two parties may have had more chance of success. The task of negotiation and mediation is to help people separate issues of ego from the responsibility a councillor has to those who elected him or her and to see that most disputes are not between good and evil, but between partially good and not totally bad, and that win-win solutions are really in their own best interests, even if they don't win everything. A good mediator can at least help and can define areas of agreement and areas that need further discussion. Perhaps this could be a future role for state faculty provosts who already have a defined responsibility to adjudicate on unresolved state faculty board disputes.

## A set of principles

An important facet of good administration is to try to make other people's dreams come true. With regard to the NRF and an FRM, this was the case from Easter 1990 to the end of 1994. From then, until 1997 when ACRRM was formed, the stated aim of the majority of Council and the secretariat of the RACGP was to crush the 'pesky' Queensland members of the NRF.

These NRF members make the retrospective and perhaps self-serving observation that no one from the RACGP Council or Executive Board ever took them aside to explain the process for getting new measures through Council. This may not have averted the clash of cultures, but such mentoring is a helpful process for newcomers to any established organisation.[27]

The motto on the RACGP college crest is 'Cum Scientia Caritas' (with skill and tender loving care). These words are intended as a guide to the relationships between GPs and patients. But the RACGP and its secretariat would have benefitted by consciously applying the spirit of its motto to all its deliberations, endeavours and actions.

## The presidential mandate

It is to be hoped that members who seek high office within the RACGP are good politicians, in the sense that politics is the art of the possible. One of the strengths (and weaknesses) of a democratic college is that any member can stand for president, even if they have had little or no previous experience in the affairs of the RACGP. Once elected, a president can legitimately try to lead or at least influence policy, especially if that policy was part of his or her election platform. Hence, as Col Owen, 1994–1996 President, had been elected on a clear rural development and educational agenda, he believed he had a mandate to pursue it.

Dr Owen's pursuit of his agenda brought him into conflict with Council and with his duty (that he took seriously, but was unable to project to the Council and senior Fellows of the RACGP) to maintain the integrity and wellbeing of the RACGP as a whole.[49] The RACGP needs to develop a policy on the rights and duties of a president who is elected on a particular platform but whose platform is for one reason or another, blocked by Council.

# *Concluding comments*

Many senior and long-serving RACGP Fellows have been deeply hurt, scarred and alienated by this decade-long rural–city struggle. They feel that their work and dedication to the RACGP has been ignored or discounted and that 'the college doesn't care'.[65] Conversely, current rural general practitioners who had 'fantastic training by fantastic mentors' under the auspices of the RACGP are annoyed by claims that their training and, by implication, their standards of practice are not as good or as safe as those who trained under the ACRRM.[52]

The rural doctors I interviewed had a detailed memory of the events and told the same story, even if they had not seen each other for 15 or more years. This included the personalities involved, their arguments, the decisions that were made, the emotions around these decisions, their high regard for their colleagues, and their suspicions about the motives of many of their opponents on Council and on the Board of Censors. For them, the issue is as alive today as it was when it happened. Their views on many of the then RACGP Council and its secretariat have softened, but not in all cases.

The RDAA doctors are proud of their success in setting up their own college and proud of the quality of the original staff they selected who, being 'true rural believers', took on their jobs at very low rates of pay and with the knowledge that there was only sufficient money in the bank for a one-year contract. Many of those original staff members are still with them including their CEO Marita Cowie who, after 20 years in the job, has achieved legendary status. The original ACRRM activists are also proud of their founding colleagues in their college, and point out that most of them are still active rural doctors.[66]

Some FACRRM stalwarts hark back to their recent history and point out that a monopoly encourages oppressive behaviour and a duopoly encourages competition that can raise standards and provide some freedom of choice for disgruntled members of either college.

Board members of the 1990s Faculty of Rural Medicine who stayed with the RACGP also had a clear and consistent memory of the roller-coaster events of that time.[33,67] However, many of the then office holders in the RACGP had less clear memories of these events. My reading of this phenomenon is two-fold: many of my RACGP informants were somewhat older than the RDAA and FRM doctors who are all still working, and the rural–city issue was less high on their scale of priorities than it was with the single-minded RDAA doctors.

In 1996, Brian Williams, the then Director of the UWA Centre for Remote and Rural Medicine and a former chairperson of the NRF of the RACGP, gave a memorable keynote address at the 39th ASM in Perth. He called for reconciliation between the city and rural factions. He reminded his audience that reconciliation involves a painful recognition of past failures and a readiness to learn from the past in a way that benefits a shared future.[68] I hope that this history fulfils that need.

Brian Williams also reminded us that opportunities for reconciliation cannot be invented, but when they do occur they should be grasped with both hands.[68] The ministerial announcement, on 25 October 2017, that responsibility for GP training would return to the RACGP and ACRRM is such an opportunity.[69]

As with any divorce the wounds that resulted from this dispute are still raw. But time, concern about what is best for the children (in this case the GP registrars) and a new generation of leaders will heal them. This will present the opportunity for reconciliation of the GP family. It is my organisational experience that fusion is more effective and less debilitating than fission. Australian General Practice education, training and political influence will be the stronger if we speak with one voice rather than two.

# *List of interviewees*

Dr Neil Beaton, FMP registrar, 1995

Dr Michael Bollen, RACGP Secretary-General, 1993–1998

Dr Bruce Chater, RDAQ and RDAA founding convener; ACRRM President, 2003–2005

Dr Paul Collett, NRF Censor, 1992–1994

Dr Bill Coote, AMA CEO, 1992–1998; adviser to Minister for Health, 1999–2001; GPET CEO, 2001–2005

Dr Mark Craig, NRF Censor, 1992, 1994–1996

Dr Karen Flegg, NSW Faculty representative RACGP Council, 1995–1996; RACGP Treasurer, 1996

Dr Digby Hoyal, RDAQ foundation member

Dr Beth Jane, RACGP NSW Faculty censor, 1992–1997

Dr Peter Joseph, RACGP President, 1996–1998

Dr John Kramer, Rural Faculty Representative, RACGP Council, 1997–2000

Dr Geoff Martin, RACGP Honorary Secretary, 1994–1995

Dr Col Owen, NRF representative on Council 1994–1995; RACGP President, 1996–1998

Dr John Turnbull, RACGP Censor-in-Chief, 1992–1994; Council Chair, 1994–1998

Dr Alan Wallace, NRF Chair, 1992–1993, 1995–1996

Dr Olga Ward, registrar representative on Council, 1996

Dr Howard Watts, RACGP WA Faculty censor, 1992–1996

Prof Ian Wilson, RACGP SA Faculty censor, 1992–1994; Chair Board of Censors, 1994–1998

Prof Ross Wilson, Rural Faculty Chair, 1997–2000

# *Timeline of events that led to and influenced the development of the RACGP Rural Faculty and the ACRRM, 1973–2006*

**1973** Labor Government funds RACGP FMP.

**1976** June. Charleville, QLD. Formation of the Western Queensland Medical Superintendents' Association, the first rural doctors' political organisation in Australia.

**1977** The Medical Education Committee of the RACGP sets up a sub-committee on rural practice. It recommends that a national conference be held to address the issue of rural practice.

**1978** March. The RACGP Queensland Faculty (Peter Doyle, Keith Shaw, Mary Mahoney et al, recommend the formation of an RACGP North Queensland Sub-faculty.

**1978** November. The RACGP Victoria Faculty and the Victorian Academy of General Practice organise a conference on 'Country Towns, Country Doctors'. It has over 200 participants – doctors, health personnel and citizens from all over Australia. It embraces all communities, including indigenous participants. The conference produces many useful recommendations. The proceedings are edited into a book by the conference convenor, Dr Rex Walpole.

Following the RACGP conference, the RACGP NSW Faculty forms a working party that presents a plan for rural registrar procedural training posts in country base hospitals, and a joint diploma in obstetrics and gynecology is developed in conjunction with The Royal Australian College of Obstetricians and Gynaecologists. Otherwise, the impetus provided by this conference is not maintained.

**1984** 18 October. Townsville. First meeting of the RACGP North Queensland Sub-faculty. Peter Doyle, chairman, Richard Hays, secretary/treasurer.

**1987** NSW Rural Doctors' Dispute ignites over the issue of a major reduction in rural hospital on-call and after-hours emergency fees, introduced with the intention of curbing rorting by city-based entrepreneurial 24-hour clinics. This is the catalyst for the growth of the rural doctors' political movement.

**1987** March. Rural Doctors Association of NSW formed at a meeting in Mudgee.

**1987** December. The 'Kamien Report' is published – *Report of the ministerial inquiry into recruitment and retention of country doctors in Western Australia*. This provides a data based academic platform for the rural doctors' political campaign.

The Commonwealth Government Department of Health introduces a rural incentive program.

**1988** Formation of the NSW Rural Doctors Network.

**1989** Vocational register allows recognised GPs access to higher Medicare rebates in return for continuing their professional development.

**1989** Formation of the WA Centre of Rural and Remote Medicine within the Department of General Practice at the University of Western Australia. Dr Bill Jackson (RACGP President 1978–1980) is the inaugural director.

**1989** 23 March. Medical Superintendents with the Right of Private Practice (MSRPP) v Queensland Health Department. The QIRC granted MSRPP a special award, including guaranteed recreation and study leave and locum provision, to be paid by Queensland Health. Dr Col Owen is one of the four MSRPP negotiators. This is the culmination of 12 years of protracted negotiations with Queensland Health for a professional career structure and improved working conditions for rural doctors. This success engendered a spirit of solidarity among Queensland rural doctors and was one of the catalysts in the formation of the RDAQ.

**1989** 16 June. RDAQ formed at a meeting in Roma, QLD. Their mission statement: *Highest standard of healthcare for people in rural Queensland. Medical practitioners with the skills necessary for rural practice.*

Col Owen is elected RDAQ President. In his inaugural address, he states: 'We are the specialists in the area of rural health. Our commitment to rural health is greater than that of any other group. We have the ability to define the problems, find the solutions, develop policies and set agendas. We have the capacity to negotiate these policies and agendas with various bodies.'

Mark Craig floats the idea of a post-nominal rural Fellowship.

**1990** January. Richard Nowotny appointed FMP executive director.

**1990** Easter, Longreach, QLD. Col Owen, RDAQ President and Geoff Gates, RACGP President, meet to discuss cooperation in setting up a rural training unit and developing a qualification in rural medicine. Their original choice of names includes Fellow of Australian Rural Medicine (FARM).

**1990** May. Bruce Chater leads a small deputation of rural doctors to meet the new Federal Minister for Health, Brian Howe. They present him with proposals for overcoming the problems of rural health training and workforce. He is receptive to their suggestions.

**1990** August, Brisbane. A steering committee is formed to progress the formation of a Faculty of Australian Rural Medicine within the RACGP.

**1990** August. Establishment of the Rural Health Support Education and Training (RHSET) program, a Commonwealth Government grants program to enhance access of rural communities to effective health services.

**1990** RACGP AGM, Perth. Convocation votes in favour of forming a National Rural Faculty.

**1991** RDAA formed. Col Owen elected first president.

**1991** January. Monash University School of Rural Health begins in Moe, Victoria. Roger Strasser is the first director.

**1991** 14–16 February, Toowoomba, QLD. First National Rural Health Conference. Sponsor, RDAQ; Convenor, Bruce Chater; Editor of Conference Proceedings, Mark Craig. Brian Howe, Minister for Health and Joan Lipscombe, Assistant Secretary of Health Care Strategies Branch attend all three days. This leads to the development of a national rural health strategy.

**1991** 22 March. Inaugural meeting (teleconference) of the Rural Medicine Committee of Council (RMCC). RACGP President, Tony Buhagiar, foreshadows that the RMCC will develop into a new rural faculty of the RACGP that will have separate financing and a separate chairman and censor. Alan Wallace is elected acting chair. He states that the new faculty will be a purely academic body that sets curricula for rural practice training and accredits rural teaching programs. He envisages an award for rural medicine training that would be additional to the FRACGP. This first RMCC meeting finishes on an optimistic note, but the issues of a separate fellowship and the use of the term 'faculty' do not sit well with all of the 12 original attendees.

**1991** 26 April. The RACGP Council resolves to form a national rural faculty to be called the Faculty of Rural Medicine. This will replace the above Standing Committee.

**1992** 13–14 June, Melbourne. First face-to-face meeting of the Board of the Faculty of Rural Medicine. The board's first chair is QLD representative Alan Wallace; Deputy Chair, SA representative Jack Shepherd, and the representative to the RACGP Council is QLD member Col Owen. Other office holders are: Honorary Treasurer, Morris Williams (QLD); Honorary Secretary and NSW representative, Peter Annetts; Honorary Assistant Treasurer and TAS representative Vernon Powell; Censor, Mark Craig. The first Provost is WA representative Bill Jackson. The States are represented by Roger Strasser (VIC) and Bill Jackson (WA). The RDAA representative is Terry Lyons. An award additional to the FRACGP is discussed.

**1992** The RACGP history timeline reports that 'The college is strengthened by the establishment of the Faculty of Rural Medicine'.

**1992** 24 September. First general meeting of the Faculty of Rural Medicine is held during the RACGP Annual Scientific Convention in Melbourne. It is agreed that the Faculty of Rural Medicine will be involved with education and training and the RDAA with politics. The two major thrusts for the Faculty of Rural Medicine were to 'energetically represent rural practice' within the RACGP and to 'encourage the development and funding of rural training units' throughout Australia.

**1993** FMP renamed RACGP Training Program.

**1993** February. Second National Rural Health Conference is held in Armidale, NSW.

**1993** May. Position of National Director, Rural Education and Training is advertised.

The Faculty of Rural Medicine (Neil Beaton, Chair, Planning Committee) obtains a $350,000 RHSET grant to design a curriculum in Aboriginal health.

**1993** June. A clinical school is established at James Cook University, Townsville, funded jointly by the University of Queensland and the RACGP Training Program.

**1993** August. Council endorses the document '*The role of the Faculty of Rural Medicine in The Royal Australian College of General Practitioners'*. This endorsement reiterates the Faculty of Rural Medicine's commitment to rural Australians through its pursuit of education, training and high standards of rural practice.

Council endorses the role of the faculty. An Award Sub-Committee of the faculty presented its report on certification for rural training to the RACGP Council. At the 1994 AGM, Col Owen states that the Faculty of Rural Medicine would like to award rural Fellowships as soon as possible.

**1993** September. Tom Doolan (QLD) is appointed National Director of Rural Education and Training.

**1993** October. The Award Sub-Committee of the Faculty of Rural Medicine raises the issue of a rural Fellowship in its report to RACGP Council on certification for rural training. Col Owen requests that rural Fellowships be awarded at the 1994 AGM.

**1994** February. Council approves the Board of Censors' recommendation that recognition of completion of rural training be by the award of the Fellowship of the RACGP in Rural Medicine (FRACGP RM). This recommendation had the support of a large majority of the state faculties. One hundred and forty trainees around Australia have entered the rural training stream and it is anticipated that the number will increase to around 200 in 1995.

**1994** The conditions of grant to the training program are expanded to allow an additional period of elective training and/or leave of absence up to a period of one year. Trainees selected in the rural training stream are required to complete an additional year in an advanced rural skills training post.

**1994** August. The State Public Services Federation of Queensland (SPSFQ) brings a case before the QIRC for increased payment to doctors who work under the Queensland State Medical Specialist and Medical Officers' Award. The SPSFQ asks Alan Wallace and two rural hospital medical superintendents to be witnesses to support their application. These witnesses inform the commission about the proposed FRM. The commissioners bring down an in-principle judgement that states:

> *Well trained rural doctors with a Fellowship in rural medicine would have a higher level of skill than doctors who had only an FRACGP and this higher level should be rewarded by increasing their award to two increments above that of an FRACGP. This award can only come into practice when the Fellowship of rural medicine received official recognition by the* RACGP.

Most members of Council do not become aware of this in-principle award until June 1996.

**1994** 14 September. Third AGM of the Faculty of Rural Medicine in Canberra. In his annual report for the 1994 year, Chair Brian Williams thanks the RACGP president and secretary-general for their efforts in assisting the faculty throughout the year. He notes that a decision by RACGP Council on the proposed certification of the four-year training program for rural trainees is imminent. The Faculty of Rural Medicine also recommends further decentralisation of general practice training through well-resourced rural health training units.

**1994** September. Col Owen is inducted as the 18th President of the RACGP. His election platform is to improve health services for rural people and the training of rural generalists to serve those people.

The new RACGP Council has 14 members. This includes four councillors from QLD (the president, treasurer, a faculty representative and rural faculty representative) and five from SA (chair of Council, censor-in-chief, honorary secretary, a faculty representative and the registrar's representative). They vote as state blocks. This leads to problems.

**1994** November. RACGP censors meet in Melbourne. Their main purpose is to discuss the previous FRACGP exam results. As part of general business the censors agree, by a large majority, to support the qualification of an FRM rather than a graduate diploma. The meeting concludes and Paul Collett, Faculty of Rural Medicine Censor, leaves. On directions from Council, the meeting is reconvened and the two-hour-old decision to recommend a FRM is overturned in favour of a graduate diploma.

There are no minutes of this meeting in the RACGP archives. Two of the state censors (Howard Watts and Beth Jane) recall that the rural censor (Paul Collet) was the first to leave.

*Soon after, the chief censor told the board that Council had just contacted him and asked him to revisit the issue of the wish of the Rural Faculty to have a separate degree for rural doctors. We weren't given all the background, other than it was the majority view of Council that it would lead to divisions because there would be a grade of super GPs. The censors were asked their opinions in their role as standard setters. We were all rather unfamiliar with the background and we made a rushed decision to oppose the rural qualification. I felt some unease that the rural censor was absent and had not had the opportunity to put the other side of the story*.

The decision was overturned, and the following day, Paul Collett, a long-time Fellow and staunch RACGP advocate, educational innovator and opinion leader, resigns from the RACGP.

**1994** 3 December. Having pressured the censors on how to vote, Council now accepts their advice to reverse its earlier decision to award an FRACGP RM. It resolves that a Graduate Diploma in Rural General Practice be awarded to those doctors who have satisfactorily completed the requirements of the rural training scheme in addition to the FRACGP. Col Owen abstained, Bruce Chater voted against.

Furthermore, Council resolves that the censor-in-chief convene a meeting of representatives of the censors, the RACGP Training Program and FRM to develop the Graduate Diploma in Rural General Practice. This decision shocks and angers the Faculty of Rural Medicine. They pass a motion that the Faculty of Rural Medicine has no confidence in the RACGP Training Program as currently constituted to provide adequate rural training. They call for an urgent independent review of the management of the RACGP Training Program.

Council's reasoning was later explained in the minutes of their meeting of 20 May 1995, item 10.2.6:

*There are two overriding principles:*

- *To adequately reward the additional training undertaken by rural trainees in the RACGP training program.*
- *To maintain the standing and primacy of the FRACGP.*

The censors and the majority of Council are aware that the Faculty of Rural Medicine perceive rural training as a continuum over four years rather than an additional year added to the general three years. However, they maintain that there is such a large overlap in the knowledge, skills and attitudes of rural and non-rural GPs that the difference does not warrant a separate Fellowship.

Council also declares that according to the RACGP Constitution, the Faculty of Rural Medicine has the same organisational status as a state faculty – that it is an integral part of the RACGP and does not represent a distinct and separate organisation. Therefore, the Fellowship in Rural Medicine is not and cannot be, a registrable qualification.

**1994** December. The RDAQ rejects a graduate diploma that only entails an extra year's training in one or two branches of medicine (eg anaesthetics and/or obstetrics). RDAQ demands a four-year integrated rural training program with the end point being a qualification that indicates competence to practise high

standard medicine across a broad range of the medical disciplines in an environment of isolation. That qualification is a Fellowship in Rural Medicine (FRM).

Alan Wallace still hopes that the RACGP Council will listen to the Faculty of Rural Medicine's argument. He warns Council that 'there are small bushfires breaking out and unless we address them now there is a risk that they will exceed the capacity of the RACGP fire brigade in the near future'.

Bruce Chater, Faculty of Rural Medicine representative on Council, reinforces this warning:

> *There are a large number of disaffected rural doctors who believe that the actions of the RACGP confirm its lack of serious commitment to rural practice as part of general practice. An FRM will not devalue the FRACGP. A diploma will not do because it will not provide adequate recognition amongst other colleges or the bureaucracy. Other colleges have two Fellowships, why can't we? We must decide whether we will grasp this opportunity or let it slip through our hands.*

**1995** The RACGP examination for Fellowship became the compulsory end point of training and entry to the profession.

**1995** February. Third National Rural Health Conference, Mount Beauty, Victoria. Neil Beaton presents the *Report on the RACGP/NACCHO design project for a curriculum in Aboriginal health*. It is well received and becomes the template for future developments in consultative national rural curriculum design.

Despite the seemingly final decisions of RACGP Council, the debate about the rural qualification continues. The RDAA announces a plebiscite to ask country doctors if they wish to continue their academic association with the RACGP.

**1995** June. The RACGP submits an application for recognition of the Graduate Diploma in Rural General Practice under the *Tertiary Education Act*, 1993. The Faculty of Rural Medicine writes to the Higher Education Authority expressing its opposition to the application.

Col Owen establishes presidential task forces to examine the role, function and definition of general practice. These include special interest groups, Aboriginal health, standards and accreditation. He also organises for the next Council meeting to take place in Toowoomba.

**1995** 22–23 July. At the Toowoomba Council meeting, Bruce Chater, on behalf of the RACGP Faculty of Rural Medicine Board, presents Council with four non-negotiable propositions concerning rural qualification and training:

1. Establish a Faculty of Rural Medicine (instead of a rural faculty of the RACGP).
2. Have an FRM (instead of a Graduate Diploma in Rural General Practice).
3. RACGP Faculty of Rural Medicine to have censorial oversight of the FRM.
4. Have a separate four-year rural training scheme under the direction of the Director of Rural Education and Training.

Dr Chater states that unless all propositions are accepted by Council, many rural GPs plan to leave the RACGP and set up their own college, the Australian College of Rural Medicine, in order to achieve those ends.

Geoff Martin, Honorary Secretary of Council, is gravely concerned at the possibility of rural GPs leaving the RACGP and the resulting far-reaching consequences for general practice as a whole. He appeals to those who presented these non-negotiable demands to reconsider their position and not cause a split in the ranks of general practice.

Dr Chater later said, 'this was the final schism moment, our vote was lost when the Tasmanian representative moved to the NO camp.'[10]

**1995** August. Council did not accept that the Faculty of Rural Medicine demands represented the position of the majority of rural members and trainees. Council decided to test their belief by conducting a survey of RACGP members.

A letter written by Mark Craig, acting honorary secretary and censor of the Rural Faculty (apparently distributed by the RDAA without his knowledge or permission), advises Faculty of Rural Medicine members to 'record a protest vote, by not answering the questions and writing "INVALID" on the RACGP plebiscite before returning it'. Because this would render the survey unrepresentative, Council defers the plebiscite.

Council's position is that there should not be a split in the ranks of general practice, but that this should not be avoided at the cost of yielding to the demands of a minority group whose actions they equate with bullying. Council wishes to continue discussions with rural members to try to find a way forward.

**1995** 4 August. Mark Craig presents an options paper on rural training to the Faculty of Rural Medicine Board. He advocates for a four-year training program, integrating rural general practice skills with procedural skills, followed by an assessment program leading to the award of an FRM under the aegis of an Australian College of Rural Medicine. This is a comprehensive, politically savvy document setting out the strengths and weaknesses of creating a specialist rural college:

> *Our strongest ally in a campaign to push for a college of rural medicine and its Fellowship will undoubtedly come from rural patients and rural organisations. The RACGP can be expected to vigorously defend its territory. However, relationships with the RACGP will need to be maintained, which is difficult with current personalities.*

Mark Craig points out that the planned RDAA plebiscite of rural doctors and the opinion of trainees is 'absolutely critical to the course of action that we take'. This paper is prophetic – all Mark Craig's preferred options come to pass.

**1995** 15 September. A front page article in the *Medical Observer* quotes RDAA President, David Rosenthal, as saying 'RACGP intransigence (with its rural faculty) over rural training certification and control is moving rural GPs closer to a split with the college'. Karen Flegg, the RACGP NSW Faculty representative on Council replies:

> *Intransigence, control, split … the ingredients are all certainly there but who is intransigent, who seeks to control, who seeks to split? No one on Council wants to create a schism. The schism was created when rural doctors put four non-negotiable demands to Council and threatened that if they were not passed a schism in general practice would result.*

**1995** 29 September–2 October. RACGP Annual Scientific Convention at Jupiter's Hotel Casino, Gold Coast, Queensland. A delegation of past presidents of the RACGP meet with the current president (Col Owen) and the parties concerned and think they have negotiated a peaceful settlement. But it is not to be. The RACGP image is not improved by public disagreements between the president and the secretary-general.

At Convocation, several motions are accepted without notice. Peter Joseph and Peter Hopkins argue about the undue power and influence on Council exercised by the chair, the honorary secretary and the secretary-general who, they maintain, have not been popularly elected. They successfully move two motions about structural reform of the RACGP with regard to abandoning the appointment of the censor-in-chief, holding a national popular election for Council Executive and enlarging Council by electing a vice-president and six members at large. Council forms an electoral structures working group and puts the Convocation proposal to a plebiscite of all RACGP members. It is rejected, by a substantial majority.

**1995** 1 October. Council approves in principle that:

1. To be consistent with the other state faculties, the Faculty of Rural Medicine shall be re-named the RACGP Rural Faculty.
2. Fellows of the RACGP may be elected to Fellowship of the Rural Faculty if they have attained the Graduate Diploma in Rural General Practice or satisfied other criteria (to be determined by the censors) and have spent an appropriate time in active rural general practice.
3. Such Fellows will be entitled to use the post-nominal FRACGP (Rural) and will be styled 'Rural Fellows' of the RACGP.

Council also affirms that training for rural general practice is the RACGP's highest priority and will be delivered predominantly by rural GPs, in rural settings, with an explicit rural focus. This compromise is unanimously passed by Council and subsequently supported by all state faculties of the college. Bruce Chater expresses his pleasure at the rapprochement that had been achieved and thanks Council for its very positive efforts in this regard and undertakes to convey this to the RACGP Rural Faculty.

The RACGP issues a STOP PRESS – 'Peace in Our Time'. As with British Prime Minister Neville Chamberlain's fateful statement on his return from Munich in October 1938, it was not to be.

The boards of the RACGP Rural Faculty and the RDAQ are not happy with this compromise and accuse Col Owen and Bruce Chater of 'selling out' to the RACGP Council.

The distrust between the NQRNs and the AM increases. The NQRNs are fed up with the decision-making processes and backsliding of the Council. The AM suspect that the real motivation of the NQRNs is their quest for recognition and higher rebates for their higher skill level than their urban colleagues. The AM are sure that the RACGP Rural Faculty is in the process of starting a new college of rural and remote medicine, and that this explains the delaying tactics of non-negotiable demands and failure of the RACGP Rural Faculty to respond to correspondence from the Council. The AM also suspects that the Faculty of Rural Medicine Board proposal to split the training program into a four-year rural and a separate three-year general stream is an attempt to pave the way for the Faculty of Rural Medicine to split from the RACGP and take an established training program with it.

The RACGP NSW Faculty representative on Council, Karen Flegg, argues that the Faculty of Rural Medicine proposal requiring trainees to commit to a rural or a general training stream would likely reduce, not increase, the number of rural GPs. She cites her own experience of getting a taste of rural general practice as part of (the then named) FMP training and not coming back to the city for six years.

**1995** October. Application for accreditation of the Graduate Diploma in Rural General Practice under the *Tertiary Education Act*, 1993 is approved, despite FRM objections to the Higher Education Authority.

Tom Doolan, National Director of Rural Education and Training, resigns.

**1995** December. Bruce Chater reports to Council that the RACGP Rural Faculty chair advises that he has not received any formal notification regarding queries from Council about setting up a rival college and is therefore not in a position to respond. Council regard this non-response as another delaying tactic until arrangements are in place to announce the formation of the Australian College of Rural Medicine.

Later that month the RACGP Rural Faculty and RDAA announce that a steering committee has been formed to establish an Australian College of Rural Medicine.

**1996** February. The criteria for the Graduate Diploma in Rural General Practice and the FRM are finalised.

**1996** April. The secretary-general reports that a major row has erupted because of Council's decision to reject a separate FRM in addition to the FRACGP. This failure to reach a satisfactory outcome results in a protracted RACGP Rural Faculty–Council battle that, due to regular medical press reports, makes the RACGP appear to be in constant disarray.

**1996** May. The RACGP Rural Faculty officially launches the RACGP Core Curriculum in Aboriginal Health in Alice Springs. This RHSET funded project was led by Neil Beaton, Jane Smith and Anna Nichols and developed in consultation with over 300 Aboriginal people. Ada Parry (NT) is appointed the first RACGP Aboriginal cultural tutor.

Dr Chater reports to Council that the RACGP Rural Faculty Board has not made any resolutions concerning the previously agreed recommendations about the qualification and renaming of the board. In his opinion the majority of the board does not support the proposals. The RACGP Rural Faculty continue to regard the proposed Graduate Diploma in Rural General Practice as an inappropriate award for rural training. They will only accept an FRM awarded in addition to the FRACGP. The RACGP Rural Faculty directs Dr Chater, their representative on Council, to vote against the previously agreed resolutions concerning the graduate diploma.

The RDAA plebiscite results are released. Of the 1500 rural doctors who voted, 1000 registered discontent with the standards of rural training and their representation by the RACGP. This is the green light for the RDAA to set about forming the ACRRM. The RACGP Rural Faculty Chair, Alan Wallace, remarks that 'This is a tragedy for any who believe that general practice is best served by a single, united voice'. State faculties also express concern at the potential loss of valued rural members.

**1996** 19 May. RACGP President, Dr Owen and RACGP Rural Faculty representative to Council, Dr Chater announce that they have become foundation members of a new rival group, the ACRRM. Council takes this to be the end of the debate and resolves to implement the previous October 1995 resolutions of Council concerning recognition of rural qualifications in general practice. The RACGP will begin awarding the Graduate Diploma in Rural General Practice to those registrars who have already fulfilled the requirements for that qualification.

**1996** 10 June. Some members of Council become aware of the QIRC in-principle judgement of 1994 (see September 1994). The AM on Council interpret this as an issue of non-disclosure by the Queensland 'company directors', who they then accuse of putting money and status for themselves above the wellbeing of general practice a whole. For the non-rural majority of Council, it explains why the North Queensland Fellows have been so insistent on having the post-nominal qualification of FRM (Fellowship in Rural Medicine or FRACGP-Rural) and why so many meetings between Council and the RACGP Rural Faculty have resulted in stalemate.

These non-rural Council members are disgusted by this failure of disclosure and variously describe it as 'Machiavellian', 'dishonest', 'willfully and hypocritically deceptive and playing dirty'. They seek a legal opinion from Australia's leading industrial law firm, Tress, Cocks & Maddocks. That opinion confirms their view that Dr Owen, Dr Chater and other office bearers in the RACGP Rural Faculty stand to gain financially from the awarding of an FRM and are therefore clearly in breach of their duties under corporation law. They invite these RDAQ doctors to resign from the RACGP.

The lawyers have cause to revise their opinion when they are informed that the QIRC determination does not apply to the award under which Dr Owen, Dr Chater and Dr Wallace are employed. The monetary value of the proposed two higher increments is $4200 (1994 dollars) a year.

**1996** 21 June. Dr Owen writes an opinion piece in *Australian Doctor*, 'When the unelected overrule the elected'. He claims that the votes of the (two) appointed, not elected, councillors' secured a slim majority for (anti-RACGP Rural Faculty) Council resolutions. His claims and versions of events are firmly disputed by five state Council representatives from NSW, VIC, SA, WA and TAS, under the heading 'Elected Representatives Speak Out.' They state that 'even if those two unelected (out of 14) councillors had not voted, Council's resolutions on any rural issues would have been passed by a comfortable majority.'

The five state representatives on Council assert that the antagonism between the president's rural faction and the other members of Council is not simply a dispute between progressive radicals who demand change and conservatives who seek to resist it. Rather, 'it is a desire of the majority of Council members to protect the majority of its members from a president and his small group of unquestioning supporters who represent only a very small proportion of the membership'.

They finish their article on a very strong note to the Queensland members of Council:

Company law in Australia demands that directors act honestly and in the best interests of their company and its shareholders. Our patients expect that we will act in their best interests to the best of our ability. Similarly, the college must be able to rely on all councillors, including the president, to act in the best interests of the college and all its members. Any councillor who cannot fulfil that requirement should resign their office.

**1996** 22 June. RACGP past-presidents issue a statement calling for Dr Owen's resignation and also that of Peter Joseph, the president-elect who they see as a follower of Dr Owen.

**1996** September. RACGP President, Dr Owen, in his final Annual Report, writes:

> *Sadly, there is little joy in the area of academic general practice unity. Alternative general practice training pathways have solid support from a number of quarters and a second general practice college is in the development phase. Some factors leading to these situations were beyond the control of the college; others were not.*

He concludes: 'Finally, I express my thanks to those who have shared my dream and vision of a strong unified college leading Australian general practice into and through the challenges of the future'.

**1996** 12 September. Rural GPs and rural nurses from NSW and Queensland meet at the Cunningham Centre, Toowoomba to discuss whether to form a College of Rural Health or a College of Rural Medicine. The nurses (Hegney et al) decided that a College of Rural Health wouldn't work because the doctors would take it over and the decision was then to form ACRRM.

**1996** October. Alan Wallace, once again Chair of the RACGP Rural Faculty, presents the RACGP Rural Faculty Annual Report. He laments that 1996 had been a tumultuous year in which it was 'difficult to maintain the enthusiasm for the college process'. He expresses disappointment at the inability of the RACGP Rural Faculty Board to persuade Council of the extent of the discontent with the college that exists in the country.

Dr Wallace urges Council to attempt to re-establish a working relationship between the RACGP and the RDAA. He warns that the single worst disincentive to young doctors that the profession could contrive is to permit the development of an adversarial relationship between the two organisations training doctors for rural practice. Each organisation would waste substantial energy and resources competing with each other. Ever loyal to the RACGP, Dr Wallace advocates the need for a pathway whereby ACRRM, its people, knowledge and energy can be accommodated under the RACGP umbrella in a way that maintains honour on both sides. He conveys these views to the incoming RACGP president and secretary-general, and to the Minister for Health.

RDAQ President Digby Hoyal informs Council of the necessity for change in the administration of rural training. He speaks of the plebiscite of rural doctors and the formation of ACRRM. He confirms that the aim of ACRRM is to look after the standards, training and continuing education of rural doctors. However, it is not ACRRM's intention to set up a training scheme since he cannot see the point in duplicating something that appears to be going well. His view is that all that is required is better utilisation of the rural health training units and a different approach to the administration of the RACGP Training Program.

**1996** 16 October. Peter Joseph is installed by Dr Owen as the 19th president of the RACGP at the 39th AGM, held in Perth. The Minister for Health, Dr Michael Wooldridge, tells the audience that in order to compete for the scarce health dollar general practice has to be 'a united, cohesive and politically astute, force'. He states that he had resisted calls to split the training program into rural and others.

Brian Williams, the director of WACRRM, delivers an address entitled 'City to farm and beyond'. He urges city GPs to consider rural practice and so build a bridge to unite the aspirations of rural and city GPs. The new president is moved by this speech and later inaugurates the Brian Williams Award that becomes the highest accolade awarded to a member of the RACGP Rural Faculty who has made a significant contribution to the personal and professional welfare of rural doctors.

**1996** December. Dr Wallace advises Council that the RACGP Rural Faculty does not wish to proceed with the FRM at this time.

Sarah Strasser commences as RACGP Executive Director of Rural Training. Forty per cent of general practice registrar terms are already taken in rural areas.

**1997** January. Paul Worley, a senior lecturer at Flinders University, starts the Riverland Parallel Rural Community Curriculum, the first Australian project in decentralised rural undergraduate medical education.

**1997** February. The ACCRM is inaugurated. It releases its prospectus and announces that it has 550 foundation members.

The first Graduate Diploma in Rural General Practice is ratified by Council.

**1997** March. Richard Lawrance is appointed RACGP Rural Faculty Education and Development Officer. He introduces structured teleconference interviews of rural registrars and edits a new monthly newsletter, *Bush Alert.*

**1997** May. Council accepts the advice of its Rural Faculty to recognise the ACCRM as a body that has expertise in rural medicine and to establish a formal consultative structure with them, particularly in regard to rural training.

**1997** June. Government initiated mandatory six-month FMP rural terms are, as was predicted, very unpopular. Olga Ward (WA) joined the RACGP Rural Faculty in 1995 and was appointed the registrar representative on the Board in 1996. Her concerns were that compulsory rural terms were expensive, caused family disruption and failed to take into account any recognition of prior rural experience. She states that the college was not listening to or talking with the registrars and that the graduate diploma was of such little worth that it did not even guarantee her hospital privileges in the country.

Dr Cameron Gent, a Perth-based RACGP Training Program registrar, warns the RACGP that it may actually destroy itself in the long term by attempting to satisfy its external customers (the government) in the short term and ignoring its internal customers (the registrars).

**1997** September. Ross Wilson, the RACGP Rural Faculty Chair, reports that the 'smouldering ruins of the Rural Faculty and the frustrations, disappointments and anger over the events of the last two years are slowly yielding to the work of college stalwarts who are determined to maintain a rural presence and voice within the RACGP'.

**1997** December. Negotiations between the RACGP and ACRRM begin. There is mistrust on both sides and progress is slow.

Minister Wooldridge appoints Bryce Phillips, a former president of the AMA and a Melbourne GP, to head a committee to review general practice training in Australia.

**1998** 30 March. The Bryce Phillips Committee submits its report, *Ministerial review of general practice training. General practice education: The way forward.* The Phillips review recommends the formation of a National Council for General Practice Education and Training (NCGPET) to advise the Minister for Health on the best direction for achieving a high-quality, efficient general practice education system.

The review committee also puts forward four options for the role of NCGPET. These range from a purely advisory role to a full funding model. The committee recommended option 3, which would give the NCGPET a moderate level of funding to set up consortia, support innovation, and create an environment for all parties to participate in planning improvements to general practice education and training. In this model the Commonwealth would continue to fund vocational training provided by the RACGP and ACRRM.

The Bryce Phillips Committee advises against option 4, based on a performance funding model, because this would take longer to implement than any of the other options and bring the risk of creating additional, unnecessary machinery to manage a new system. They comment that 'Option 4 is not warranted on the basis of the available evidence'. Due to pressure from his rurally based National Party colleagues, Minister Wooldridge chooses that option.

**1998** May. After irreconcilable differences with Council extending through the previous 12 months, Michael Bollen resigns as Secretary-General. He predicts that the next few years will be a watershed for the RACGP.

**1998** October. John Locke, RDAQ president, reports that the RACGP Council is forcing rural doctors to make a decision between membership of either ACRRM or the RACGP. He complains that the RACGP are continuing to thwart negotiations between ACCRM and the federal government over rural education and the setting of rural qualification standards. The RACGP tactic is to remind the minister that its rural doctor membership is numerically greater than that of ACRRM, indicating that ACRRM does not have the support of all rural doctors.

**1998** 15 October. Margaret Kilmartin (TAS) is installed as the 20th president of the RACGP. She believes that there is little difference between urban and rural general practice.

**1998** November. Gerry Mak is appointed CEO of the RACGP.

**1998** 14 December. End point of rural training workshop, Melbourne, chaired by Dr Wallace. There is consensus that the most serious issues confronting rural training are:

1. Relationships between the Rural Faculty and Council.
2. Relationships between the RACGP and ACRRM.
3. JCCs where specialists impart skills to GPs.

**1999** February. RACGP and ACRRM sign an agreement establishing a Joint Venture Board (JVB). Its main task is to develop a common response about general practice training in negotiations with the Commonwealth Department of Health.

**1999** March. A high-profile team of senior politicians, the AMA president and RACGP representatives make a fact-finding tour of south-west Queensland. This results in John Kramer and Geoff White (RDAA President) developing a pilot scheme of distant supervision for remote registrars, known as 'the Mungindi Solution'.

**1999** October. Sarah Strasser resigns as RACGP Executive Director of Rural Training.

**2000** February. Richard Lawrance is appointed RACGP Executive Director of Rural Training.

Ross Wilson, RACGP Rural Faculty Chair, reports that the AMA Council of General Practice has unanimously resolved that the interests of general practice education and training will be best served by both colleges working cooperatively. The AMA states that general practice registrars do not want two separate training programs. The AMA offers the services of its national president, David Brand, a GP, to broker a solution between the two parties.

**2000** February. Dr Richard Nowotny, the Executive Director of Education and Training, resigns after 12 years in that role.

**2000** April. Rural doctor advocates want more rural influence and control over the public funds that support general practice training. They maintain that the RACGP Training Program is 'metrocentric'.

Margaret Kilmartin (RACGP President) and Gerry Mak (CEO) meet in Parliament House, Canberra, with Minister Wooldridge and the Deputy Leader of the National Party, John Anderson. This is the last chance for the RACGP to convince government to preserve the RACGP Training Program. They are not successful.

**2000** 3 May. Special meeting of Council on the new arrangements for vocational training for general practice is held at College House, South Melbourne. Invited guests are Dr Michael Wooldridge, Minister for Health and Aged Care and Dr Bill Coote, his senior policy adviser.

Minister Wooldridge advises that the future provision of general practice training will be by competitive tender. He expresses his disappointment with the JVB, which he describes as 'dysfunctional'. He also notes that there is a broader general practice educational canvas with consumers, universities and divisions of general practice keen to become involved. His department has advised him to leave urban general practice training with the RACGP and offer rural general practice training to the JVB. He does not consider this to be feasible.

Barry Kable, then Chair of Council, asks if unity between stakeholders would avoid the termination of the RACGP Training Program. Minister Wooldridge answers that this unity had been previously requested. He cannot see a future for the RACGP as the sole provider of general practice education.

**2000** May. The Commonwealth Government formally announces plans for a radical change to the delivery of general practice training. The change will see a move towards a competitive system and the possibility of using universities, divisions of general practice and community-based organisations to deliver vocational training. It will be run by a government-owned company, GPET, created to establish a system of RTPs and to oversee the implementation of a new system of vocational training, the AGPT program. The RACGP will retain training for 2001 but a new system will be in place by 2002.

The RACGP censor-in-chief expresses his concerns about non-GPs controlling general practice training and the renewed campaign for the grandfathering of non-vocationally registered GPs. He states that these initiatives risk undermining the 30 years of work that has gone into building up the significance of the Fellowship examination.

The Minister for Health announces that due to the chronic shortage of graduates from Australian medical schools who wish to work in rural and remote areas, doctors will be recruited from overseas to go into those areas.

The RACGP develops a practice-based assessment as an alternative pathway to Fellowship (first proposed by James Watson, RACGP President, in 1976).

The GPET program introduces new training arrangements with national terms and conditions for registrars and sees a strong increase in numbers in rural general practice. It also places a high priority on training in Aboriginal health for all registrars, improves distance education for registrars, and for the first time includes a statement of the minimum and essential knowledge and skills for general practice.

**2002** The Graduate Diploma in General Practice is approved for a further five years.

**2003** The RACGP Rural Faculty convinces Council that their role is different to that of a state faculty. Council agrees that the name of the faculty will revert from the RACGP Rural Faculty back to the original National Rural Faculty (NRF) of 1992.

**2004** David Thomson, NRF Chair, reports a high level of activity on behalf of the rural membership with a significant role in the redevelopment of national practice standards.

**2006** The Diploma in Rural General Practice is accredited as a formal tertiary qualification. Despite this recognition, the RACGP replaces it with a new Fellowship in Advanced Rural General Practice (FARGP). It has 170 enrollees. The NRF sees this as a sign that the faculty will survive and go from strength to strength.

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