FINAL REPORT

Assessment of rural and remote medicine as a medical specialty

RECOGNITION OF MEDICAL SPECIALTIES ADVISORY COMMITTEE
NOVEMBER 2005

Appendices

Executive Summary

The assessment of applications for recognition of new medical specialties

The Australian Medical Council (AMC) manages a process for assessing applications for the recognition of medical specialties and sub-specialties. Recognition through this process signifies that a medical specialty or sub-specialty is developing in Australia in response to a demonstrable need for specialist medical services and that its development is in the best interests of the Australian community.

This recognition process results in advice to the Minister for Health and Ageing to assist in deciding which new medical specialties will be recognised for the purposes of being listed in Schedule 4 of the Health Insurance Regulations 1975 *(Health Insurance Act 1973)*. The process managed by the AMC also provides for applicants seeking recognition for other purposes. For example, organisations may wish to have specialist medical skills and knowledge acknowledged, and the education and training programs that lead to these attributes accepted as the standard for a particular area of practice without seeking recognition for the purposes of the Health Insurance Act. Recognition of such specialties results in inclusion in a separate List of Australian Recognised Medical Specialties and Sub-specialties, maintained by the AMC.

The purpose of this report

The Australian College of Rural and Remote Medicine (ACRRM) has sought recognition of rural and remote medicine as a medical specialty.

This report is the assessment by an AMC recognition review group (called the Review Group in this report), of the case for and against the recognition of rural and remote medicine as a medical specialty, assessed according to the criteria for recognition detailed in the Guidelines for Recognition, *The Recognition of Medical Specialties and Sub-specialties*.

The report is not a commentary on the medical service needs of rural and remote Australia. The AMC is very aware of the major health and health care needs of rural and remote Australians, and of the very significant Government support for a range of initiatives to address these needs including rural health services, programs to support the recruitment and retention of generalist and specialist practitioners and long-term measures to increase the rural workforce. It is also aware of significant issues of morale for general practitioners, including those in rural and remote locations.

The Review Group assessed the application following the process described in the Guidelines for Recognition. In its assessment, the Review Group considered the application for recognition, discussed the application with Directors and staff of the Australian College of Rural and Remote Medicine, sought additional written information from the College, sought public submissions on the application, gathered information relevant to the application, and conducted a series of interviews and site visits.

The College provided an extensive application with supporting material and references, and three sets of supplementary material. The Review Group has not referenced all this material in its assessment. It did, however, consider all the material provided or referred to by ACRRM, and the material provided in submissions on the case for recognition.

The report contains a summary of the key material presented to the Review Group, and the Review Group's assessment of the strengths and weaknesses of the case presented.

The Review Group is not responsible for advising on whether or not rural and remote medicine should be recognised as a specialty. It is responsible for providing the information on which the Recognition of Medical Specialties Advisory Committee can develop recommendations to the Australian Medical Council. Taking account of the material presented to it, the Council itself decides on the advice to the Minister about the recognition of the specialty. The conclusions that the AMC may come to regarding the case made for recognition are part of the advice to the Minister. This advice is confidential.

The application for recognition of rural and remote medicine as a medical specialty

In Australia, medical practice divides broadly into non-referred generalist medical practice and referred specialist practice. The term 'general practice' is commonly used to describe non-referred general medical services.

The case for recognition presented by ACRRM is that rural and remote medicine is a second, distinct specialty within the area of generalist medicine. The College is not seeking recognition of rural and remote medicine as a field of referred specialist medical practice. It describes the practice as 'non-referred, first access practice' and has indicated a preference not to use the terms primary care and general practice which it considers do not describe the scope of practice of rural and remote practitioners.

ACRRM states: "Rural and Remote Medicine is a well defined specialty with knowledge, skills and attitudes that differ to a large extent in depth and complexity, from the other major generalist specialty, General Practice."[1]

The College's application for recognition describes rural and remote medicine as follows:

> "Rural and Remote Medicine operates on a unique paradigm of primary, secondary and tertiary medical care, with increased individual responsibility owing to relative professional isolation, geographic isolation, limited resources and special cultural and sociological factors.
>
> A specialist in Rural and Remote Medicine requires a broad understanding of diagnosis, treatment and management from the perspective of a number of medical and surgical disciplines and applies these skills along the continuum of care from primary presentation to secondary and sometimes tertiary care. Practitioners are able to adapt and build their skills in response to the health needs of a diverse range of rural and remote community settings and the degree of isolation from other health services and resources.
>
> Rural and Remote Medicine is the specialty that focuses on securing optimum patient and community health outcomes utilising a particular range and depth of knowledge, skills and attitudes not common to any other medical craft group to achieve the desired outcomes within the parameters of practice imposed by rural and remote environments.
>
> The defining characteristics of the specialty are the specific content, context and consequent complexity of the discipline."[2]

Assessment of the application by the Australian Medical Council

The Australian College of Rural and Remote Medicine's application for recognition was considered by the June 2004 meeting of the AMC Recognition of Medical Specialties Advisory Committee. The application indicated that 'recognition was being sought for a range of reasons including for the

[1] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 13.
[2] ibid, p. 14.

purposes of the Health Insurance Act.' At the Committee's request, the College provided additional information clarifying its expectations of the process, specifically that it was seeking recognition of rural and remote medicine as a field of generalist medical practice.

The application for recognition was subsequently accepted by Australian Medical Council in July 2004, and a Recognition Review Group was established to assess the application.

The AMC received 326 submissions on the application for recognition. The Review Group reviewed carefully the information provided in the submissions, noting those that addressed the criteria for recognition, and the large number that were more general statements of support for ACRRM, for recognition of its Fellows, or for accreditation of its training. There were many submissions that expressed strong feelings about the issue, both in favour and against recognition. Some disputed claims made in the application.

Having identified key issues from the submissions, the Review Group invited a number of stakeholders to meet members of the Group to discuss these issues.

The Review Group completed an extensive program of site visits to rural and remote practices, to assist its understanding of the spectrum of rural and remote medical practice. In selecting the sites to visit, the Review Group took account of advice from ACRRM, the submissions received, and advice from the RACGP concerning sites where the Review Group would encounter rural general practice.

Outline of the assessment of the case for recognition

The issues raised in the assessment of the case for recognition of rural and remote medicine are complex.

There are issues relating to the current framework for providing medical services in Australia, which defines generalist and specialist medical practice. In particular, the way in which this framework relates general practice education and training and the category of vocational registration of general practitioners to the standards and processes of the Royal Australian College of General Practitioners is described. The role of the Australian College of Rural and Remote Medicine in this framework is also described. These matters are dealt with in section 3 of the report.

The multiple objectives of the ACRRM in seeking recognition, as outlined to the Review Group, are set out in section 4 of the report. ACRRM has stated[3] that it has the following objectives in seeking recognition:

1. Recognition of a specialty of rural and remote medicine as distinct to other specialties.

2. A training and standards framework matched to the needs of rural and remote medicine. The application for recognition argues that the general practice framework is misaligned with the vocational model likely to appeal to the rural and remote medicine personality type; does not offer clear vocational identity or appeal in content.

3. Vocational registration (or an equivalent government recognised status). ACRRM intends that its vocational training pathways leading to Fellowship of ACRRM would be an independent means for rural doctors to attain access to a generalist vocational register recognised for the purposes of the Medicare Benefits Schedule. It proposes that this be a separate Rural and Remote Medicine Register and that the entry point to this would be an ACRRM Fellows list, analogous to the RACGP Fellows list for entry to the General Practice Vocational Register. Medical practitioners would need to hold FACRRM to be listed on the Rural and Remote Medicine Register. It proposes

[3] Australian College of Rural and Remote Medicine *Supplementary Information in Support of The Application to have Rural and Remote Medicine recognised as a Medical Specialty* July 2004

that rural and remote practitioners would have permanent entry into the MBS, so long as they maintain continuing professional development requirements.

4. Access to A1 item numbers on the Medicare Benefits Schedule and access to all of the current government incentives and support for general practice.

5. Fully transferable access to A1 item numbers anywhere in Australia from both the proposed Rural and Remote Medicine Register and the Vocational Register (i.e. a Fellow of ACRRM can work in the city and a Fellow of the RACGP in the country).

6. Recognition and appropriate remuneration of ACRRM accredited rural specialist services (which ACRRM indicates would be services involving skills appropriate to the rural environment and more complex than those ordinarily associated with generalist practice and/or requiring greater responsibilities and/or time demands).

The report provides information on the numbers of medical practitioners in rural and remote Australia, and the range of incentives to recruit and retain practitioners. These are outlined in section 5 of the report.

Applications for recognition are assessed against core criteria, which are detailed in the Guidelines for Recognition. In summary, these are:

1. Recognition will improve the safety of health care.

2. Recognition will or is likely to improve the standards of health care and that the data, where available, demonstrate better outcomes.

3. Recognition will result in health care that uses available resources wisely and/or that the community benefits justify the increased costs of health care.

Section 6 of the report assesses the case for and against recognition using these criteria.

1. Introduction

1.1 Role of the Australian Medical Council

The Australian Medical Council (AMC) is an independent national standards body for medical education and training. Its mission is: 'To promote and protect public health and safety by ensuring a safe and competent workforce distributed across Australia to meet community needs.' Membership of the Council includes health consumers and community members, and nominees of the State and Territory medical boards, the universities, the specialist medical colleges, the Australian Medical Association, and the Commonwealth and the States.

In 1998, the Commonwealth Minister for Health and Aged Care sought the AMC's involvement in the recognition of medical specialties. In response, an AMC working party, with members from the specialist medical colleges, the medical boards, the Commonwealth Department of Health and Aged Care and the community, prepared a discussion paper outlining a new model for recognition of medical specialties with three linked components:

- a national process for assessing requests to establish medical specialties and to have them formally recognised;
- a national process for review and accreditation of both new and existing specialist medical training and professional development programs;
- an enhanced system of registration of medical practitioners.

Responses indicated general support for the model, and the working party recommended to the Council that it accept the Minister's invitation and develop this model further. The Council accepted this recommendation in July 1999.

Separate working groups then developed the components of the model. In developing the plans for a new recognition process the AMC consulted widely. In November 2001 it amended its Constitution to take on the role of advising on the recognition of medical specialties. The Commonwealth Minister for Health and Ageing approved the recognition process proposed by the AMC in November 2002 and invited the AMC to implement it. The recognition process is described in the Guidelines, *The Recognition of Medical Specialties and Sub-specialties,* published in December 2002.

1.2 Aim of the process of recognising medical specialties and sub-specialties

The Minister for Health and Ageing makes the final decision concerning recognition of a new medical specialty. The role of AMC is to assess the case for and against recognition of the proposed specialty and provide advice to the Minister. Formal recognition through this assessment process signifies that a medical specialty or sub-specialty is developing in Australia in response to a demonstrable need for specialist medical services and that its development is in the best interests of the Australian community.

The Guidelines for Recognition set out the aims of recognition through the AMC process, as well as the core criteria that must be addressed by the case for recognition of a new specialty. These are provided in full at Appendix 1 but, in summary, are as follows:

1. Recognition will improve the safety of health care.
2. Recognition will or is likely to improve the standards of health care and that the data, where available, demonstrate better outcomes.

3. Recognition will result in health care that uses available resources wisely and/or that the community benefits justify the increased costs of health care.

It is important to note that the case must be made that **recognition** will lead to these improvements, not just that the activities of the college or group of practitioners has already made improvements in safety, standards and the effective use of health care resources.

Whilst three core criteria for recognition are described, the Guidelines indicate that this does not necessarily imply that equal weighting will be given to the three criteria.

In addition to the core criteria, the Guidelines for Recognition indicate that applications with certain features would need to make a particularly strong case for recognition. These include:

- Fields of medical practice based on particular requirements such as geographic or demographic delineation, a single disease, or a single modality of treatment would need to demonstrate that the benefits of recognition of the specialty to the targeted population group would substantially outweigh any disadvantages to the broader community.
- An application for recognition of an area of practice substantially recognised under a different name would need to be based on a very strong case. The option exists for the body seeking recognition to apply for accreditation as a provider of training and professional development programs for the existing specialty or sub-specialty.

1.3 Recognition of Medical Specialties Advisory Committee

Within the AMC, the Recognition of Medical Specialties Advisory Committee oversees the recognition process. The Committee's functions are:

- To develop guidelines, policies and procedures relating to the recognition of medical specialties and sub-specialties, including by:
    - making recommendations to the Council on policies and procedures;
    - periodically reviewing guidelines, policies and procedures relating to the recognition of medical specialties and sub-specialties and recommending to the Council any changes it considers appropriate.
- To oversee the Council's processes and procedures for the recognition of medical specialties and sub-specialties, including by:
    - implementing the Council's policies and procedures relating to the recognition of medical specialties and sub-specialties;
    - making recommendations on the recognition of medical specialties and sub-specialties;
    - maintaining the List of Australian Recognised Medical Specialties and Sub-specialties.

The Committee is assisted by an Economic Sub-committee, established in July 2004, which contributes to the development of the policy and procedural guides for the recognition process, and provides advice to recognition review groups to assist in the assessment of the costs and benefits of recognition of a new specialist or sub-specialty. The Council will review the Sub-committee's role annually.

1.4 Outline of the standard process

The Guidelines for Recognition describe a standard process that the AMC applies to the assessment of each application for recognition. In summary, applications are managed as follows:

1. The AMC has established a priority order for considering applications for recognition. The priority order is reconsidered bi-annually, in February and September.

2. The applicant lodges a preliminary application either in February or September.

3. The Recognition of Medical Specialties Advisory Committee decides if the application should be considered further and, if so, where in the priority order it should be placed.

4. If the application is placed in the priority order, the AMC invites the applicant to lodge a full application at the priority date.

5. When the full application is lodged, the Recognition of Medical Specialties Advisory Committee considers it and advises the Council on whether or not the application is sufficiently developed to proceed with or without further information. If the Council decides the application should proceed, the AMC Secretariat invites submissions on the application.

6. The Council establishes a recognition review group to consider the case for recognition.

7. The application is passed to the recognition review group, which plans its approach to the assessment of the application. This may include seeking additional information or data, and conducting site visits and interviews.

8. At the same time, the application is reviewed by the Economic Sub-committee, which advises on the assessment of the costs and benefits of recognition.

9. The recognition review group assesses the case for recognition against the criteria set out in the Guidelines for Recognition.

10. The recognition review group prepares a draft assessment. The Economic Sub-committee considers the review group's comments on the costs and benefits of recognition. The applicant is invited to review the assessment document.

11. The review group considers the applicant's comments and prepares its final assessment. This document is submitted to the Recognition of Medical Specialties Advisory Committee.

12. The Committee considers the review group's assessment, and prepares a report and recommendations to the AMC Council. A copy of the report is provided to the applicant, who may seek a review if dissatisfied with the assessment.

13. Council considers the Recognition of Medical Specialties Advisory Committee's assessment and any report produced following a review (if required).

14. Council submits to the Minister of Health and Ageing the assessment and its advice on recognition.

2. Assessment of the Rural and Remote Medicine Application

In April 2004, the Australian College of Rural and Remote Medicine submitted its application for recognition of rural and remote medicine as a medical specialty.

The Recognition of Medical Specialties Advisory Committee considered the application in June 2004, and advised ACRRM that two areas of the application required clarification before the AMC could begin a detailed assessment of the case and seek public submissions on the application. The information sought by the Committee was as follows:

- clarification of what ACRRM was applying for and what ACRRM expected from the application;
- further information on the practice profile of Fellows of the Australian College of Rural and Remote Medicine.

The information provided in response to this request indicated that ACRRM was seeking recognition of rural and remote medicine as a field of generalist practice, not as a field of referred specialist medical practice. ACRRM outlined its proposal for a separate rural and remote medicine register, which would be a generalist vocational register recognised for the purposes of the Medicare Benefits Schedule. ACRRM stated that it intended that its vocational training pathways leading to Fellowship of ACRRM would be an independent means for rural doctors to attain access to this register.

Following this clarification, the Recognition of Medical Specialties Advisory Committee debated at length the extent to which the application submitted by the Australian College of Rural and Remote Medicine fell within the aims of the process managed by the AMC. Issues raised by these discussions included:

- The process managed by the AMC results in advice to the Minister for Health and Ageing to assist in deciding which new medical specialties will be recognised either for the purposes of being listed in Schedule 4 of the Health Insurance Regulations 1975 *(Health Insurance Act 1973)* or for other purposes. According to correspondence from the Department of Health and Ageing, Schedule 4 is the definitive list of recognised medical specialties as it lists the names of all medical colleges and fellowship qualifications that have been recognised for the purposes of the *Health Insurance Act 1973*, that is, for the purposes of attracting Medicare rebates at the specialist level. The AMC process also provides for applicants seeking recognition for other purposes. For example, organisations may wish to have specialist medical skills and knowledge acknowledged, and the education and training programs that lead to these attributes accepted as the standard for a particular area of practice without seeking recognition for the purposes of the Health Insurance Act. Recognition of such specialties results in inclusion in a separate List of Australian Recognised Medical Specialties and Sub-specialties, maintained by the AMC.[4]
- The Guidelines for Recognition indicate clearly the Australian Medical Council's view that general practice should be regarded as a specialist/vocational field of medical practice, which has led it to include general practice in its List of Australian Recognised Medical Specialties and Sub-specialties. In support of this view, the Guidelines cite the legislative changes that have formalised the need for postgraduate training and maintenance of standards of practice in general practice. Since 1989, the Health Insurance Act has provided a process for the recognised general practitioners who are listed on the Vocational Register of General Practitioners or who are Fellows of the RACGP to bill Medicare items specifically designated for them (A1 items) and for their patients to receive higher Medicare rebates for prescribed medical services. Fellowship of the Royal Australian College of General Practitioners (FRACGP) is presently the only recognised end point of vocational training which leads to recognition of general practitioners for vocational

[4] Letter Director, Specialist and Prevocational Workforce, Health Industry and Investment Division, Department of Health and Ageing to Presidents of Medical Colleges, 29 March 2004

registration. Initially, eligibility for inclusion on the Vocational Register, which closed in 1996, was based on either training of the RACGP or on a grandparenting process.

- The *Health Insurance Act* uses the term 'specialist' to mean those medical practitioners whose qualifications are listed in Schedule 4 of the Health Insurance Regulations 1975 to whom general practitioners (either vocationally registered or non-vocationally registered) and other health professionals refer patients and who can legitimately claim Medicare rebates at the specialist level.

- Vocationally registered and non-vocationally registered general practitioners cannot claim items under the Medicare Benefits Schedule which are restricted to those doctors who meet qualifications identified in Schedule 4.

The Committee noted that there is not a separate process to deal with alternate generalist specialties, such as that proposed by ACRRM. Members agreed that it would be sensible for the AMC to be able to advise the Minister that a field of medical practice satisfies the criteria for recognition as a specialty but that it is not a referred specialty. The Committee considered that the standard criteria and process would be appropriate to conduct this assessment. In advising the Council on ACRRM's application for recognition, the Recognition of Medical Specialties Advisory Committee indicated that it was not certain that the assessment process it administers was the appropriate pathway to advise on a generalist specialty, that is one where recognition is sought for the purposes of the *Health Insurance Act* but not for listing in Schedule 4 of the Act. The Committee advised the July 2004 meeting of the Council to accept the application and assess the case before it, namely the case for recognition of a medical specialty of rural and remote medicine.

The Council accepted the application and, consistent with the process described in the Guidelines for Recognition, appointed a recognition review group (called 'the Review Group' in this report) to assess the detailed case for recognition of rural and remote medicine as a medical specialty. A list of the members of the Rural and Remote Medicine Recognition Review Group is at Appendix 2.

The Review Group held its first meeting on 5 October 2004. The Review Group discussed the application by the Australian College of Rural and Remote Medicine, and the process for seeking additional information and for assessing the claims in the application. The Economic Sub-committee, which assists in the assessment of the costs and benefits of recognition of a proposed specialty, reviewed the application on 11 October 2004. Together, these two meetings generated a list of questions for ACRRM concerning some of the claims in the application for recognition. The AMC sent the additional questions to ACRRM in November 2004, and proposed a meeting between ACRRM officers and the Review Group in December 2004 to clarify the issues raised.

Following the Council's acceptance of the application for recognition in July 2004, the AMC Secretariat sought public submissions on the application from groups within the health services and the community both by direct notice, by advertisements in country and metropolitan newspapers, and via the AMC website. To facilitate public comment, the AMC placed the College's application on its website. The AMC has a list of 90 key stakeholders it routinely invites to comment on all applications for recognition, and an additional 12 specific to this application. It received submissions from 35 of these groups. In total, it received 326 submissions. Information on the submissions received is provided at Appendix 3.

The Review Group met on 7 December 2004 to assess the submissions received on the application, and to discuss the application and the assessment process with ACRRM officers. Discussions with ACRRM officers centred on:

- the additional questions from the AMC and a timeline for answering them;

- the key arguments in support of the application for recognition;

- contributing to the Review Group's understanding of rural and remote medical practice through a program of site visits;
- the Review Group's plans to assess the differences and similarities between the training for rural and remote medicine and for general practice through a curriculum mapping exercise.

In December 2004, at the request of the Review Group, the Recognition of Medical Specialties Advisory Committee commissioned a comparison of the curriculum for training leading to Fellowship of ACRRM with the curriculum for training leading to Fellowship of the Royal Australian College of General Practitioners and the Graduate Diploma in Rural General Practice. This exercise aimed to assess claims in the application for recognition concerning differences and overlaps with general practice, as exemplified by the statement: "Rural and remote medicine is a broad discipline that includes skills sets that overlap with many specialties including general practice. In these areas the specialist in rural and remote medicine must have a broader and deeper understanding of these areas as he/she will be required to deal with greater complexity in the management of the presenting conditions and with more professional isolation. There are also additional areas of practice that are not incorporated or considered integral to the skill set required for fellowship of general practice: procedural skills; hospital practice; population health; indigenous health; emergency medicine, and extended skills in areas such as psychiatry. The curricula for training in rural and remote medicine and general practice have been mapped and contain substantive difference in areas of content."[5]

A copy of the brief provided to the consultants for this work is in Appendix 4.

In April 2005, ACRRM provided additional information in response to the AMC's questions.

The Review Group also began a program of meetings with stakeholder bodies and site visits to rural and remote locations in April 2005. These visits aimed to enhance the Review Group's understanding of rural and remote medical practice, the issues of concern to rural and remote practitioners, training in rural and remote medicine, and the interactions between rural and remote medical practitioners and other medical and health practitioners. Because of the large number of stakeholder submissions, and the diverse locations in which rural and remote medicine is practiced, the Review Group undertook a substantial program of site visits.

In choosing the sites to visit, the Review Group noted that the spectrum of rural and remote medical practice is wide, and agreed that it should see a variety of practices and locations, including a mix of states and regions, small and large centres, and rural and remote practitioners.

The Review Group asked ACRRM to recommend sites. ACRRM suggested five locations and the Review Group visited four of these. The Review Group also asked the Rural Faculty of the RACGP to recommend sites, which would assist the Review Group's understanding of differences and similarities between rural and remote medical practice and rural general practice. The RACGP suggested six locations, and the Review Group visited one of these.

All the practices visited by the Review Group included at least one Fellow of ACRRM. The Review Group understood that it would meet practitioners with a wide variety of skills, experience and interests. Because the ACRRM Vocational Preparation Pathways is yet to graduate Fellows, all the Fellows met by the Review Group had gained their skills through other training and experience.

The Review Group took account of the range of submissions received from individual practitioners and stakeholder bodies, and opportunities to add visits to other travel by Review Group members.

[5] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 21.

A summary of the program of site visits is provided below. More detailed information is provided in Appendix 5.

- April 2005 - Site visits and stakeholder meetings in the Northern Territory (Darwin and Katherine) western Victoria (Koroit, Warrnambool and Camperdown), and central Victoria (Echuca, Bendigo and Gisborne)
- May 2005 – Stakeholder meetings in Brisbane and site visits in south-east Queensland (Toowoomba, Warwick and Beaudesert), north Queensland (Atherton), and central New South Wales (Scone, Muswellbrook and Newcastle)
- July 2005 - Stakeholder discussions in Alice Springs
- August 2005 - Stakeholder meetings in Perth.

The AMC Secretariat provided background information and an outline of the aims of the visit to each site and group visited. The information provided to groups visited indicated that:

- The AMC was not assessing the provision of medical and other health care services in rural and remote Australia, but the case for recognition of a specialty of rural and remote medicine against agreed criteria.
- The visits were one of many sources of information available to the Review Group.
- The key issues to be explored included:
  - medical practice in rural and remote areas, and the knowledge and skills that are required for practice;
  - the interactions between rural and remote medicine specialists and other medical and health practitioners;
  - training for rural and remote medicine;
  - the claim that rural and remote medicine is a well-defined specialty with knowledge, skills and attitudes that differ to a large extent in depth and complexity from the other major generalist specialty, general practice;
  - how recognition of a speciality of rural and remote medicine would affect patient safety, standards of care, and the cost of health care.

Review Group members were provided with a briefing paper summarising the AMC's assessment process and a list of standard questions concerning the region being visited; the medical services available locally; the practice being visited; the experience, skills and qualifications of the practitioners; the medical training opportunities available locally and the continuing professional development sought by practitioners.

The site visits provided valuable insight into the patterns of practice of rural and remote practitioners, and allowed Review Group members to experience first hand the enthusiasm and commitment of the practitioners. The Review Group acknowledges with thanks the assistance of the practitioners who arranged these visits and those who gave time to meet members of the Review Group.

The President of ACRRM wrote to the AMC outlining a number of concerns regarding the Review Group's selection of site visits. These concerns were considered by the Recognition of Medical Specialties Advisory Committee, and a response to them was provided from the AMC Chief Executive Officer. This response covered: the nature of the recognition process; consultation between the AMC and the College; the level of involvement of the RACGP in the process and the requirement that the Review Group gather information and ideas from multiple sources and viewpoints; and ACRRM involvement in the arrangement of site visits. It also indicated that the process, whilst collegiate and cooperative in the provision of information to assess applications for recognition, was investigative in nature and required an independent review of the case for recognition.

In August 2005, the Review Group met members of the ACRRM Executive:

- to provide feedback on the assessment of the case for recognition of rural and remote medicine as a medical specialty;
- to seek clarification from ACRRM to assist in finalising the Review Group's assessment report.

The large number of submissions on the application was noted, and the ACRRM Executive was invited to respond to issues raised by the submissions. The ACRRM President asked the Review Group to identify particular issues in the submissions that might require a response. This led to the development of a list of key questions. Whilst a number of these issues were canvassed at the meeting, the Review Group gave three weeks for ACRRM to provide a written response. This was received on 16 September 2005.

3. Generalist and Specialist Medical Practice in the Health Care System

Medical practice in Australia divides broadly into non-referred generalist medical practice and referred specialist practice. The term 'general practitioner' is commonly used in Australia to describe the providers of non-referred general medical services.

ACRRM is applying for recognition of rural and remote medicine as a generalist specialty. It states: "Rural and Remote Medicine is a well defined specialty with knowledge, skills and attitudes that differ to a large extent in depth and complexity, from the other major generalist specialty, General Practice."[6]

ACRRM's application for recognition also notes: "Since the formation of the General Practice specialty and legislative arrangements tying all non-referred care providers to General Practice and its training programs, General Practice is the mandatory filter from which Rural and Remote Medical Practitioners can be recruited."[7] It argues elsewhere that much of the rural and remote medicine workforce and practice settings do not match the definitions and requirements for general practice.

In this context, it is necessary to consider the current framework for medical services provision in Australia that defines generalist and specialist medical practice, and the historical development of medical specialties and of the generalist medical tradition.

3.1 Generalist practice and referred specialties

The health system in Australia is shaped by the historical development of generalist and specialist medicine internationally on the one hand and by Australian law on the other.

3.1.1 Historical context

The word generalist is defined as "a person with a broad education and ability to grasp basic concepts in various fields". The word specialist is defined as "someone who is devoted to one subject or to one particular branch of a subject or pursuit."[8]

Within the context of medicine, specialist disciplines have developed over the last century based on the knowledge, skills and attitudes relevant to physicians or the knowledge, skills and attitudes relevant to surgeons. A specialist area of medicine usually evolves over a number of years, in response to a combination of clinical, technological and scientific advances. A body of knowledge and specific skills relating to the area emerge, and medical practitioners who have gained that knowledge and those skills through training and experience begin to practise primarily in the new medical specialty. At this stage, the separate training requirements of practitioners in the specialist area are formalised through the establishment of distinct postgraduate medical training and examination requirements, and requirements for ongoing continuing professional development. The community has become increasingly aware of the improved outcomes that may be achieved by specialist skills, and these expectations may give impetus to the identification of a new specialty.

Both medical and surgical specialties have historically been strongly associated with hospital settings. Both have become increasingly sub-specialised, and increasingly dependent on the human, technological and other resources located in large hospitals. Both have long academic and professional traditions associated with them.

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[6] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 13.

[7] Australian College of Rural and Remote Medicine *Supplementary Information in Support of The Application to have Rural and Remote Medicine recognised as a Medical Specialty*, July 2004, p. 30

[8] *Macquarie Dictionary* Revised 3rd Edition 2001

The term 'general practitioner', used particularly in the United Kingdom, Australia and New Zealand, has denoted a medically qualified person who continued to undertake physician-type activities and surgical activities rather than specialising in one or the other. Often they provided these services within their communities and, when necessary, within smaller hospitals found in those communities.

3.1.2 General practice/family medicine

General practice has also evolved into a specialty or vocation, with formal training requirements, training programs and ongoing educational expectations, although the academic and professional underpinnings of general practice or family medicine (the terms can be considered interchangeable) are more recent.

McWhinney[9] outlined nine principles of general practice in 1989 and these are summarised below:

- a focus on a person, rather than a particular body of knowledge, group of diseases or particular technique;
- concern with the 'context' of the person presenting, the background information relating to the family, the work, the culture, as well as the foreground information concerning the particular symptom or issue presented;
- opportunistic prevention and health education potential within each doctor-patient contact;
- commitment to a practice population at risk – proactive preventive care;
- networked to community resources that can facilitate whole person management;
- having a visible presence in the communities they serve;
- the patient and doctor, rather than an institution, controlling the environment of the consultation i.e. patients may be seen at home, at the office or in hospital;
- subjectively determined realities given equal consideration with objectively determined realities;
- management of resources (investigations, referrals, etc) an important consideration.

The first principle clearly identifies a generalist orientation; the general practitioner is committed to assisting individuals manage the issues they present and a broad understanding of various fields is essential to this end. This commitment should not be confused with the generalist providing all the diagnostic, therapeutic or other management expertise. The generalist knows their abilities and limitations and appropriately engages the resources available, including specialist resources, to provide the necessary care. McWhinney makes clear that these principles are not exclusive to general practice, nor is it the case that all general practitioners exemplify all nine principles. "Taken together they do represent a distinctive world view – a system of values and an approach to problems – that is identifiably different from that of other disciplines."[10]

As a discipline, family medicine/general practice continues to develop its distinctive world view. Definitions of the discipline have evolved as account is taken of the different contextual factors that operate in various countries. A recent definition of the family doctor by the World Organisation of Family Doctors (the peak international body for Colleges and Academies of Family Medicine and General Practice) is a "physician who is a specialist trained to provide health care services for all individuals regardless of age, sex or type of health problem; provide primary and continuing care for entire families within their communities; address physical, psychological and social problems;

[9] I.R. McWhinney, *A Textbook of Family Medicine* Oxford University Press 1989
[10] ibid.

coordinate comprehensive health care services with other specialists as needed; may also be known as family physician or general practitioner (GP) depending on location of practice."[11]

The connection between this definition and McWhinney's nine principles is evident.

3.2 Levels in health care systems and referral

Functional subsets of the health systems include primary care, secondary care and tertiary care. Although there is debate over precise definitions, primary care includes the notions of point of first contact with the health system and delivery of services at a local level; secondary care includes activities provided on the basis of a referral from a primary care clinician and delivered usually by consultants or specialists; and tertiary care includes activities delivered within large hospital settings requiring sophisticated technology. Referral is a vital connecting activity between these levels, including referral to more specialised levels within the system and, on completion of the specialised service, referral back to more generalised levels.

3.3 The Australian context

The operation of general practice and referred specialist practice in Australia is substantially influenced by Australian Government legislation, specifically the *Health Insurance Act 1973*, which defines Medicare, and to a lesser extent the *Therapeutic Goods Act 1989*. The *Health Insurance Act* defines categories of medical practitioners and services eligible for payment through Medicare, and the Medicare Benefits Schedule interprets them:

"for a practitioner to be eligible to provide a medical service which can attract a Medicare benefit, or to provide services on behalf of another practitioner…the person is a recognised specialist, consultant physician or general practitioner."[12]

Eligible medical practitioners must have a *'provider number'* if they wish to raise valid referrals for specialist services, or requests for pathology and diagnostic imaging services.

For a medical practitioner to be recognised as a specialist or consultant physician for the purposes of the Health Insurance Act, the practitioner must make a formal application and pay a fee. He or she:

- "Is registered as a specialist under State or Territory law; or
- Holds a Fellowship of a specified specialist College; or
- Is recommended for recognition as a specialist or consultant physician by the Specialist Recognition Advisory Committee"[13]

General Practice items may be claimed when the services have been provided by a medical practitioner who is:

- "Vocationally Registered under section 3F of the Health Insurance Act;
- A holder of the FRACGP who participates in and meets the requirements for quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Education Program; or

[11] Boelen C, Haq C, Hunt V, Rivo M, Shahady E. *Improving Health Systems: The contribution of family medicine – A guidebook*. World Organization of Family Doctors, Bestprint Printing Company, Singapore, 2002
[12] Australian Government Department of Health and Ageing, Medicare Benefits Schedule Book Section 2.1.1 November 2004
[13] ibid, Section 5.1.1

- Undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP, or undertaking an approved placement in general practice as part of some other training program recognised by the RACGP as being of an equivalent standard."[14]

Section 5 of this report describes other circumstances in which doctors may claim General Practice items, particularly as incentives for recruitment and retention of rural medical practitioners.

Eligibility for vocational registration is certified against criteria of the Royal Australian College of General Practitioners relating to training, experience and assessment in general practice. According to the Medicare Benefits Schedule: "Continued vocational registration is dependent upon involvement in appropriate Continuing Medical Education (CME) and Quality Assurance (QA) programs approved by the RACGP, and the practitioner continuing to be predominantly in general practice."[15] Patients of vocationally registered doctors are able to receive higher Medicare rebates for prescribed medical services (known as A1 items).

The *Health Insurance Act* specifically considers referral because benefits payable through Medicare are dependent on evidence that particular services have been provided following referral. The Schedule defines referral as: "a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s)."[16]

The act of referral should follow careful thought on the part of the referring doctor about the need for referral, and communication, in writing, of the relevant information to the specialist or consultant physician. Specialists and consulting physicians must show the provider number of the referring doctor, date of referral and duration of referral in order for claims for that consultation to be eligible within Medicare.

The general practitioner is regarded as the primary source of referrals.

The academic and professional development of general practice within Australia has been driven from within the profession, particularly by the RACGP with more recent contributions from university departments of general practice.

The RACGP provides the following definitions of general practice and the general practitioner role.

"General practice is part of the Australian health care system and operates predominantly through private medical practices, which provide universal unreferred access to whole person medical care for individuals, families and communities. General practice care means comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health", and

"A general practitioner is a registered medical practitioner who is qualified and competent for general practice in Australia. A general practitioner:

- Has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care; and
- Maintains professional competence for general practice." [17]

[14] op cit, section 4.1.1
[15] op cit, section 4.3.8
[16] op cit, section 6.4.1
[17] http://www.racgp.org.au/document.asp?id=6234 (Accessed 7.3.2005)

Australian Government policy and incentives have also contributed to the development of general practice as a vocational field of medical practice and to general practice education and training. These include:

- The requirements of the Health Insurance Act, as outlined above.
- The Australian Government funds general practice education and training and, on its behalf, the Department of Health and Ageing establishes overall directions and performance outcomes based on Government priorities and perceived system needs.
- In order for general practitioners to access a range of Commonwealth general practice incentive payments, the practice in which they work must adhere to RACGP standards for general practices.

In the last three years, the RACGP's role in general practice training has changed and, for the purposes of continued vocational registration, the RACGP has approved the Professional Development Program of ACRRM as a Quality Assurance and Continuing Education Program. These changes are outlined in section 3.5 and 3.6 of the report.

3.4 Summary of generalist and specialist practice

The current Australian health system includes the provision of services by medical practitioners with a generalist orientation, and by medical practitioners with a specialist or consultant orientation. The generalist tradition is distinct from the specialist tradition as reflected in the principles which underpin generalist practice. The act of referral is a key process linking generalist services with specialist services. The *Health Insurance Act 1973* provides the legal framework for the operation of general practitioner services and specialist or consultant services.

3.5 Vocational training for generalist practice

For almost 30 years, training for general practice in Australia was undertaken by the Royal College of General Practitioners (1974 to 2001), through the RACGP Training Program.

In 1997, the Commonwealth Minister for Health and Family Services initiated two reviews of general practice, the Review of the General Practice Strategy and the Review of General Practice Training. The Review of General Practice Training considered educational service delivery mechanisms, and advised on practical support for rural vocational training, articulation of hospital experience and GP training, and linkages between undergraduate, postgraduate and continuing general practice education.

In response to these reviews, in June 2000 the Minister announced a reform of general practice education and training. The training program is now managed by General Practice Education and Training Limited (GPET), a company established by the Commonwealth.

Regional training providers (RTPs) deliver vocational training to registrars. On behalf of the Commonwealth, GPET allocates funding for training to RTPs, which are independent business entities that contract with GPET. Regional training providers are selected by GPET following a tender process. There are 22 approved and funded RTPs.

GPET is a Commonwealth company limited by guarantee and governed by a Board of Directors. Membership of the Board includes nominees of RACGP, ACRRM, General Practice Registrars Association (GPRA), Australian Association for Academic General Practice (AAAGP), Committee of Deans of Australian Medical Schools, and the Australian Divisions of General Practice, together with others with a strong interest or contribution to make to the sector.

Under its Constitution, GPET is to "work closely with the medical profession to ensure that all GP education and vocational training continues to meet the standards which are set by the profession's relevant colleges."[18] GPET documentation indicates that both the RACGP Training Program Curriculum and the ACRRM Primary Curriculum bear on the delivery of general practice training. The Constitution indicates: "Medical Profession' has its usual meaning and includes the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM)".[19]

Training occurs in either the General Pathway or the Rural Pathway. The difference between these pathways lies in the training placements in general practice (urban or rural/remote) and the tailored learning plan developed by the individual trainee, his/her medical educator and the regional training provider.

Trainees in the Rural Pathway undertake their community-based training in mainly rural locations. This pathway requires registrars to undertake a minimum of 18 months of rural training in rural, remote and metropolitan areas (RRMA) 4 to 7. The General Pathway includes at least six months of rural training 'except when registrars demonstrate exceptional circumstances'. If an exemption is granted, this requirement can be met by working in an area of medical service need rather than in a rural term. Registrars in the General Pathway in the six state capital cities and Canberra are also required to complete a minimum of six months in an outer metropolitan area with demonstrated area of service need status.

To date, the RACGP Fellowship has signified entry-level competence for unsupervised general practice anywhere in Australia. Within the GPET Framework, the RACGP sets academic and clinical standards, defines the curriculum and assesses the adequacy of training for general practice. Successful completion of the training program and formal assessment by the RACGP examination leads to the award of Fellowship of the Royal Australian College of General Practitioners (FRACGP) and vocational registration with the Health Insurance Commission. RTPs are required to participate in monitoring, accreditation, review, evaluation and reporting processes implemented and overseen by GPET, and to deliver general practice training and education to RACGP standards.

For completion of Australian General Practice Training, the key elements are as follows:

Year 1 entails one year of hospital-based training (or equivalent) subsequent to the intern year in RACGP accredited training posts.

Year 2 entails six months of basic GP terms and six months of advanced GP terms. Under the relevant RACGP Standards, in basic terms, teaching practices are to offer: a minimum of three hours per week teaching other than corridor consultations, and registrars are to engage in half a day per week, or equivalent, of external educational activities. For Advanced GP units, supervisors are to offer one and one half hours per week of dedicated teaching time, and half a day per fortnight or equivalent for external education activities.

Year 3 entails twelve months of subsequent (mentored) GP experience, with the provision to spend up to six months of this period in special skills terms in clinical areas of particular relevance to general practice. The special skills include women's health counselling, sports medicine, drug and alcohol, sexual health/STD/HIV medicine, palliative care, geriatrics, public health, emergency medicine, anaesthetics, obstetrics or surgery.

An optional Year 4 comprises 12 months of Advanced Rural Skills Posts or Advanced Academic General Practice Posts.

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[18] General Practice Education and Training Ltd http://www.agpt.com.au/pdf/GPETPromo.pdf Viewed 18 November 2005

[19] General Practice Education and Training Constitution 1/03/01 p. 3

Courses by a wide range of other education providers may be undertaken as an option at any stage in the training. Doctors working towards the FRACGP are also able to work towards other complementary awards, including the RACGP Graduate Diploma in Rural General Practice, the Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (DRANZCOG), which can be taken by medical graduates in at least their second year after graduation, masters of public health, and diplomas in paediatrics, dermatology, sexual heath and other areas of special interest and skill.

The GPET Framework also is used to deliver training to ACRRM standards. The key elements of the ACRRM Vocational Preparation Pathway are as follows:

The first year, described as the core clinical year, comprises 12 months rotating clinical training in a metropolitan, provincial or large rural centre (subject to ACRRM accreditation). It must include a term in paediatrics.

Twelve months core rural and remote medical training, of which up to six months may include approved hospital or community based experience.

Twelve months advanced rural and remote medical training, of which up to six months may include approved hospital, Aboriginal Medical Service or community based experience.

Twelve months specialty rural skills training, which may include but is not limited to accredited Advanced Rural Skills Posts in surgery, obstetrics, anaesthetics, aboriginal health, emergency medicine, psychiatry, adult internal medicine, population health, radiology/ultrasonography, ophthalmology or up to six months of approved elective training.

ACRRM indicates that satisfactory completion at least two ACRRM-approved emergency courses is also required.

The delivery of the FACRRM Program within the GPET environment is subject to an assessment by ACRRM of the capacity of the RTP to deliver training to ACRRM standards. ACRRM has indicated that as of October 2005, all rural or regional RTPs (i.e. 18 of the 22 RTPs nationally) had registered with ACRRM to be assessed to deliver the FACRRM.

In October 2004, the GPET Board endorsed an Enhanced Rural Training Framework. This development is the outcome of collaboration by the RACGP, ACRRM, the General Practice Registrars Association and Doctors in Rural and Remote Training, under the auspices of GPET.

The Framework acknowledges that preparation for competent general practice is encompassed by completion of the Fellowship of the Royal Australian College of General Practitioners (FRACGP), but that practice in specific rural and remote contexts may require knowledge and skills in addition to those acquired through successful completion of the FRACGP. The development of the Framework is an approach to promote and integrate rural training components into vocational training, so that registrars receive appropriate placements and training opportunities to prepare them for short term or committed long term work in a rural or remote setting. The Framework provides guidance on engagement in rural experience, placements and training opportunities for both general practice registrars undertaking rural training (in either the General or the Rural Pathway).

"It establishes a structure within Australian General Practice Training (AGPT) so that registrars can choose to work towards a postgraduate award in rural general practice (the RACGP Graduate Diploma in Rural General Practice) and/or rural and remote medicine (Fellowship of the Australian College of Rural and Remote Medicine) during their vocational training."[20]

[20] General Practice Education and Training Ltd *Enhanced Rural Training Framework* 2005 p. 3

More detailed information on the Framework is provided in Section 5.4.1 of this report.

3.6 Requirements for continuing professional development for generalist practice

Since the introduction of vocational registration in 1989, all recognised general practitioners have been required to participate in an authorised quality assurance program.

The RACGP has had a quality assurance program since 1987. There are currently 21,000 general practitioners enrolled in the Quality Assurance and Continuing Professional Development (QA & CPD) program, including practitioners grandfathered into vocational registration who do not hold the FRACGP. There are currently 4,300 enrolled practitioners in rural and remote areas.

The program cycle spans three years. Participants are encouraged to undertake a range of different activities covering the content of all five domains of general practice to address their individual learning needs required to achieve a minimum of 130 points per triennium. Minimum requirements, in terms of the points allocated, are listed for each type of activity.

The program employs education and development officers based in each State/Territory Faculty to assess applications from GPs and QA&CPD providers for recognition with the program. Since 1997, a Rural Education and Development Officer, based in the Rural Faculty of RACGP, has been responsible for the assessment of the QA&CPD needs of rural and remote practitioners and has developed strategies to support these doctors. In particular, the Rural Faculty offers a range of clinical audits and CPD activities, including distance learning modules, clinical attachments and small group learning opportunities to rural and remote practitioners.

The ACRRM Professional Development Program (PDP) was established in 1998. There are currently 1,609 doctors enrolled in the program, including 1,051 participating in order to maintain their vocational registration status.

In 2003, the then Minister for Health brokered an agreement for the RACGP to recognise participation in the ACRRM PDP towards the triennial Commonwealth quality assurance requirement for vocational registration with the Health Insurance Commission. ACRRM subsequently secured funding from the Commonwealth to enhance the quality assurance program.

In 2004, 945 practitioners chose to undertake QA&CPD requirements with the ACRRM Professional Development Program for vocational registration purposes (nearly five per cent of all vocationally recognised general practitioners and 22 per cent of the 4,300 rural and remote practitioners cited above). A further 607 non-vocationally registered doctors participated in the program (largely representative of salaried medical officers and Rural Other Medical Practitioners with no formal CPD requirements outside those of ACRRM).

The ACRRM PDP is summarised in section 4.3.

4. Précis of the Case made by the Australian College of Rural and Remote Medicine (ACRRM)

4.1 ACRRM's definition of rural and remote medicine

ACRRM defines Rural and Remote Medicine as:

> "the specialty that focuses on securing optimum patient and community health outcomes utilising a particular range and depth of knowledge, skills and attitudes not common to any other medical craft group to achieve the desired outcomes within the parameters of practice imposed by rural and remote environments.
>
> Rural and Remote Medicine operates on a unique paradigm of primary, secondary and tertiary medical care, with increased individual responsibility owing to relative professional isolation, geographic isolation, limited resources and special cultural and sociological factors.
>
> A specialist in Rural and Remote Medicine requires a broad understanding of diagnosis, treatment and management from the perspective of a number of medical and surgical disciplines and applies these skills along the continuum of care from primary presentation to secondary and sometimes tertiary care. Practitioners are able to adapt and build their skills in response to the health needs of a diverse range of rural and remote community settings and the degree of isolation from other health services and resources.
>
> The defining characteristics of the specialty are the specific content, context and consequent complexity of the discipline." [21]

In terms of **content** ACRRM goes on to say:

> "Rural and Remote Medicine is a specialty that takes a broad range of consulting room practice responsibilities to meet the demands of the rural and remote context and combines them with sets of skills and expertise from a number of relevant specialties. Rural and Remote Medicine shares content with Obstetrics, Emergency Medicine, Surgery, Psychiatry, Public Health, Internal Medicine, Paediatrics, Radiology, Anaesthetics, Ophthalmology, Pathology, Gerontology, ENT, Aboriginal and Torres Strait Islander Health and General Practice, and also requires a working knowledge of many allied health fields such as podiatry, social work, physical and occupational therapy. It applies to all age groups and covers all symptoms and presentations." [22]

Context is explained as:

> "The practice of Rural and Remote Medicine is shaped by the nature and patterns of mortality and morbidity across rural and remote Australia and internationally. The health status of Australians in rural and remote regions is substantially poorer than that of their urban counterparts and there is a link between remoteness and decreasing levels of health for both Indigenous and non-Indigenous people." [23]

[21] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine,* April 2004, p. 14.
[22] ibid, p. 14
[23] op cit, p. 15

Complexity is treated thus:

> "Rural medical practitioners are called to administer more complex regimes (sic) of management and treatment with a relatively lower resource base (professional and physical). Practitioners must be able to determine when to transfer and when to treat. They must be acutely aware of the resources and support that is available locally as well as at the nearest referral base. As such they must undertake unique forms of clinical risk analysis and make informed clinical judgments." [24]

4.2 ACRRM's description of the emergence of rural and remote medicine

ACRRM identifies the roots of rural and remote medicine in traditional generalist family practice, small hospital practice and public health practice. It states that, with the increase of specialisation and sub-specialisation and the subsequent delineation of general practice as a specialty within the primary care field, the discipline of rural and remote medicine has emerged and differentiated itself from other specialties. ACRRM describes rural and remote medicine as encapsulating a mixture and quality of medical care that is not replicated or significantly shared by other medical craft groups. It states that rural and remote medicine incorporates many elements of generalist practice, hospital practice and public health in a unique discipline adapted to the rural and remote environment.

The application for recognition indicates that rural and remote medicine may be practised in private practice, hospitals, clinics and other community settings such as the Royal Flying Doctor Service, Aboriginal Medical Services, community health centres and hospices. Practitioners may work in public or private capacities or in a combination of both. It is a common feature of the practice that doctors at different times and under concurrent practice commitments work in various capacities under a range of different employment arrangements. Longer working hours and on-call responsibilities are considered to be characteristics of rural and remote medicine.

The application for recognition maintains that formal recognition of a speciality of rural and remote medicine will have the following benefits:

- enhance training for new practitioners and ensure adequate professional and educational support for current practitioners where that support has not been available in the past;
- make rural and remote medicine a more attractive career path, thus ensuring an adequate supply of urgently needed practitioners;
- enhance the calibre of medical care provided to Australian rural and remote communities;
- result in more effective and efficient use of health resources;
- provide an appropriate environment for ACRRM and other related stakeholders to continue to develop and consolidate the best practice guidelines and standards of rural and remote medicine;
- overcome many of the current inequities that rural patients experience in accessing appropriately trained practitioners who can delivery comprehensive and high quality care.

In essence, ACRRM considers that recognition of rural and remote medicine is critical to ensure that the unique scope and model of practice of rural and remote medicine continues to be fostered and taught to new generations of doctors. It regards the alternative to be failure to meet the medical needs of rural and remote communities, which will significantly contribute to the higher death and morbidity rates. ACRRM states that there has been a compelling and urgent case to address the public interest and health care needs of rural and remote communities, with a severe shortage of practitioners compared to community need. Many rural communities do not have any local medical services

[24] op cit, p. 20

available while some have services that may be limited by the practitioner's inexperience, lack of adequate training or poor access to ongoing education or support.

The application for recognition outlines developments in rural health policy in other countries, including Canada, the United State of America and New Zealand. It lists medical schools internationally that have specific missions to address rural medicine, and professional organisations with a primary focus on supporting rural medical practice.

4.3 The Australian College of Rural and Remote Medicine

4.3.1 ACRRM's development as a professional standards setting body

ACRRM states that it is the peak professional association for rural and remote medical education and training in Australia.

The mission statement of ACRRM is: 'To advance and promote high quality professional standards, education, clinical best practice and patient safety in Rural and Remote Medicine.' ACRRM states that its core function is to determine and uphold the standards that define and govern competent independent rural and remote medical practice.

ACRRM's application for recognition describes the genesis of the College. Essentially, it developed following a period of disagreement concerning the place of rural practice in the RACGP, and the attention given to the professional advancement and the general needs of primary care doctors outside metropolitan areas.

ACRRM was incorporated in March 1997 with 600 foundation members. In 2004, ACRRM had an overall membership of: 1,347 Fellows, 172 rural doctor Members, 103 Associate Members (retired rural doctors, junior doctors, students), and 43 Registrar Members. In November 2005, that number had grown to more than 1,800.

There are 20 full and part-time staff members working in the national headquarters. The College also employs a small number of staff in other towns and cities throughout Australia.

ACRRM is governed by a national Board of Directors that is elected from the College members in line with the Constitution. There are directors in the following categories: directors from each State/region; an academic elected director; a 'Women in rural practice' director; a Rural Doctors Association director; a remote director, and a registrar director. The Board generates policy and makes decisions in consultation with a series of advisory committees and reference groups within the College. Key advisory committees relating to education, training and practice standards are the Censors Committee; the Vocational Preparation Committee; the Professional Development Committee; the Practice Accreditation Committee; Practitioner Standards Committee and Ethics and Appeals Committee.

All Fellows and members provide their services to ACRRM on an honorary basis.

The objectives of ACRRM are[25]:

1. To define and promote professional standards in Rural and Remote Medicine by:
    - Documenting and upholding quality of care and educational standards for the discipline
    - Conducting prevocational and vocational training programs
    - Conferring appropriate qualifications to individuals that have demonstrated attainment of the requisite standards

[25] op cit, p. 63

- Conducting continuing professional development programs
- Communicate with government and other agencies regarding professional standards and practice principles

2. To promote education in Rural and Remote Medicine by:
   - Fostering career paths in rural medicine
   - Advancing teaching and learning opportunities in the discipline
   - Promoting continuing professional development to Fellows and practitioners
   - Collaborate with other organisations to provide and support appropriate resources for education

3. To advocate and support rural medical practice
   - Interact with other professional bodies and the international community to share knowledge, skills and developments
   - Provide advice to Government and other stakeholders on matters relating to rural practice and rural medical practitioners
   - Support research in the discipline
   - Ensure a sustainable organisational infrastructure and capacity for Rural and Remote Medicine

4.3.2 ACRRM's training roles

Contribution to medical undergraduate and prevocational training

ACRRM encourages medical student exposure to rural and remote practice. The College sponsors an annual award for an undergraduate medical student from the National Rural Health Network to spend two weeks in a clinical placement at a location of the student's choice. Together with the Australian Divisions of General Practice, the Rural Doctors Association of Australia and the Australian Rural Health Education Network (ARHEN), ACRRM administers the John Flynn Scholarship Scheme, which affords students the opportunity to spend two weeks each year in a rural or remote community.

ACRRM's Rural and Remote Area Placement Program (RRAPP) is an initiative targeting prevocational medical doctors who have not yet selected a specialty vocational training program. The program offers the opportunity to spend a 12-week term working under supervision in a rural or remote medical practice. The Remote, Rural and Regional components of the Pre-Vocational General Practice Placements Program, based on the RRAPP, supports junior doctors wanting continuing involvement in rural and remote practice. This is administered by ACRRM. An estimated 350 rural placements have been funded to July 2007.

Vocational Training

ACRRM states: "FACRRM qualifications recognise attainment of a skills set that extends beyond that ordinarily encapsulated in primary care and includes many skills that in 'General Practice' would be routinely the purview of a specialist. All Fellows have a common set of skills based on the ACRRM Primary Curriculum."[26]

ACRRM defines its specialists (Fellows) as having attained the skills and competencies required for safe, independent, comprehensive practice in a rural and remote setting. ACRRM distinguishes the practice from urban generalist practice by its relative professional isolation, limited resources, distance from specialists and speciality facilities, different patterns of health and different socio-cultural environment. ACRRM based training is directed to support the practitioner in this context. The application for recognition states that ACRRM Fellows are the only doctors whose rural and remote

[26] Australian College of Rural and Remote Medicine *Supplementary Information in Support of The Application to have Rural and Remote Medicine recognised as a Medical Specialty*, July 2004, p. 5.

medical capacity has been appropriately assessed. It further states that practice in a rural environment changes the scope and nature of practice for all doctors. For the specialist in rural and remote medicine, however, it means the development and maintenance of a unique and defining set of skills that partially overlap with other medical craft groups but are not coincident in scope of application with any one of those groups. Doctors qualified in other medical specialties may additionally attain FACRRM in recognition of their specialist rural skills set. As of July 2004, there were 22 Fellows of ACRRM with Australian recognised specialist qualifications, of which most are joint qualifications with surgery, internal medicine and public health medicine. There were 382 Fellows of ACRRM (28 per cent of the Fellows) who also held the FRACGP.[27]

The application for recognition describes three vocational training pathways that lead to Fellowship of ACRRM. The requirements for training in all three are summarised in the application for recognition and set out in detail in the ACRRM Vocational Training Handbook (see Appendix 9 to the application for recognition). The learning approaches include self-directed learning, information technology based distance learning modules, interactive teleconferences, small group learning, problem based learning, workshops and conferences, procedural skills training, multidisciplinary approaches and clinical audit.

These pathways are:

1. *The four-year Vocational Preparation Program.* Training is delivered through Australian General Practice Training, managed by GPET and the regional training providers. Presently, trainees in the vocational preparation pathway are also enrolled in the Royal Australian College of General Practice (RACGP) training, as attainment of an unrestricted Medicare provider number is dependent on the award of FRACGP. ACRRM's application for recognition notes that under Australian General Practice Training there are 200 places annually in the Rural Pathway[28]. The application for recognition notes that these positions are not dedicated to rural and remote medicine training, but states that it could be expected that a significant number of these registrars (perhaps up to 100) would be interested in pursuing rural and remote medicine qualifications at the same time as general practice qualifications. The application for recognition also anticipates that, if the current compulsory requirements for registrars to pursue general practice qualifications were removed, registrar enrolments would increase as the requirement to complete two awards is a significant barrier in terms of additional educational requirements.

   When this pathway was introduced in 2003, 10 trainees ('registrars') enrolled. In October 2005 there were 41 registrars enrolled in this pathway. ACRRM indicates that the number has increased substantially since the implementation of the Enhanced Rural Training Framework in 2005.

   The ACRRM Primary Curriculum describes an educational pathway to FACRRM based on seven domains:

   1. Core clinical knowledge and skills: Primary care generalist knowledge and consulting skills extended to encompass the morbidity and mortality patterns of people in rural and remote areas, small communities, limited resources and teamwork.

   2. Advanced clinical knowledge and skills: Diagnostic, therapeutic and clinical management skills of specialist areas adapted to suit the rural and remote environment.

   3. Emergency care: Resuscitation, stabilisation and transfer skills, acute accident care.

[27] Ibid, pp 4 - 5

[28] Australian General Practice Training 2006 Information Guide for Applicants indicates that about 40 % of the 600 places available are in the Rural Pathway i.e. 240 places

4. Population health: Health education and promotion, public health issues of hygiene, sanitation, immunisation and health screening activities.

5. Aboriginal and Torres Strait Health: Aboriginal and Torres Strait history and culture, cross-cultural communication, community controlled health services and teamwork.

6. Professional and ethical practice: Use of information and telecommunication technology, practice management and personal work/life balance.

7. Rural and remote practice: Responsiveness to the social values and health needs of remote communities.

The registrar is required to complete a minimum of 48 months of vocational training in practices and posts approved by ACRRM. The structure is outlined in section 3.5 of the report.

2. *Independent Training Pathway*. This pathway is designed for more experienced medical practitioners who are working in busy rural and remote communities. The applicant must have completed a primary medical degree, at least one year of hospital internship or residency and be registered to practise in Australia. This is a flexible program for self-directed learners. Training is based on a learning plan, developed following assessment of the candidate's skills and experience against the ACRRM educational standards as defined in the ACRRM Curriculum. Candidates are directed to ACRRM accredited practices within their region and develop their training portfolio in consultation with the Censor and an ACRRM mentor/supervisor.

   Supervision and mentorship is provided according to the doctor's experience, skill set and practice type. Recognition is given for prior learning. In 2003, there were 20 individuals enrolled in this pathway, and ACRRM has projected enrolments of up to 50 trainees per annum.

   The application for recognition describes this model as a flexible mechanism by which Other Medical Practitioners (OMPs) including overseas-trained doctors, can meet requirements for vocational competency in rural and remote medicine. ACRRM's projection of a considerable expansion to this program is based on the approximately 600 OMPs in ACRRM and approximately 1300 rural OMPs in Australia.

   The training comprises:

   - 36 months clinical training including hospital, core and advanced rural and remote medical training
   - 12 months speciality rural skills training
   - completion of a case report or project
   - satisfactory assessment for all training periods
   - successful completion of the ACRRM Fellowship assessment.

3. *Remote Vocational Training Scheme*. This program is run cooperatively with the RACGP. It provides vocational training for isolated rural medical practitioners who under ordinary circumstances could not complete this except by leaving their communities. It is delivered almost entirely through distance-based education and support. Successful completion qualifies participants for award of both the FACRRM and the FRACGP. Thirteen participants have successfully completed the program and attained both awards. Eleven are currently working towards this. The RVTS has a dedicated coordinator and secretariat and involves ACRRM accredited practice sites and supervisors/mentors.

   ACRRM standards underpin the delivery of the program which ensures that this program broadly replicates the Vocational Preparation Pathway through distance education and remote supervision.

This program has been piloted and has now been recognised as a discrete pathway, but continues to be limited to a small number of places nationally.

Professional development programs

The ACRRM Professional Development Program Handbook (see Appendix 8 of the application for recognition) details the requirements for professional development. Participation in the Professional Development Program (PDP) is mandatory for College Fellows.

ACRRM has allowed for substantial cross-accreditation of education with similar programs run by other medical colleges. The ACRRM professional development program is recognised by the RACGP for maintenance of vocational registration.

The program comprises assessed clinical experience and relevant education activities from a wide range of delivery organisations including regional training providers, university departments of rural health/rural clinical school networks, universities and medical colleges. and some provided directly by ACRRM. As is common for such programs, it is self-directed with Fellows responsible for determining their needs and planning educational activities relevant to their professional and community needs. Documentation is by a combination of self-recording and notification by education providers. ACRRM's online resource Rural and Remote Medicine Education Online (RRMEO) facilitates identification and secure booking of workshops and meetings, self-directed learning using specifically designed modules, electronic resources such as clinical protocols and online submission of PDP points.

General categories of activities accredited for award of PDP points include:
- General continuing medical education (conferences, meetings, self–directed learning)
- Practice Improvement/Quality Assurance/Clinical Assessment (clinical audit, peer review groups, ACRRM Practice Analysis Package, skills laboratory training)
- Practice accreditation and reaccreditation/teaching practice accreditation
- Educator activities (teaching, supervision, development of education programs, research, publication and scientific presentation)
- Educational development (university degree or courses, clinical or non-clinical short courses)
- Other activities (assessed on individual basis).

Participants must accumulate 100 points per triennium in accredited activities. Most activities are allocated one point per hour, and practice improvement projects are awarded two to five points per hour. A minimum of 20 points per triennium must be obtained by Practice Improvement/Quality Assurance or Clinical Assessment activities.

4.4 ACRRM's objectives in seeking recognition

In its application, subsequent material and in meetings with the Review Group, ACRRM has stated that it has the following objectives in seeking recognition[29]:

1. Recognition of a specialty of rural and remote medicine as distinct to other specialties.

2. A training and standards framework matched to the needs of rural and remote medicine. Since the formation of the general practice specialty and legislative arrangements tying all non-referred care providers to general practice and its training programs, entry to generalist rural and remote medical practice at present requires completion of the Fellowship of the RACGP. ACRRM is

[29] Australian College of Rural and Remote Medicine *Supplementary Information in Support of The Application to have Rural And Remote Medicine Recognised as A Medical Specialty*, July 2004.

aiming for general practice training to no longer be the filter for recruitment and training of rural and remote medicine practitioners.

3. Vocational registration (or an equivalent government recognised status). ACRRM intends that its vocational training pathways leading to Fellowship of ACRRM would be an independent means for rural doctors to attain access to a generalist vocational register recognised for the purposes of the MBS. It proposes that this be a separate Rural and Remote Medicine Register and that the entry point to this would be an ACRRM Fellows list - analogous to the RACGP Fellows list for entry to the General Practice Vocational Register (VR). Medical practitioners would need to hold FACRRM to be listed on the Rural and Remote Medicine Register. It proposes that rural and remote practitioners would have permanent entry into the MBS, so long as they undertake continuing professional development requirements.

4. Access to A1 item numbers on the Medicare Benefits Schedule and access to all of the current government incentives and support for generalist practice.

5. Fully transferable access to A1 item numbers anywhere in Australia from both the proposed Rural and Remote Medicine Register and the Vocational Register (i.e. a Fellow of ACRRM can work in the city and a Fellow of the RACGP in the country).

6. Recognition and appropriate remuneration of ACRRM accredited rural specialist services (which ACRRM indicates would be services involving skills appropriate to the rural environment and more complex than those ordinarily associated with generalist practice and/or requiring greater responsibilities and/or time demands).

5. Rural and Remote Medical Practice

5.1 Definitions

Discussion of medical practice in rural and remote Australia begins with a consideration of definitions. Definitions of rural and remote practice have gradually evolved; since 2001, the Accessibility Remote Index of Australia (ARIA) has begun to supersede the Rural, Remote and Metropolitan Areas classification (RRMA).

RRMA was developed in 1994 as a framework for the analysis of a range of data sources. It combines a distance measure with a population density measure. RRMA includes two metropolitan, three rural and two remote zones, based around Statistical Local Areas boundaries, which may provide an imperfect reflection of physical remoteness. The ARIA framework, on the other hand, is based explicitly along geographical lines. By means of a one kilometre grid over the entire country, including 201 specified service centres, the remoteness of 11,340 communities can be derived and classified broadly into five groups: major cities, inner regional, outer regional, remote and very remote Australia (simplifying the 0 to 12 points scoring system). Subsequently 'ARIA +' has been developed, with a 15-point scoring system, reflecting an additional category of service centre (population 1,000 to 4,999)[30] which was not included in the original ARIA.

While ARIA is used increasingly to describe the demographics and distribution of the medical workforce, RRMA remains the system upon which most Australian Government medical workforce incentives are based. The RRMA classification system is presently under review, because of its perceived limitations as a geographical classification, and its failure to take account of important specific factors such as the workforce level or the health needs of a region.

5.2 Number of practitioners in rural and remote medical practice

The Medical labour force 2002 report, published in 2004[31], describes in detail population and medical workforce demographics. It was estimated that there were 59,023 registered medical practitioners in Australia, 92.8 per cent of whom were in the medical workforce. The largest proportion of these practitioners was in primary care (43.7%), about one-third were specialists (35.6%) and the remainder either specialists-in-training (11.0%) or hospital-based, non-specialist practitioners (9.7%). Compared with 1997, there was an increase in the number of practitioners in all states and territories. These changes were most marked in the Northern Territory (up 48.1%), the Australian Capital Territory (25.1%) and Victoria (23.7%); the increase nationally was 12%. However, when controlled for hours worked and converted to full time equivalents (FTE), based on a 45 hour week, there were increases in only three jurisdictions, Victoria (from 276 to 301 FTE per 100,000 population), the Northern Territory (from 258 to 346) and the Australian Capital Territory (from 324 to 370). In contrast there were decreases in supply in the remaining States, ranging from three FTE in South Australia (from 303 to 300) to 30 FTE in Queensland (from 247 to 217).

As stated, the ARIA model describes the distribution of populations (and medical practitioners) among five regions, classified by remoteness. In 2002 about 66.3 per cent of Australians (i.e. 13.03 million people) lived in major cities, where 75.9 per cent of medical practitioners provided services, working on average 44.1 hours each week. In comparison, 1.7 per cent of Australians (320,000) lived in remote areas and 0.8 per cent (433) medical practitioners provided services, working on average 47.1 hours per week. In very remote areas, 0.9 per cent of Australians (180,000) lived, and 0.4 per cent (231) medical practitioners provided services, working on average 49.1 hours per week. Thus in 2002

[30] The new classification is described by the ABS as a 'remoteness structure'

[31] Australian Institute of Health and Welfare 2004. Medical labour force 2002. AIHW cat. no. HWL 30. Canberra. AIHW (National Health Labour Force Series No. 30)

there were in total 664 medical practitioners in 2002 serving the needs of Australians living in locations that are classified as remote and very remote.[32][33]

In 2002, medical practitioners working in remote and very remote areas were on average three to four years younger than their city colleagues and worked three and a half to five hours per week longer. The trend for an increasing proportion of female medical practitioners continued (compared to 1997), this effect was most pronounced in very remote areas, which saw a 10.7 per cent increase (to 38.5 per cent) in the number of female practitioners. There were notable changes in supply of all practitioners, compared to 1997, which varied according to the region. There was a slight decrease for example in total FTE in major cities, down from 315 to 312. In contrast there was an increase in supply in other areas, particularly in very remote areas (up from 112 to 141 FTE) and remote areas (up from 129 to 140 FTE).

The distribution of **primary care** practitioners to very remote areas in 2002 increased in FTE from 67 to 93 per 100,000. At the same time, the hours worked by primary care practitioners in very remote areas increased slightly, from 47.7 hours per week in 1997 to 48.4 hours per week in 2002. In contrast, their colleagues in other areas reduced their hours by 3.5 to 4.4 hours per week. For this reason, the FTE supply of primary care practitioners fell in other areas compared with 1997.

To complicate the description of the geographical distribution of medical practitioners, some practitioners work in more that one area. For example, in 2002, 934 practitioners based in major cities also practised in a less populated region. Thus 25 city based practitioners averaged around a day per week (9.4 hours) in remote areas, and 10 averaged a day per week (6.8 hours) in very remote areas. Thus in total, remote and very remote areas received services from 116 practitioners based outside these regions, equating to 22 FTEs or a supply increase of 9 FTE per 100,000 population across these two areas. Correcting practitioners' hours to take account of the regions where they supplied services, to some extent reduces the disparity seen between major cities (312 FTE reduced to 308 FTE per 100,000 of population) and very remote areas (141 FTE increasing to 154 FTE per 100,000 of population), although a two fold disparity remains between major cities and very remote areas in FTE practitioners per 100,000 population.

5.3 Support and incentives for rural and remote medicine practice

A complex and overlapping range of incentives, available from medical school to fully trained vocationally registered practitioner, is designed to recruit, retain and up-skill the medical workforce in rural and remote areas of the country. A brief description of the range of incentives, as contained in the Australian Department of Health and Ageing website[34], is provided below. Many of these incentives have a long lead time, medical undergraduate scholarships for example, thus it may be too soon to expect outcome evaluations of individual initiatives. A September 2001 study of workforce retention in rural and remote Australia (RRMA 3 to 7) found that professional considerations, i.e. on-call arrangements, professional support and the varied nature of rural practice were ranked as the top three issues among the 677 questionnaires returned from 1344 eligible GPs.[35]

[32] ibid
[33] Numbers given in this paragraph are actual practitioner numbers not FTE
[34] Australian Government Department of Health and Ageing at www.health.gov.au
[35] Humphreys JS, Jones MP, Jones JA, Mara PR. Workforce retention in rural and remote Australia: determining factors that influence length of practice. Med J Aust, 176:472-6, 2002

5.3.1 University medical training

The **additional university departments of rural health and clinical schools** builds on existing Federal support for the Regional Clinical Training School at Wagga Wagga and seven university departments of rural health. It provides nine new clinical schools in rural and regional areas and three new university departments of rural health. The initiative creates almost 250 new medical school places with funding to cover the cost of undergraduate education.

The Program exposes students to rural practice through long-term placements in rural areas during their clinical training years. From the commencement of the 2004 academic year, one-quarter of medical students are required to undertake half of their clinical training in a rural location. Almost 150 students undertook long-term clinical placements in rural areas in 2003.

A **Medical Rural Bonded Scholarship program** is available to those wishing to study medicine, who are also willing to be bonded to work in areas of workforce shortage for six years. In exchange, they receive up to $20,000 per annum (indexed) as a medical student.

When established in 2000 a budget of $32.4 million over four years was allocated, sufficient for 100 medical school places.

A two-year pilot program of enhanced support for scholars was established in July 2003. The support is being provided by ACRRM in partnership with the Rural Doctors Association of Australia, and in consultation with the rural clinical schools.

Almost 400 **Rural Australian Medical Undergraduate Scholarships (RAMUS)** are available annually to students with a rural background and limited financial means, value $10,000 per annum. Scholarship holders are not bonded, however they undertake mentorship with a rural practitioner, including regular visits to the practice. The aim is to increase the number of rural students choosing a career in medicine; rural students are more likely than metropolitan students to undertake rural practice once they have completed training.[36]

5.3.2 Existing workforce

Depending on definition there are at least eight programs and sub-programs which directly offer incentives to general practitioners to work in rural and remote Australia:

1. The **HECS Reimbursement Scheme** was introduced in 2000 to 2001 to promote careers in rural medicine. Medical practitioners who undertake training or who provide services in designated rural and remote areas will have one-fifth of their Higher Education Contribution Scheme medicine fees reimbursed for each year of service. The scheme is eligible to permanent residents or citizens who have completed an accredited medical course in Australia, and who have worked in RRMA 3 to 7 locations for an initial period of 12 months. Initial funding of $4.3 million was provided from 2000-01 until 2003-04, allowing eligible medical practitioners to work off their debt working in a designated area over five years.

2. The **Practice Incentive Program Procedural Payment** was introduced in November 2003 as part of a range of measures to strengthen Medicare. It aims to support procedural GPs in providing local access to surgical, anaesthetic, obstetric and after-hours services in rural areas. It is targeted at RRMA 3 to 7. There are three tiers of support which involve payments of $1,000 to $3,000 per annum depending on the number of procedures performed each year.

[36] Azer SA, Simmons D, Elliott SL. Rural training and the state of rural health services: effect of rural background on the perception and attitude of first year medical students at the University of Melbourne. Aust J Rural Health. 9:178-185, 2001

3. **Medicare Plus** encompasses a range of measures designed to help general practitioners develop and maintain procedural skills. It provides up to $10,000 per annum to support a procedural GP undertaking two weeks training. The Procedural Medicine collaboration between the RACGP and ACRRM assists in the certification of eligible doctors and PDP and the administration of this program. There is a bulk-billing incentive, raising the payment from $5 to $7.50 for GPs in RRMA 4 to 7 whose services are bulk billed and delivered to concession card holders and children under 16 years.

4. **Medical Indemnity Subsidy for Proceduralists**. The Australian Government Department of Health and Ageing provides additional assistance for practitioners in rural areas performing procedural work, meeting 75% of the difference between indemnity costs for a procedural practitioner and a non-procedural practitioner.

5. The **Rural and Remote General Practice Program** was introduced in 1998, it uses State and Northern Territory based Rural Workforce Agencies to provide continuing medical education, locums, relocation, retention, training and remote area grants for general practitioners. The Rural Workforce Agencies are also funded to provide support for general practitioners and their families.

6. The **Remote Vocational Training Scheme (RVTS**). This scheme is directed at isolated doctors who under normal circumstances could only complete vocational training by leaving their communities. The definition of remote/rural practice here is rural practice in communities over 80 kilometres or more than one hour by road from a centre with no less than a continuous specialist service in anaesthesia, obstetrics and surgery and a fully functional operating theatre. The majority of the training must be completed in RRMA 4 to 7 locations. Recruitment for up to 11 RVTS training registrars took place in December 2003 to January 2004. Registrars will rely on remote supervision, supported by innovative information and telecommunications technologies.

   Other registrars in RRMA 4 to 7 training in the Rural Pathway are eligible for financial support through the General Practice **Registrars' Rural Incentives Payments Scheme (RRIPS).** Up to $60,000 (including $30,000 in Year 3) will be paid over three years to participating general practice trainees, who may subsequently also obtain vocational recognition.

7. **Workforce Support for Rural General Practitioners Program**. This initiative is used to support newly arrived and existing general practice workforce in rural areas, it includes support for training, professional development and locum coverage. The program is managed by eligible Divisions of General Practice.

8. The **Rural 'Other Medical Practitioners' (ROMPS) program** was introduced in the 2000-2001 Budget, in recognition of the value of services provided by non-vocationally registered medical practitioners in RRMA 4 to 7 locations. 'Other Medical Practitioners' are general practitioners who are not vocationally registered. The Rural OMPs program extends the full Medicare rebate to all GP services provided by eligible practitioners in designated rural and remote areas of Australia. Eligible practitioners are able to bill A1 Medicare Benefits Schedule items and, as a consequence, their patients receive the higher Medicare rebate.

   Eligibility includes a requirement that practitioners register an interest in undertaking a pathway to Fellowship of the Royal Australian College of General Practitioners (FRACGP).

   A review in 2003 confirmed that the program resulted in an increase in the number of medical practitioners providing these services.

9. The **Rural Retention Program** was introduced in 1999-2000, aiming to recognise and retain long-term, long serving general practitioners in rural and remote communities. There is a central payments system, based on Medicare data and, a flexible payments system administered by Rural Workforce Agencies for those practitioners whose work is outside Medicare. The complex system recognises five categories of rural and remote location, and depending on the time spent, payments are triggered each quarter. For example, in the most remote communities, i.e. category E, a period of 12 months work will trigger payment up to $25,000 annually, while in relation to category A, six year's work is required before payment of up to $5,000 per annum is triggered. This maximum annual payment accrues when Medicare billing reaches $80,000 in a year. Accompanying the explanatory document is a 92-page list of place names classifying eligible locations, which are sorted alphabetically and by state. It is unclear how this list relates to the RRMA and the ARIA classification also used by the Federal Department of Health and Ageing to determine remoteness.

10. The Specialist Rural Workforce, the **Support Scheme for Rural Specialists** (SSRS), which began in 2003, provides funding for continuing professional development of specialists practicing in rural areas. In addition, funding has been provided for newly accredited **Advanced Specialist Training Posts in Rural Areas** (ASTPRA) with up to $75,000 per post for up to two years. The Federal Government is offering States and the Northern Territory $2million for 30 to 35 positions. Finally, the **Medical Specialist Outreach Assistance Program** (MSOAP) supports the costs associated with providing outreach specialist services to rural and remote Australia. As of September 2004, 1,100 specialist services had been developed with the support of this program.

11. The **Rural Primary Health program**, introduced in 2004-2005, combines three programs from the previous Regional Health Strategy. These are the Regional Health Services program, the More Allied Health Services program and the Rural Chronic Disease Initiative. There are 118 approved Regional Health Services providing access to primary health services in over 900 rural communities. There are 65 rural Divisions of General Practice funded to provide additional allied health services, such as mental health workers, social workers, podiatrists, physiotherapists and dieticians. Building on the existing Rural Chronic Disease Initiative, a further $7.8 million has been provided over four years to fund initiatives to address more directly the causes of health differences between metropolitan and rural and remote Australians, and to extend allied and primary health services to more remote areas.

5.3.3 Access to medical services

Under the Australian Health Care Agreement, States and Territories are responsible for ensuring that eligible persons should have equitable access to public hospital services, regardless of their geographical location. This principle underpins schemes which operate in each State and Territory.

Patient Travel and Accommodation Subsidies
Each State and Territory health department provides a system to improve access for rural and remote residents in the state to obtain specialist services, by supporting travel and accommodation if they are referred for specialist care in a larger centre. The precise rules vary, some are capped and require a patient contribution; in some states a nexus is drawn between expenditure of resources on travel and accommodation for patients, and the funds used to support specialist outreach services from larger centres.

The Royal Flying Doctor Service (RFDS)
The RFDS which began operations in 1928 is an important health services provider, both emergency and ambulatory, helping to overcome difficulties of access in outback Australia. Its annual report

2004[37] shows the service covers more than seven million square kilometres from 23 bases, it runs on average 27 clinics each day, reviewing almost 600 patients daily, (i.e. approximately 150,000 consults per annum) in addition performing 86 aerial evacuations each day, with a staff numbering 609, including 138 part-time staff. If the population of rural and remote Australia is 500,000[38] and the average number of GP visits each year is 4.9[39], then it would appear that RFDS clinics perform around 16% of the consultations in rural and remote Australia. The RFDS operating budget for 2003-2004 was $27.825 million.

5.4 Training frameworks for rural and remote practice

Section 5.3 above outlines initiatives to encourage medical students' exposure to rural and remote practice. These initiatives recognise that rural origin, rural experience and rural training are significant factors in attracting and retaining doctors to rural practice. In some rural clinical schools, medical students learn the major disciplines of medicine, from a rural generalist practice perspective. Many medical schools arrange rural clinical workshops and cultural camps.

The establishment of Australian General Practice Training has led to significant investments in educational infrastructure in rural areas. With the allocation of more than 200 general practice registrar places to the Rural Pathway, new funding and infrastructure has been made available for rural and remote practitioners for rural training and support activities.

Entry into vocational training for general practice generally occurs in the second postgraduate year but later applications are also considered and retrospective credit may be awarded for previous experience. Individuals interested in pursuing a career in rural practice may be encouraged to undertake prevocational training in regional centres. Cultural awareness programs are strongly emphasised in particular regions.

In recent years, prevocational doctors have the opportunity to experience a term of up to 12 weeks in a rural or remote general practice. This program is administered by ACRRM, and has proved a useful clinical and cultural experience for many, irrespective of their final career choice.

Prevocational doctors are exposed to formal courses such as Early Management of Severe Trauma, Advanced Paediatric Life Support Course, Advanced Life Support and Advanced Life Support in Obstetrics, valuable for generalist practice anywhere in Australia.

An outline of the three ACRRM pathways to vocational training in rural and remote medicine is provided in section 4.3 of this report.

General practice trainees may elect to undertake a fourth year in advanced skills training, leading to the formal tertiary award of Graduate Diploma in Rural General Practice. GP registrars or eligible general practitioners who wish to be awarded the FRACGP and the RACGP Graduate Diploma in Rural General Practice need first to complete 12 months of rural posts in the three-year training for the FRACGP. They then complete a fourth year of training entailing 12 months in advanced rural skills posts (ARSPs) and the relevant education requirements (720 hours) for the Graduate Diploma. Posts currently available include Aboriginal health, adult internal medicine, anaesthetics, emergency medicine, obstetrics, child and adolescent health, mental health and surgery. The RACGP has produced detailed statements of the objectives and formative and summative assessment requirements

[37] The Royal Flying Doctor Service Australian Council Annual Report 2004, available in electronic form through www.rfds.org.au

[38] Australian Institute of Health and Welfare 2004. Medical labour force 2002. AIHW cat. no. HWL 30. Canberra. AIHW (National Health Labour Force Series No. 30)

[39] Britt H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C, O'Halloran J, Ng A 2004. General practice activity in Australia, 2003-4. AIHW Cat. No. GEP 16. Canberra: Australian Institute of Health and Welfare (General Practice Series no. 16).

of each post. Where possible, their curricula have been developed with, and approved by, Joint Consultative Committees.

Joint Consultative Committees (JCCs) are tripartite committees that focus primarily on general practice education and training, particularly in relation to the Advanced Rural Skills Posts. JCCs set standards, identify the training and skills needs in areas of general practice special interest, advise on the content of the vocational training curriculum and continuing professional development activities, and are involved in the accreditation of Advanced Rural Skills Posts. Each JCC has representatives from the relevant specialist college, the RACGP (nominated by the National Rural Faculty) and the Australian College of Rural and Remote Medicine. Some, for example the JCC Aboriginal Health and the General Practice Mental Health Standards Collaboration, have broader representation.

The fourth year of general practice advanced skills is generally but not exclusively pursued by trainees in the Rural Pathway of Australian General Practice Training.

5.4.1 Enhanced Rural Training Framework

Recently, an Enhanced Rural Training Framework was implemented within Australian General Practice Training, which will provide additional funding for regional training providers for education and training initiatives and medical educators to support rural and remote training. The Framework also provides funding for a fourth year of training, thus funding trainees to work towards the FRACGP and the Graduate Diploma in Rural General Practice or FACRRM.

The Enhanced Rural Training Framework was endorsed by the GPET Board in October 2004. Page 5 of the Handbook includes a statement endorsed by the GPET Board, the RACGP and ACRRM that:

"Whilst recognising that the preparation for competent general practice is encompassed by the Fellowship of the Royal Australian College of General Practitioners (FRACGP), the ERT Working Party, and subsequently the GPET Board, endorses the principle that medical practice in specific rural and remote contexts requires knowledge and skills in addition to those acquired through successful completion of the FRACGP. The required knowledge and skills are embodied in such programs as those leading to the RACGP Graduate Diploma in Rural General Practice (Grad Dip Rural) and the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM)."[40]

The Framework is described as based on the principles of partnership using the strengths of existing curricula and accredited educational programs; regionally based training programs and the tailoring of training to the needs of registrars. The Framework promotes:

- training opportunities to prepare registrars both culturally and clinically for compulsory and voluntary placements in a rural setting
- training in areas relevant to the provision of clinical practice in rural and remote areas
- training towards a rural postgraduate award (the RACGP Graduate Diploma in Rural General Practice and/or the Fellowship of the Australian College or Rural and Remote medicine.

The educational components of the ERTF are drawn from the following documents:

- RACGP curriculum
- ACRRM primary curriculum
- RACGP Grad Dip Rural Curriculum (including the Advanced Rural Skills Curriculum)
- Rural Vocational Training Scheme
- Advanced Curricula endorsed by Joint Consultative Committees
- relevant, essential and advanced procedural skills lists of both ACRRM and the RACGP.

[40] General Practice Education and Training Ltd, *Enhanced Rural Training Framework*, p. 5

Within the Framework, the following levels of preparation for rural practice are recognised:

Level A: Core knowledge and skills for general practice and/or rural and remote medicine. This training can take place in metropolitan, provincial, rural or remote locations. All registrars are required to complete at least 12 months of rotating clinical terms, which must include paediatrics. Preparation for rural clinical practice includes a personal learning plan developed in consultation with the regional training provider and the medical educator. This plan is likely to include cultural awareness and communication components; an understanding of the factors that influence health outcomes in rural and remote contexts, e.g. transport risk, public health risk, social risk, personal risk, indigenous health and population health, resuscitation and stabilisation and transfer skills and an understanding of the Australian health insurance system.

Level B: Knowledge and skills for rural general practice and/or rural and remote medicine. This training occurs in a rural or remote context. The learning plan of the registrar is rurally focused with respect to medical content and the broader community needs. Doctors working in rural areas are encouraged to attend the following workshops as appropriate for the registrar's learning plan and proposed place of work:

- Early Management of Severe Trauma - Royal Australian College of Surgeons
- Advanced Paediatric Life Support Course - Advanced Life Support Group
- Emergency Life support Course – Australasian Society for Emergency Medicine
- Rural Medical Emergency Course - Queensland Rural Workforce Agency
- Advanced Life Support
- Pre-Hospital Trauma Life Support – Pre-Hospital Trauma Life Support Committee
- Advanced Life Support in Obstetrics
- Rural Emergency Skills Training – Rural Workforce Agency Victoria.

Level C: Knowledge and skills for advanced rural general practice and/or remote medicine. This training can be in metropolitan, provincial, rural or remote locations and applied in a rural or remote context. The registrars undertake the curriculum modules required by their college of choice - the Graduate Diploma in Rural General Practice curriculum of the RACGP or the Primary Curriculum of ACRRM. Special skills terms may be undertaken in anaesthetics, child and adolescent health, dermatology, emergency medicine, indigenous health, mental health, obstetrics and gynaecology, population health and surgery. To be eligible for the postgraduate rural awards, the registrar must complete 12 months in an accredited advanced rural skills post.

Enhanced rural training is considered an integral part of Australian General Practice Training and no additional assessment requirements have been mandated. Formative assessment is based on the registrar's learning plan, developed in consultation with a medical educator. Summative assessments include the RACGP Fellowship examination, the Graduate Diploma and the proposed FACRRM examination.

6. Assessment against the Core Criteria for Recognition

The Review Group's assessment focussed on the key question: 'Is a specialty of rural and remote medicine developing in response to a demonstrable need for specialist medical services and is its development in the best interests of the Australian community?'

The Review Group's assessment against the three core criteria is outlined below. Where elements of the case made to justify the recognition of the specialty are applicable to more than one criterion, the Review Group has not repeated the argument under each criterion.

6.1 Will recognition of rural and remote medicine as a specialty improve patient safety?

The Guidelines for Recognition list the following points that should be addressed by the case for recognition:

(a) that the medical specialty or sub-specialty is based on substantiated and major concepts in medical science and health care delivery and that it represents a well-defined and distinct field of medical practice, both here and in comparable countries;

(b) that the practice of the specialty or sub-specialty requires the possession of a defined body of knowledge, and specific clinical skills or specific aggregations of clinical skills or expertise;

(c) that a demonstrable link exists between patient safety and competence in the skills and expertise required of the practitioners;

(d) that where the specialist medical services are already provided or could be provided by practitioners in an existing specialty or sub-specialty or a combination of specialty groupings, provision of these services by a single specialty or sub-specialty would enhance the safety of health care;

(e) that the development and recognition of this medical specialty or sub-specialty will not adversely affect safety, for example through the deskilling of other practitioners.

6.1.1 The nature of the medical practice, and the required knowledge and skills required for rural and remote medical practice.

The case for recognition needs to demonstrate that the practitioners practise in a well defined field of practice, have a defined body of knowledge and specific clinical skills or specific aggregations of clinical skills, and that there is a link between this knowledge and these skills and patient safety.

The application for recognition outlines comprehensively ACRRM's claim that: "Rural and Remote Medicine is distinctive both in its practice and knowledge base. Its distinctions are apparent both in Australia and internationally."[41] Relevant statements in the application for recognition include:

- "Rural and remote medical practice is a unique paradigm. Its skills and competencies are not contained within any specialty or combination of specialties nor can it be simply defined by a 'General Practice plus' model. Rural and Remote Medicine is a horizontal specialisation incorporating elements of a wide range of specialties in a range of work settings and in a range of different collaborative teamwork arrangements. Isolation adds to the complexity of clinical decision-making and necessitates a multiplicity of additional skills, (e.g. procedural, emergency,

[41] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine,* April 2004, p. 2

transport and retrieval skills; knowing when to refer; telemedicine); and the unique interface between the practitioner and their rural community further transforms the nature of practice."[42]

- The ACRRM definition of rural and remote medicine (quoted on page 26 of the report) states that the defining characteristics of the specialty are the specific content, context and consequent complexity of the discipline. The application for recognition cites[43] four domains that characterise the rural and remote practitioner:
  - practice patterns;
  - longer hours and frequent 'on-call' work of rural doctors, relating to workforce shortages;
  - a wide variety of roles and workforce settings;
  - advanced and complex care.

  Context includes both specific aspects of rural culture and the health and morbidity pattern of rural and remote Australians.

- ACRRM aims at providing generalist rural doctors with procedural and advanced care skills.[44]

- ACRRM states that rural doctors are commonly called upon to deal with medical problems from presentation to resolution and their practices incorporate aspects of a range of specialties, primary, secondary and occasionally tertiary. Office-based consultations require more complex decision making and there is a need for a greater provision of procedural and other advanced skills.

There were many submissions supporting recognition of rural and remote medicine as a specialty, and a number of them raised points concerning this criterion.

A number of rural and remote practitioners, including Fellows of ACRRM, provided information about how they practise. Many of these commented on the differences they perceived between their practice and practice as an urban general practitioner. In general, these supportive submissions argue:

- that rural and remote practitioners need to be able to cope in isolation with medical emergencies;

- that an additional broad range of skills is required of rural and remote practitioners, procedural skills were the most commonly cited.

One example given to the Review Group was as follows:

"A local farmer was cleaning hay from a baling machine when his arm became trapped between the pulley and belt. The machine continued to run for the next hour until he managed to stop the engine by putting a wrench in the motor. He remained trapped and by removing his trousers and waving them above the machine managed to attract the attention of a passing accountant, who helped wind the machine back and free his arm. The accountant the developed crushing central chest pain and was unable to drive. Thus the farmer with the injured arm drove the accountant to attend casualty at my small rural hospital.

Later that afternoon the farmers cousin amputated his thumb in another accident, the following week another farmer lost his lower leg in a auger accident.

These extreme events are not common, but they do occur – and we must have proper recognition of the skill sets that rural and remote medicine demands."[45]

[42] ibid, p. 4
[43] op cit, p. 2
[44] op cit, p. 3
[45] Dr S Holmes, Submission, AMC Internet Site

Some of these submissions indicated that the additional skills and knowledge of rural and remote practitioners enhances patient safety, through reduced error, and the capacity to manage a wide range of presentations locally.

A number of educational organisations with a focus on rural health or rural and remote medical practice have endorsed these views.[46] Although its examples were not limited to medical practice, the Combined Universities Centre for Rural Health[47], indicated:

"The distinguishing features of rural and remote practice include the following and are as relevant for a general practitioner, physiotherapist or paediatrician:

The generalist role. As is frequently emphasised, the rural and remote practitioner needs to master a diverse set of practices including many procedures not typically called upon in urban practice. This is professionally demanding, requiring extensive and well-planned continuing professional development. It also calls for a very different relationship with specialist services, often relying on forms of e-Medicine or telehealth.

Integration or coordination across the primary care team. In rural and remote areas the primary care team has a different composition and usually works in a more coordinated manner. Closer relationships exist between the general practitioner and the local hospital and specific positions such as nurse practitioners and generic therapy assistants have been created to address the unique challenges of rural and remote practice.

Unique patterns of morbidity requiring specific skills sets. Rheumatic fever and lower limb ulcers are two classic examples of diseases or conditions seen in much greater frequency or severity in remote areas.

Unique risk factors requiring specific skills sets. Road trauma and various occupational and recreational injuries are examples of greater risk factors in rural areas. Rural and remote health services must be able to respond to these."

A number of bodies with a particular interest in workforce also commented on this criterion. For example, Queensland Health wrote: "Queensland Health supports the application for recognition of rural and remote medicine as a medical specialty. We conclude that recognition of rural and remote medical specialty would provide significant value in safety, standards and cost-effectiveness of health care to rural and remote Queensland communities."[48]

A number of submissions to the Review Group questioned whether rural and remote medicine can be defined as separate and distinct discipline, or whether it is an area of practice substantially recognised under the specialty of general practice, or is a subspecialty of general practice. These comments included:

- "It appears to me that the application seeks to define a new specialty in relation not only to a body of knowledge but to where people apply that knowledge." [49]

- "A clear distinction is drawn in the proposal between rural and remote medicine and general practice. This is because it incorporates 'elements of a wide range of specialties in a range of work settings and in a range of different collaborative teamwork arrangements.' This is surely true of general practice. General practice places particular emphasis on the principles of access to health

[46] Among others, these include the Australian Rural Health Education Network (ARHEN), the Rural Workforce Agency Victoria, New England Area Training Services, Northern Territory General Practice Education
[47] Combined Universities Centre for Rural Health, Submission, AMC Internet Site
[48] Covering letter to Queensland Health Submission, AMC Internet Site
[49] Professor Paul Gatenby Dean, Australian National University Medical School, Submission, AMC Internet Site

care, comprehensive and preventive health care, continuity of care and coordination of care. Surely isolation in small communities makes these principles even more important.

We believe strongly in the importance of special programs to attract, train and support doctors in rural areas and the useful role of rural medical bodies such as ACRRM in advocating for rural medicine and rural practitioners. However we do not believe that a strong case has been made for establishing a separate specialty." [50]

- "I do not consider the criteria for a specialty are met. Even as a sub-specialty, rural medicine is not well defined; the educational needs for a rural practitioner are more extensive than for some city GPs, but vary greatly from place to place. Certainly in remote and isolated areas significant additional skills would be required. However, the major components are those of general practice with additions, as required, from the disciplines of surgery, emergency medicine, anaesthesia, obstetrics and paediatrics. The distinctive difference from most urban general practice is the need to maintain certain defined skills to enable the practitioner to function in greater isolation and with autonomy, depending on the location and composition of the practice.

  Rural and remote medicine now represents in part, the older practice model where the GP was expected to be able to do everything. The growth of specialization and modern technology, improved transport, the reduction of rural population in small centres and the reluctance of state governments to support small rural hospitals have all contributed to alter the nature of General Practice. There is a need for all practitioners to be multiskilled but this will vary according to location. In 1960, every rural GP delivered babies and could remove an appendix as did many urban and regional GPs. The needs and opportunities for such activities are now much reduced. I consider that the way to deal with the problem is not to reinvent or revisit the so called old style of general practice by inventing a new specialty, but to ensure that GPs going to the country are well trained first and foremost as GPs, which is the remit of the RACGP; and also provide opportunities for appropriate skills development appropriate to the location of particular rural practitioners." [51]

- "From an RACGP perspective, there is no identification in the ACRRM application of the difference in skills, knowledge, role, function and experience which distinguishes rural and remote medicine from rural and remote general practice, except in:
  - exclusions of the RACGP and its qualifications from accounts which aim to present rural and remote medicine at the centre of rural primary health care, coupled with
  - the semantic/linguistic transpositions of 'generalist' for 'general' and 'General Practice' for 'general practice'." [52]

A difficulty in assessing the distinctive nature of rural and remote medical practice is that the spectrum of practice is wide, as is the spectrum of practice of the Fellows of the Australian College of Rural and Remote Medicine. The ACRRM application cites figures from the Australian Institute for Health and Welfare medical labour force survey, indicating that there are 5,096 doctors practicing in rural Australia, including 3,605 primary care practitioners and 403 hospital non-specialist practitioners. There were 1,370 Fellows of ACRRM at the time of the review. ACRRM indicated that 22 of the FACRRM hold Australian recognised specialist qualifications. In addition, 28 per cent or 382 Fellows of ACRRM hold Fellowship of the RACGP. Seventy per cent work in Rural, Remote and Metropolitan Areas categories 4 to 7, and 17 per cent in RRMA 1 and 2 (metropolitan zones). Fifty-one per cent of ACRRM Fellows are practicing proceduralists. Of the ACRRM members who undertake procedural skills continuing professional development, 10.6 per cent have their practice location in RRMA categories 1 or 2.

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[50] Professor S B Dowton, Dean Faculty of Medicine, the University of New South Wales, Submission, AMC Internet Site

[51] Professor S Reid, Director, School of Rural Health Wagga Wagga, Faculty of Medicine, the University of New South Wales, Submission, AMC Internet Site, p. 4 and p. 8

[52] RACGP, Submission, AMC Internet Site, p. 24

Further information on the practitioners and the practice in rural and remote Australia can be obtained from the Australian Rural and Remote Workforce Agencies Group data.[53] This indicates that there are generally two types of doctors in rural/remote areas (for the purposes of ARRWAG data these are RRMAs 4 to 7), described as follows:

"The first is a group of older, largely male, resident GPs who work relatively long hours and who are likely to have been in rural, and to a lesser extent remote areas, for a long time. These doctors are likely to work in group practices in rural areas and in solo practices in remote areas, where group practice is not sustainable. They are more likely than other rural and remote doctors to regularly practice anaesthesia, obstetrics or surgery. The second is a group of transitory doctors who move in and out of rural and remote locations, often while training. These doctors are more likely to be younger and female, and a considerable proportion appear to be overseas trained. They work fewer hours and are less likely to practise regularly anaesthesia, obstetrics or surgery but more likely to regularly practice emergency care and Aboriginal health care."

The Review Group visited practices and met practitioners in New South Wales, Northern Territory, Queensland and Victoria where Fellows of ACRRM conducted general practices and in addition cared for hospital inpatients and provided services such as trauma management, obstetrics, anaesthetics and minor surgery. The Review Group also encountered Fellows of RACGP who practised in a similar fashion. On the other hand, the Group met Fellows of ACRRM who were not in procedural practice. The Review Group noted that the skills required varied considerably according to location. It was informed, for example, that in Western Australia, there was a greater need for chronic disease management skills in rural areas than procedural skills.

Because the case for recognition relies so strongly on the distinction of rural and remote medicine from general practice, it is essential to consider definitions of general practice. The application for recognition applies a quite narrow definition of general practice, characterising urban general practice as office-based consulting practice. ACRRM distinguishes rural and remote medical practice from urban generalist practice by its relative professional isolation, limited resources, distance from specialists and speciality facilities, the area of risk (treat versus transfer), different patterns of health and different socio-cultural environment. It also claims that rural and remote medicine has a scope of practice that is fundamentally and substantially broader, deeper and different in context and professional culture to that of general practice.

The site visits conducted by the Review Group highlighted the difficulties for generalist practitioners as distance from referral centres increased. The Review Group was impressed by the high standards of practice that it witnessed, and the commitment of practitioners to providing the broad spectrum of services relevant to local needs. The Group noted that, in group practices, practitioners often had complementary skills, for example one might provide anaesthetic services and another might provide obstetric services. Rural and remote practitioners have followed a range of training pathways, and such practices often included FACRRM and FRACGP as well as practitioners with both or neither qualification.

In its submission, the RACGP argues that the core of general practice, as described in the RACGP curriculum, is the same in all clinical contexts. The core of general practice is practised in widely differing community and geographic contexts, each imposing its own demands. This leads to the

[53] ARRWAG *Reality Bites: Rural and Remote GP Workforce Information*. October 2003. ARRWAG describes its minimum data set as being compiled from State and Territory Rural Workforce Agency registers of the General Practice workforce in rural and remote areas. Each RWA has a comprehensive database of the rural and remote medical workforce in their State/Territory, derived from the rural Divisions of General Practice, Regional Training Consortiums, State Health Authorities, the administration of specific programs (including Rural Locum Relief Program and Locum and Continuing Medical Education), employment CVs, publicly available State medical board data and data provided by individual practices and practitioners.

development of both context-specific skills and additional skills relating to individual preferences. The RACGP states that the development of special skills results in significant diversity around the common core, leading to the evolution of special skills groupings and more recently, special interest networks in general practice.

In additional information provided to the Review Group, ACRRM also supported a model of core skills required for rural and remote practice, with special or advanced skills depending on location. It stated: "The skills set required for rural and remote practice at any location within this range [of population centres and range of healthcare delivery services and facilities] contains a core element described by the ACRRM Primary Curriculum together with specialised or advanced skills reflecting the requirements of the location. The core element comprises those skills that enable practitioners to deal with all common presentations locally without proximate support from specialist colleagues. These skills are not discretionary."[54]

A key issue then appears to be whether what is claimed to be the 'core' of the specialty for general practice and rural and remote medicine differ substantively. The Review Group addresses this issue below.

The application for recognition contains statements about the overlap and the differences between rural and remote medicine and **rural** general practice. ACRRM states that rural general practice is less complex than rural and remote medicine. For example, the application for recognition states that:

"The impact [of recognition] on General Practice will be that practitioners with interest in rural practice may choose to undertake a Fellowship of ACRRM as an option for their vocational training. This will create choice for career paths and benefits in terms of streamlined entry into and out of Rural and Remote Medicine. Existing General Practitioners could also elect to seek the Fellowship of ACRRM, not as an entry to practice, but as a means of switching between or combining specialties. This type of career development is quite common in rural and remote settings.

RACGP offers a 12 month Graduate Diploma for General Practice to achieve some up-skilling for rural General Practice. This would cater for the needs of those practitioners who do not wish to undertake the full scope and depth of skills required for Rural and Remote Medicine."[55]

A number of submissions, including that by the RACGP, argue that no evidence is provided to support the claim that rural general practice is less complex than rural and remote medicine.

A range of studies compares generalist practice across the geographical divide between metropolitan and rural Australia.[56] [57] [58] A variety of sources is used, including data from the BEACH program, the Medicare Benefit and Pharmaceutical Benefit Schemes, demographic and mortality figures and hospital discharge information.[59] [60] There are significant health inequalities between metropolitan and

[54] Australian College of Rural and Remote Medicine *Supplementary Information in Support of The Application to have Rural and Remote Medicine recognised as a Medical Specialty* April 2005, p. 1

[55] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, pp. 47 & 48

[56] Britt H, Miller GC, Valenti L 2001. It's different in the bush. A comparison of general practice activity in metropolitan and rural areas of Australia 1998-2000. AIHW Cat. No. GEP 6. Canberra: Australian Institute of Health and Welfare.

[57] Health services in the city and the bush: measures of access and use derived from linked administrative data. Occasional Papers: New Series Number 13. Portfolio Strategies Division. Commonwealth Department of Health and Aged Care. September 2001

[58] Britt H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C, O'Halloran J, Ng A 2004. General practice activity in Australia, 2003-4. AIHW Cat. No. GEP 16. Canberra: Australian Institute of Health and Welfare (General Practice Series no. 16).

[59] Australian Institute of Health and Welfare 2003. Rural, regional and remote health: a study on mortality (summary of findings). AIHW cat.no.PHE 49. Canberra: AIHW (Rural Health Series no. 3)

rural and remote inhabitants. In general, life expectancy reduces (across all age groups and both genders), and the incidence of most conditions affecting health increases with rurality. Care must be exercised in interpreting these data by controlling for aboriginality; while the poor health status of aboriginal people is a major issue, aboriginal people are 'under-represented' in metropolitan practice and by the same token 'over-represented' in rural practice, thus one would expect health status to be worse in rural areas for this reason alone. Yet the differences persist once data is controlled for aboriginality.[61]

It is, however, not clearly apparent how these differences fundamentally affect rural as compared with metropolitan generalist practice. As the comparison of general practice activity in metropolitan and rural areas of Australia 1998-2000 concludes: "with only a few exceptions, the activities of GPs in the rural and remote centres parallel those of metropolitan GPs".[62]

The differences identified between rural and metropolitan practice were somewhat fewer than identified ten years before. Examples of differences include after hours arrangements (use of deputizing services was almost non-existent in rural areas), and the use of computers (higher in rural than metropolitan areas).

Patients in rural areas tended to be older than in metropolitan areas, and health care card holders were more likely in rural areas. There was a greater prevalence of overweight in rural areas and obesity in small rural areas than in metropolitan areas, and the proportion of men (not women) drinking at hazardous levels was greater in rural areas than metropolitan areas.

In relation to 'reasons for encounter', respiratory symptoms, digestive symptoms and psychological symptoms were less frequently recorded in small rural areas. There were higher rates of ear problems in large rural areas than in metropolitan areas, and skin problems were more frequently managed in rural areas. Rates of therapeutic procedures were significantly higher in rural areas than in metropolitan areas. In relation to prescribing rates, while there were small differences in some classes of medication, in relation to 'most frequently prescribed medications' no significant differences emerge.

In general the differences above are small, i.e. in relation to upper respiratory tract infection, there were 6.9 (6.6-7.2) (95% CI) presentations per 100 encounters in metropolitan practice against 5.1 (4.3-5.9) presentations per 100 encounters in large rural centres and 4.3 (3.6-5.0) in small rural centres. Thus minor differences in 'reasons for encounter' do not support rural and remote practice being distinct and different from metropolitan practice. The BEACH data does derive however from practitioners who are vocationally registered or who are able to use VR Medicare item numbers and does not include practitioners who bill non VR items.

Regarding the core clinical knowledge and skills, the application for recognition states: "This incorporates core primary care services but their delivery typically involves a higher degree of complexity. It extends to a wide range of additional services many at more advanced levels and involving modified delivery models to those in urban practice. They include:

- diverse service areas ordinarily the province of other specialties, including: aged care, rehabilitative care, post-operative care, palliative care, mental health care, radiology and obstetric ultrasound and public health;

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[60] Australian Institute of Health and Welfare 2005. Health Inequalities in Australia: Mortality. Health Inequalities Monitoring Series No. 1 AIHW Cat. No. PHE-55.

[61] Australian Institute of Health and Welfare 2003. Rural, regional and remote health: a study on mortality (summary of findings). AIHW cat.no.PHE 49. Canberra: AIHW (Rural Health Series no. 3)

[62] Australian Institute of Health and Welfare 2004. Medical labour force 2002. AIHW cat. no. HWL 30. Canberra. AIHW (National Health Labour Force Series No. 30)

- special skills associated with care provision locally without immediate access to comprehensive medical care network, (e.g. tele-consulting, working with non-specialist nurses and health workers, performing procedures without advanced medical technologies);
- services associated with common problems, presentations and conditions of rural and remote communities that may be considered relatively unusual in urban contexts (e.g. managing envenomation, stabilization of common farm injuries);
- secondary care provided as an essential part of medical care in a rural; and
- remote context including performance of basic obstetric, surgery and anaesthetic procedures." [63]

ACRRM states: "Rural and Remote Medicine is based on the principles of medical science and healthcare delivery including the social sciences such as sociology, psychology, and epidemiology set in the rural and remote context. The specialty engenders a common experience of clinical problems specific to this context and an appropriate clinical method and research agenda that reflects these realities. It includes research questions that can only be addressed from inside the discipline such as identifying best practice in rural and remote procedural obstetrics." [64]

There is strong support in the evidence presented for the view that medical practice in specific rural and remote contexts requires knowledge and skills in addition to that certified by the award of the FRACGP for general practitioners. There is greater complexity of care in some rural and remote contexts, including in the depth of treatment by the doctor and the work up before or decision regarding disposition. This view is supported by the submissions received, and by the Review Group's site visits and meetings with practitioners and stakeholders. It is also supported by the decision of General Practice Education and Training Ltd (in collaboration with ACRRM and the RACGP) to develop the Enhanced Rural Training Framework within Australian General Practice Training. This Framework is described in detail in section 5.4.1 of the report. A number of submissions to the Review Group noted that medical practitioners often cite lack of confidence and training as a disincentive to rural practice.

Of the many submissions by rural and remote practitioners supporting the view that rural practice requires additional skills, many did not expand on the areas of difference. An example of a submission[65] that did outline perceived difference is:

"Having been in rural practice for over 20 years and urban practice before that, I can attest to them being two quite different specialities. The skill set required is different in many regards even if one is not a Hospital VMO. In urban areas I struggled to get patients with chest pain admitted when needed but could get Specialist face to face opinions at the drop of a hat. Type 1 diabetes, most malignancies, chemotherapy, renal failure, much of the palliative care etc were all treated by Specialists with the help of support teams eg Palliative Care Nurses, Occupational Therapists, Psychologists etc. In many rural areas they do not exist and we must be able to do it as there is NO ONE else apart from our Hospital Nurses, the Pharmacist and the Ambos. There is not even a Physiotherapist here so we have to teach the exercises ourselves. A constant impediment even 50 km from a Regional Centre is the lack of public transport for senior citizens to that centre.

On the other hand we can admit patients at the drop of a hat as a local Hospital bed can always be found, treat the Inpatients ourselves and even accommodate Nursing Home type patients in our Hospitals for Respite until a Nursing Home bed is found for them maybe weeks/months later. Q Fever, Leptospirosis, snake and spider bites are all dealt with routinely cf my urban colleagues.

We still do deliveries [I had 6 babies in July] but so do GPs in Melbourne and Sydney. The difference is we have no CTG, no access to epidurals and no neonatologist or specialist obstetrician around the

[63] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 22
[64] ibid, p 3
[65] Dr G White, Submission, AMC Internet Site

corner. Sometimes we don't even have a Midwife available. I have a real-time ultrasound [mostly for obstetrics] in my consultation room - next to the defibrillator."

The Review Group notes that RACGP statements concerning the Graduate Diploma in Rural General Practice support the view that: "There is a growing body of evidence to suggest that general practice in rural and remote communities has special characteristics which differentiate it from general practice in other contexts … Rural GPs … are more likely to be the sole source of medical advice for communities … tend to undertake a broader range of minor procedures (and) are more likely to be involved in providing emergency medical treatment …"[66]

The question of whether this knowledge and these skills are so different from general practice that they distinguish rural and remote medicine as a distinct generalist area of practice is more complex. Issues raised in the submissions to the Review Group included:

- "Research has shown that compared to urban based general practitioners, rural general practitioners were more likely to undertake hospital and procedural work. They were also more likely to use skills from a variety of specialities including general medicine, local anaesthetic, emergency medicine, paediatrics skills, obstetrics, counselling, radiology, orthopaedics, dermatology, general anaesthetics, psychiatry, caesarean section. This highlights the variety of clinical skills required for rural and remote practice, however, not all rural medical practitioners would possess all of these skills. Rural and remote practice is thus characterised by multi-skilling from a broad variety of skills sets but does not necessarily comprise 'specific aggregations of clinical skill or expertise', e.g. a rural medical practitioner may practice anaesthetics, but not procedural obstetrics and vice versa. This variable multiskilling is **in addition** to the core skills of primary care provided by a General Practitioner." [67]

- "Review of the curricula and definitions of General Practice, Rural General Practice and Rural and Remote Medicine suggests more similarities than differences. Rural and Remote medicine does require different skills sets, but these are in addition to core General Practice skills as already defined in the RACGP curriculum. Flexibility and choices for additional training are necessary for registrars to gain the skills for the community context where they will practice. Training to be able to practice these additional skills can occur in the current environment without having multiple training pathways and endpoints. Duplication of core training by two separate colleges does not advantage the profession or community. Multiple endpoints will create confusion for GP registrars, divide the profession further and further reduce interest in applications for the AGPTP. The GPRA is very concerned that if successful, this application will further reduce the number of trained GPs throughout Australia with negative consequences for the health care of all Australians. Additional medical skills may be acquired from a range of many other specialties e.g. anaesthetics, obstetrics, psychiatry, paediatrics. These knowledge areas are not geographically specific to rural and remote medicine. The geographical distinction is arbitrary. Rural, remote, urban fringe, inner city are all different environments with different community needs which therefore determine the skills needed by the primary care doctor. The common link is General Practice - GPs need a core of training and skills and then need additional skills according to the community context and the range of skills a General Practitioner chooses to develop." [68]

- "we would caution that there is a lack of clarity surrounding the definition of rural and remote medicine. It is not a simple matter of geography as it would be difficult to argue, for example, that a coastal community on a transport trunk route within an hour's drive of a major city presents the same challenges as a similarly sized town which is more than two hours drive from a regional hospital.

[66] Graduate Diploma in Rural General Practice 2002 p. 4
[67] General Practice Registrars Australia (GPRA) Submission, AMC Internet Site, p. 5
[68] ibid, p. 2

Nor is there an identified generic skill set. There is wide variation in the skills required for practicing in rural/remote areas and it appears difficult to reasonably capture all of these within one definition." [69]

The definition of rural and remote medicine, as evidenced by a distinct field of medical practice and a specific body of knowledge and skills, was a major question for the Review Group.

The Review Group notes that a broad definition of general practice, which fits with that of McWhinney quoted in Section 3.1, is currently applied in Australia. This is consistent with the desire for a flexible and broadly skilled generalist workforce, and is warranted in a country of large size and diverse needs such as Australia. Applying such a definition, the practice of rural and remote medicine is largely general practice, with the addition of a variable set of advanced skills that are usually procedural. These additional skills do not comprise a specific aggregation of clinical skills or specific expertise which characterises a separate medical specialty.

There was no evidence that rural general practice is substantially different to rural and remote medicine.

The Review Group notes that, in promoting a new rural and remote medicine register which would be a complementary and parallel generalist vocational register to the Vocational Register, ACRRM proposes that the rural and remote medicine register will not prevent vocationally-trained generalists from transferring between rural and metropolitan practice settings. This indicates significant overlap in the skills and knowledge of practitioners.

The ACRRM application is silent about changes that recognition of a new specialty might bring to rural and remote practice that might differentiate it more clearly from rural general practice.

6.1.2 The link between patient safety and competence in the skills and expertise required of the practitioners.

ACRRM argues that safety will be enhanced by the increased provision of skilled rural and remote practitioners in the field. The application for recognition argues that this will have many benefits including fostering further growth in research into safe clinical care and appropriately benchmarked guidelines for managing clinical risk in the rural practice context. This in turn will enhance teaching in the discipline at undergraduate and postgraduate levels. Increased numbers of practitioners will ameliorate the adverse effects of separation of patients from their families and surrounds. The enhanced standing of recognised rural and remote practitioners will increase their commitment as leaders and role models in health care teams and the community.

Increased recruitment of practitioners will, it is also argued, also improve safety, the overall level of service and potentially reduce unsafe working hours.

Whilst a number of submissions to the Review Group supported this claim, the evidence to underpin the claim was not clear.

The Review Group received a number of persuasive submissions arguing that recognition may not increase recruitment. In particular, submissions putting the views of junior doctors and general practice registrars indicated a preference for flexibility to train in a variety of urban and rural settings rather than commit to a geographical area. There are concerns about the potential to increase the urban/rural divide and decrease flexibility.

[69] Australian Medical Association, Submission, AMC Internet Site, p. 1

Comments in the submissions included:

- "The VWA considers that, on balance, the ACRRM application does not adequately demonstrate how recognising rural and remote medicine as a medical specialty would improve the safety of health care in rural and remote communities. It is clear from the application that one of the main risks to the safe provision of health care in rural and remote communities is the timely availability of a range of quality health care services. However, the application does not adequately demonstrate how recognising rural and remote medicine as a distinct discipline would effectively manage this risk.

  On the information presented, the VWA is not yet satisfied that recognition would address the issues associated with recruitment and retention of medical practitioners in rural and remote communities and result in better health care outcomes."[70]

- "While ACRRM puts forward the position that they are providing a new specialist qualification; there is a strong belief that in reality it is simply splitting general practice into two tiers, and this would discourage junior doctors from choosing either career option. All junior doctor groups are opposed to geographical provider numbers and the ACRRM application is perceived as leading towards that outcome.

  All of these factors would tend to reduce the flow of doctors to rural and remote areas and to decrease the number of doctors and the range of medical services available in these areas."[71]

- "existing practitioners have provided excellent services to rural areas for many years without the existence of a separate college/specialty. The need for selective extra training is acknowledged. The seemingly impossible proposal to become and remain so extensively skilled may be contributing significantly to the reluctance of many otherwise excellent GPs to undertake rural practice."[72]

- "There appear to be a number of issues in the submission which require further clarification. The first is that this would be the only College whose graduates were trained to provide services specifically for patients on the basis of their geographical location. Further, unless trainees were advised to undertake training in both ACRRM and RACGP programs, their careers would be restricted by location. If this is not the case, how is it possible for a trainee to undergo an education and training program which is so specific for rural and remote medicine, yet includes all of the content for trainees aspiring to RACGP certification?"[73]

- "According to ACRRM, there were 10 GP registrars enrolled in the vocational preparation program to FACRRM in 2003 (p69). Overall, this is a small percentage of training registrars. If General Practice Registrars had to choose between training to towards FRACGP vs. FACRRM or both, this could create uncertainty and confusion, which may result in a further decline in the numbers of registrar choosing rural training."[74]

  It is clear from ACRRM's application for recognition that it believes that an additional generalist pathway will create choice and therefore an increase in applications. ACRRM states that a generalist pathway in rural and remote medicine will attract a different cohort with a particular interest. It claims that junior doctors have independently indicated support for the second ACRRM pathway. This information was not available to the Review Group.

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[70] Victorian Workcover Authority, Submission, AMC Internet Site, pp. 2 and 3
[71] AMA, Submission, AMC Internet Site p. 3
[72] Professor S Reid, The University of New South Wales, School of Rural Health, Submission, AMC Internet Site, p. 5
[73] Australian and New Zealand College of Anaesthetists, Submission, AMC Internet Site
[74] GPRA, Submission, AMC Internet Site, p. 11

The Review Group notes that application numbers for both the General and the Rural Pathway have increased in 2005, with 790 applications for 600 positions in the 2006 training year.

6.1.3 The effect of recognition of a distinct specialty of rural and remote medicine on the service provision by other medical practitioners

The Guidelines for Recognition indicate that applications should address not only improvements in safety that would flow from recognition as a single specialty as the providers of services but also the potential negative impact of recognition, such as through deskilling of other practitioners. The latter might occur, for example if other practitioners ceased to perform a range of services or performed them more infrequently. This might have beneficial consequences if the knowledge and skills of the members of the new specialty grouping led to improved patient safety.

As is stated in the application for recognition and noted above, rural and remote medicine overlaps with multiple medical specialties. The application for recognition does not suggest that there are any services that are uniquely or primarily provided by rural and remote practitioners.

The ACRRM submission states: "There are no negative consequences for existing specialties arising from the emergence of the specialty of Rural and Remote Medicine. In fact, there is evidence to demonstrate that the specialty has made a significant and positive impact on the range, quality and general support available for education and skills development in generalist training. There have also been many instances of innovative and practical working relationships being developed with specialists in other fields to ensure optimum care in rural communities for specific diseases etc. … Rather than quarantining the acquisition of Rural and Remote Medicine skills within the specialty, ACRRM is a conduit for dissemination of rural and remote medical skills and approaches into other specialty areas. ACRRM provides the research, training and support infrastructure to enable it to assist (as required) in the incorporation of rural and remote medical practice approaches into other specialties and for practitioners from other specialties (including General Practice) to gain skills and qualifications in Rural and Remote Medicine. It is able to share with other colleges the particular understanding of rural health that can assist these colleges in helping their own members and it provides Collegial support and advocacy structure for all rural doctors."[75]

The Review Group supports the claim that ACRRM has influenced and contributed positively to the quality of generalist training in Australia, and the support available for rural and remote practitioners. It agrees that ACRRM provides collegial support and advocacy for all rural doctors. It does not consider this to be an argument that the provision of services by a single specialty would enhance the safety of care.

The RACGP indicates: "The ACRRM's articulation here of its role as 'a conduit for dissemination of rural and remote medical skills and approaches into other specialty areas' is perhaps closest to the RACGP's understanding of the ACRRM's function as a medical college:

- not as a specialty in its own right, but
- as a special interest college which can support and bring together the various specialties on the basis of their stakeholding in rural and remote medical practice for the benefit of rural and remote patients."[76]

There are also concerns that patient safety would not be enhanced by any outcome that led to services that should be provided by trained specialists, who have completed extended training programs, being provided by doctors with a more limited base of training and skill in those specialties.

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[75] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 31

[76] RACGP Submission, AMC Internet Site, p 70

6.2 Will recognition of rural and remote medicine as a specialty improve standards of care?

The Guidelines for Recognition list the following points that should be addressed by the case for recognition:

(a) that the medical specialty or sub-specialty has a demonstrable and sustainable base in the medical profession;
- practitioners who possess the knowledge and skills to practise in the specialty, and who practise predominantly in the specialty
- projections of the future need for special skills and knowledge in this area
- sufficient practitioners to sustain academic activities such as vocational training and assessment, continuing medical education and maintenance of professional standards
- academic journals in the specialty area
- a substantive body of research in the area that meets international standards
- the status of the area of practice and of training in the area in comparable countries;

(b) that the specific body of knowledge and skills is sufficiently complex or extensive to require a comprehensive and complete training program, and that there is a program of education, training and assessment that will develop the knowledge and skills necessary to practise safely and competently in the specialty or sub-specialty*;*

(c) that there is a program or programs for the continuing professional development and maintenance of professional standards of practitioners in the specialty or sub-specialty;

(d) that there is a professional body or professional bodies:
- responsible for setting the requirements and standards for training, assessment and certification in the specialty
- capable of defining, promoting and maintaining standards of medical practice to ensure high quality health care and capable of engaging stakeholders, including health consumers, in setting standards
- with guidelines and procedures for determining who will be foundation members of the specialist body. The level of knowledge, skills and competence of foundation members should be no lower than the level of those who will complete its training program
- with appropriate processes for determining the equivalence of the standard of education, training and experience of medical practitioners trained in the discipline overseas;

(e) that where the specialist medical services are already provided or could be provided by practitioners in an existing specialty or sub-specialty or a combination of specialty groupings, the provision of these services by a single specialty or sub-specialty would improve the standard of health care.

6.2.1 That rural and remote medicine has a demonstrable and sustainable base in the medical profession

In the Guidelines for Recognition, the AMC describes the emergence of a new medical specialty as follows: ‘A body of knowledge and specific skills relating to the area emerge, and medical practitioners who have gained that knowledge and those skills through training and experience begin to practise primarily in the new medical specialty.’

Specific skills and knowledge

The Review Group has agreed, earlier in the report, that there is evidence that specific skills and knowledge is required for rural and remote generalist practice, although the skills and knowledge vary

depending on context. It has argued, however, that applying a broad definition of general practice, the practice of rural and remote medicine is largely general practice, with the addition of a variable set of advanced skills.

The Review Group also notes that the current practitioners have followed multiple and varied pathways to rural practice.

These conclusions complicate an assessment of the claim that rural and remote medicine has a sustainable base in the medical profession, since there are:

- blurred margins between memberships of the group characterised as rural and remote practitioners and those characterised as rural general practitioners;
- overlaps in undergraduate, prevocational, vocational and professional educational activities, and in the academic literature described as pertaining to rural and remote medicine and those described as pertaining to rural general practice.

The Review Group sought additional information from ACRRM on the numbers of Fellows with the extended skills that the College considers characteristic of rural and remote medicine. In reply, the College indicated: "FACRRM qualifications recognise attainment of a skills set that extends beyond that ordinarily encapsulated in primary care and includes many skills that in 'General Practice' would be routinely the purview of a specialist. All Fellows have a common set of skills based on the ACRRM Primary Curriculum."[77]

The number of Fellows of ACRRM is given by the College as 1,370[78], but the number varies slightly in different places in the application and the supplementary material. 696 (50.8%) Fellows were 'Grandfathered', 598 (43.6%) became Fellows through a 'Pioneer' pathway and 43 (3.1%) through an Experience Based Pathway (Table F, in the Supplementary Information). The criteria for award of these Fellowships are detailed in Appendix 3 of the Supplementary information. No Fellowship has yet been awarded by examination. 1,062 (79.8%) of Fellows have no other College Fellowship (Fig 4, Supplementary Information). Approximately 70% of the Fellowship works in RRMA 4 to 7 areas (table B, Supplementary Information).

59.8% of Fellows working in RRMA 4 to 7 areas undertake procedures, compared with 32.1% of those working in RRMA 1 to 3 (Tables B and E, in the Supplementary Information).

It is difficult to estimate future needs but ACRRM presented data from which it could be calculated that Queensland, NSW, Victoria and Western Australia would together need an additional 725 rural practitioners by 2012. The proportion that would require special skills and knowledge is unknown.

Sufficient practitioners to sustain academic activities such as vocational training and assessment, continuing medical education and maintenance of professional standards

There is no doubt that ACRRM has the strong support of rural and remote medical practitioners, and that it has demonstrated a capacity to engage its Fellows in education and training activities in support of ACRRM's mission to advance and promote high quality professional standards, education, clinical best practice and patient safety in rural and remote medicine.

ACRRM indicates that a large number of Fellows has agreed to be available to support academic activities. The Review Group was impressed by the enthusiasm and commitment of the practitioners to training future rural and remote practitioners, and to their own continuing professional

[77] Australian College of Rural and Remote Medicine *Supplementary Information in Support of The Application to have Rural and Remote Medicine recognised as a Medical Specialty* April 2005, p 5
[78] ibid, p. 11

development. Through the commitment of its members, ACRRM has established a very visible role in education and training.

Of the practitioners interviewed by the Review Group, most expressed a willingness to supervise and train any rural based medical trainees, whether training towards Fellowship of ACRRM or towards Fellowship of the RACGP. There are limits to the capacity of these practitioners to supervise, teach, and continue to an increasing number of trainees and expanding training programs however. Many already are engaged in training general practice registrars and university medical students as well as the currently small number of ACRRM vocational trainees. There are also additional administrative burdens for supervisors with the requirements of two training programs.

The RACGP submits:

"The ACRRM articulate an impressive training and professional development program, and identify 619 of their 1400 odd members willing to teach and some 350 already trained or undertaking training to do so. However it is unclear how many of these members are solely committed to the specialty of Rural and Remote Medicine, especially if its recognition were to divide rural and remote general practitioners from rural and remote medicine practitioners. There is substantial dual membership between the ACRRM and the RACGP, for instance (600 is a conservative estimate), and cross membership between ACRRM and RACGP quality assurance programs.

'It is of interest, however, that the ACRRM's proposed vocational training program is currently grafted onto general practice training. The creation of a new specialty has the potential to divide and diffuse general practice training rather than strengthen both, especially in an economic climate of fiscal restraint and with a declining interest in general practice training.

'How many of the 619 or 350 ACRRM members, for instance, are already teaching in the GP training program, towards the FRACGP, and wish to continue to do so? In an environment in which there are also 11 new university Rural Clinical Schools who need to ensure 25% of their medical school undergraduates spend 50% of their time in rural locations, how many rural GPs have the time to also take on education in another curriculum? **It is unclear from this application either that there is the professional capacity to support the proposed specialty or that it will stimulate a wise use of resources**.'(RACGP emphasis)."[79]

The Review Group considers it would be very unfortunate if rural and remote general practitioners were to be divided from rural and remote medicine practitioners. In its site visits, the Review Group visited practices where there were both FACRRM and FRACGP. Many of the practitioners who met the Review Group indicated that the past differences between the two organisations were not relevant to their local practice, and expressed a wish that they would be resolved. This is a matter for the two Colleges to address.

The Review Group notes that the cross membership data quoted by the RACGP does not match that quoted by ACRRM.

There are further training pressures on rural practitioners however. In its role of assessing standards of medical education and training, the AMC has noted the expanding teaching role of non-traditional sites for clinical teaching, and the emerging competition between the various levels of education for training in community facilities, in the context of a significant increase in the number of medical students. In recognition of these concerns, the AMC is investigating the teaching and supervision workload facing the non-traditional sites of learning for medical students (expanded general practice, rural hospitals, district hospitals and private sector), the competition for teaching capacity from other sectors, both undergraduate and postgraduate, and the quality assurance processes required to ensure

[79] RACGP, Submission, AMC Internet Site, p. 28

that clinical teaching in these facilities is of an adequate standard and appropriately resourced and supported. An AMC working party will report on this issue in 2006.

Academic journals and research in rural and remote medicine

There is not strong evidence of a separate and expanding knowledge base that marks rural and remote medicine as a developing specialty.

ACRRM quotes several Australian and overseas journals devoted to rural health and rural and remote medicine.[80] The Review Group has surveyed the journals quoted by ACRRM. Again, blurred boundaries between rural medical practice, general practice in rural and remote settings, and rural and remote medicine are evident.

In its submission, the RACGP stated that these journals dealt largely with general practice in rural and remote settings. It makes the following claims:

- "…it is unlikely that a literature search would discriminate between the keywords 'Rural Medicine' and 'rural medicine', and the latter could be expected to turn up as common a range of generic references as the generic 'rural health', but with the medical qualifier. Similarly, the systematic overview cited here, by Patterson (2000), did not capitalise the keywords either.

  The Australian Journal of Rural Health is not only the official journal of the ACRRM; it is the official journal of the Australian Association of Rural Nurses, Services to Australian Rural and Remote Allied Health, the Council of Remote Area Nurses of Australia, and the National Rural Health Alliance – of which the RACGP's National Rural Faculty is a member.

  Whilst this section identifies rural and remote medicine as a topic of strong interest, there is nothing which distinguishes it from rural and remote general practice, or the rural and remote practice of any other medical specialty in Australia.

  The Rural Health Research Register to which the ACRRM refer in paragraph 4 on this page is unreferenced. A register of this name found on the website of Monash University's School of Rural Health, however, supplies 126 references under the keyword search 'rural and remote medicine', rather than the 600 projects cited by the ACRRM. The register produces the same list of references if these key words are capitalised. By comparison, it produces 159 of pretty much the same references in response to the keywords 'rural and remote general practice', and 108 in response to the term 'rural general practice.

  The cross-over between these references is interesting: of Rural and Remote Medicine's 126 citations, for instance, it shares 112 with rural and remote general practice, leaving just 11% to rural and remote medicine exclusively. More interesting is the fact that many of these citations have as much if not greater a focus on the role of allied health in these fields than the medical. Excluding these, there are 91 citations focussing (sic) on the medical side of the Rural and Remote Medicine equation, of which it shares 79 with the RRGP group – leaving only 12 exclusive to rural and remote medicine (13%)."[81]

ACRRM also quotes a large body of work referenced in Medline dealing with rural and remote medicine. In the view of the RACGP, these articles deal with rural medical and public health issues in general (see above).

[80] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 30
[81] RACGP, Submission, AMC Internet Site, p. 61

The Centre for Remote Health writes, however "in support of ACRRM's application for recognition of Rural and Remote Medicine as a medical specialty. The Centre focuses its research and education activity on Remote Health and we have a strong working relationship with ACRRM. ACRRM is the body widely recognised as representing rural and remote medicine. We hold that there is tremendous body of experience and a growing body of evidence that recognises the unique knowledge and skills required of rural and remote medical practitioners."[82]

There is also support expressed by the Editor in Chief [83]of the Journal *Rural and Remote Health*:

"Rural and Remote Health [the Journal] exists because of international recognition that the specialty of rural and remote practice in each of the major health professions requires a specialized evidence base and is already supported by a research base that warrants an international peer-reviewed journal. Our Editorial Board consists of eminent rural practitioners from, Australia, North and South America, Europe, Africa, Asia and the South Pacific. This is further demonstration of the international recognition of this specialty.

The journal is indexed by CINHAL, APAIS (incl. ATSIROM and AUSThealth), AMI (Australasian Medical Index) and registered with PANDORA and the DEST Register of Referred Journals. With four issues per year and over 200 readers per day, the journal has just been accepted for indexing with Index Medicus and Medline."

The Review Group is not convinced that the journals cited by ACRRM are evidence of a distinct specialty, rather than a special interest.

The status of rural and remote medicine in comparable countries

There appears to be no formal recognition of rural and remote medicine as a distinct specialty in other countries.

ACRRM cites several international general practice or family practice organisations that have formed rural medicine special groups. It also mentions free standing special societies in rural medicine. There appears to be one organisation, the American Academy of Family Physicians that offers training in rural medicine.

As an interest group, rural and remote medicine is a growing field. Taking a world view, 70 per cent of the human population live and work in rural areas. In less developed countries the emphasis might be more on improving basic needs but there are many issues common to rural doctors in many parts of the world. These include occupational risks in agriculture including musculoskeletal, pesticides and farm machinery hazards, safe food production, safe water, outdoor dermatology, major trauma, snake and insect bite, and solutions such as nurse practitioners as primary care providers and telemedicine. Other problems include recruitment and retention of rural doctors and professional isolation.

Canada and Australia have been leaders in developing structures to promote rural medicine, which is not surprising as they are developed countries with large remote areas and have populations concentrated in the cities.

The history of the development of the Society of Rural Physicians of Canada mirrors that of the Rural Doctors Association of Australia. Both initiated journals to, among other things, support and inform rural practitioners, influence policy on rural medicine and to promote the health of people living in rural and remote areas. These have proved important to developing knowledge specific to rural areas and making such knowledge available. This is to the credit of the individuals who have developed

[82] Professor John Wakerman, Centre for Remote Health, Joint Centre, Flinders and Charles Darwin Universities Submission, AMC Internet Site

[83] Professor Paul Worley, Editor in Chief, Rural and Remote Health, Submission, AMC Internet Site

such structures. Whilst the Society of Rural Physicians of Canada delivers and sponsors continuing medical education for rural doctors, it does not appear to have a role in vocational training. The US rural physicians are still at the stage where they tend to develop local solutions, and are not at the national arrangements stage.

The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy run out of Deakin University in Victoria provides a forum for the dissemination of information in all of the above areas and helps provide a link between the academic faculties and rural practitioners. It also pools information from places as diverse as Hungary, Italy, South Africa and San Francisco and also provides links and forums to more specialised groups, in Australia for instance, the Northern Territory Centre for Remote Health (CFRH) and the Australian Rural Health Education Network (ARHEN) and to ACRRM.

The ACRRM application describes rural and remote medicine's status as a specialty in other jurisdictions in terms of its recognition by the medical profession, academia and the wider community.[84] It describes a series of professional groups concerned with the practice of primary care medicine in rural and remote locations, as well as a series of academic appointments in rural health in Australia and overseas. All groups in other countries work within the larger rubric of General Practitioner/Family Physician Colleges and Associations. ACRRM appears to be the only college seeking independent status and is therefore the world leader in promoting rural and remote medicine.

The World Organisation of National Colleges, Academies and Academic Associations (WONCA), which is a peak body of General Practitioner/Family Physician education, has an international Rural Working Party with the same objectives as many of the country specific associations namely:

- rural health care systems with appropriate funding to meet community needs;
- integration of the family doctor into primary health care approaches for rural health care delivery;
- community participation including a multisectorial approach to health care and health promotion in rural communities;
- strategies to improve the status and health of rural women around the world;
- rural health workforce models;
- recruitment, retention and support strategies for rural practitioners;
- education and training for rural medical practice;
- research in rural health and rural practice including building research and development partnerships involving individuals and organisations in different countries.

The President of ACRRM is the current Secretary of this Working Party; this Working Party assists in cooperation and communication in promoting the interests of rural medicine, which ACRRM espouses.

6.2.2 The complexity and/or extensiveness of the training to develop the knowledge and skills necessary to practise safely and competently in rural and remote medicine

Earlier sections of the report describe the framework provided by Australian General Practice Training for training in generalist practice (section 3.5), ACRRM's three pathways to vocational training in rural and remote medicine (section 4.3); training for Fellowship of the RACGP (section 3.5) and training towards the RACGP Graduate Diploma in Rural General Practice (section 5.4 of the report).

The Review Group notes that there are 43 registrar members of ACRRM but there are as yet no graduates from the ACRRM Vocational Preparation Pathway. More than 250 practitioners have graduated from the RACGP Graduate Diploma in Rural General Practice. In addition, there is the Remote Vocational Training Stream which is a structured program based on both the RACGP

[84] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p 37-38

vocational training program and the ACRRM Vocational Preparation Pathway, which leads to award of both FRACGP and FACRRM.

There are training programs to support practitioners gain specific knowledge and skills for procedural practice, for example the Diploma of Obstetrics of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. These are open to FRACGP and FACRRM trainees

The Review Group acknowledges and supports the view that medical practice in specific rural and remote contexts requires specific knowledge and skills.

The Review Group understands that if recognition of a specialty of rural and remote medicine were granted, training for the specialty would be delivered through Australian General Practice Training, and regional training providers. This already occurs for ACRRM training. The resources available for training would be enhanced by the newly developed resources of the Enhanced Rural Training Framework. As discussed earlier in the report, the Enhanced Rural Training Framework offers training in core skills of general practice as defined by the RACGP leading to Fellowship of that College. To this can be added another year during which advanced skill sets of value in rural and remote practice can be acquired and recognised either by gaining the RACGP Graduate Diploma of Rural General Practice or Fellowship of the Australian College of Rural and Remote Medicine.

It is not clear to the Review Group how training for Fellowship of the Australian College of Rural and Remote Medicine would change if rural and remote medicine were recognised as a distinct specialty.

The application for recognition sets out comprehensively ACRRM's view that rural and remote medicine requires extended training, as embodied in the ACRRM Primary Curriculum, and that this required greater breadth and depth of understanding than is required for general practice, and should not be viewed as 'general practice plus'. Section 6.1 of this report, outlines some of the arguments against this view.

The application for recognition by ACRRM describes rural and remote medicine as a broad discipline that includes skills sets that overlap with many specialties including general practice. It states: "In these areas the specialist in rural and remote medicine must have a broader and deeper understanding of these areas as he/she will be required to deal with greater complexity in the management of the presenting conditions and with more professional isolation. There are also additional areas of practice that are not incorporated or considered integral to the skill set required for fellowship of general practice: procedural skills; hospital practice; population health; indigenous health; emergency medicine, and extended skills in areas such as psychiatry. The curricula for training in rural and remote medicine and general practice have been mapped and contain substantive difference in areas of content."[85]

Elsewhere in its application for recognition, ACRRM summarises the core and advanced clinical knowledge and skills. This list is reproduced on page 43 of this report. Concerning these skills, ACRRM states:

"These core Rural and Remote Medicine skills incorporate many of the identified essential skills of generalist and specialist care. Its core competencies extend beyond those of modern General Practice into a range of areas usually associated with other specialties (e.g. fracture and complex injury treatment, emergency care, use of ancillary equipment such a x-ray, ultrasound, slit lamp, aged care, mental health care, post-operative care).

[85] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 21

They also incorporate skills that are distinct to rural and remote delivery models including tele-consultancy and working without advanced medical facilities/specialised auxiliary support staff such as radiologists, specialist nurses and the like."[86]

Advanced knowledge and skills are also detailed on page 22 of the ACRRM submission:

"Practitioners of Rural and Remote Medicine require advanced diagnostic, therapeutic and clinical management skills that in urban areas are generally the province of specialists and sub-specialists. These skills build on what have been defined as core areas outlined above, but are in practice learned and performed in parallel as required in the training/practice environment. The key areas encompassed by this domain are in obstetrics, obstetric ultrasound, surgery, anaesthetics, mental health and population health."[87]

While many submissions from rural doctors and rural doctor support organisations, and education and training providers support the view that rural medical practice requires an extended skills set and additional knowledge, there is little comment in the supportive submissions on the ACRRM Primary Curriculum as the vehicle for provision of these skills.

Comments in support of training for specific skills for rural and remote medical practice included:

- "Recognition…may result in cost effective health care due to more specific training in the application of emergency medicine type principles that are likely to be required in rural and remote areas as opposed to metropolitan areas at a higher level of skill, and that community benefits through recognition of specialist general practitioners in rural and remote medicine in terms of attracting such practitioners to rural and remote areas would justify any increased cost."[88]

- "I think ACCRM is successful in pointing out that the specific body of knowledge and skills is sufficiently complex or extensive to require a comprehensive and complete training program. Although certainly one could get such training if one were focussed on a rural career in other colleges, again it's the collegial support network that will likely encourage practitioners to establish practice in a rural area and then maintain that practice."[89]

- "This RTP framework is based on the ACRRM model and provides the structure for the establishment of a discrete vertical rural training pathway. The end-point of this pathway will be the attainment of a separate and discrete, accredited Specialty award. In some cases, these frameworks may provide the opportunity for accelerated attainment of the knowledge, skills and attitudes required for rural and remote medicine, leading to more efficient integrated models of training.

  The ACRRM model also provides the opportunity for integrated training in other Specialist areas. As medical training is increasingly devolved to the community setting, it is possible that the integrated rural training environment will become the testing ground for innovative and cost-effective training in a range of medical specialties. The ACRRM model of the "rural generalist" has applicability to training for the broad base of knowledge and skills required for referred specialties in rural practice, including rural Physicians, rural Surgeons, rural Obstetricians, public health physicians, etc. There is significant overlap between these areas of practice and the ACRRM curriculum for Rural and Remote Medicine, which provides the ideal opportunity for rural Specialists to seek Fellowship of ACRRM and receive collegiate support from that college.

[86] ibid, p. 22
[87] op cit, p. 22
[88] Dr S Buckley, Chairman, Board of Censors, Australasian Faculty of Rehabilitation Medicine, Submission, AMC Internet Site
[89] Professor D DeWitt, Professor and Head of School of Rural Health, The University of Melbourne, Submission AMC Internet Site

This arrangement would reflect the cooperative practice arrangement that currently exists in rural Australia, where rural generalists and specialist practitioners work collaboratively in a variety of settings to provide care for rural communities.

The School also looks forward to the opportunities presented by streamlined rural training pathways in the development of joint Rural and Remote Medicine generalist/specialist award programs. We would envisage that these would be developed through conjoint arrangements between ACRRM and colleges in other relevant specialty fields such as obstetrics, emergency medicine, public health or psychiatry.

Finally, the School recognises the importance of maintaining the mobility of generalist practitioners between rural and urban practice settings and views this as a manageable goal within the proposed ACRRM structure. Training for the specialty of rural and remote medicine can be provided by RTPs alongside training for General Practice; indeed, training for the Fellowship of ACRRM includes as a subset all the requirements for training in General Practice, and the qualifications provided by both colleges should confer ability to practice in any generalist setting in Australia, with greater or lesser degrees of specialist support.

We support the contention that attainment of qualifications in the specialty of Rural and Remote Medicine will equip doctors for relatively INDEPENDENT rural practice, including competencies in public and population health, emergency care, indigenous health, palliative care, etc. This ensures vocational recognition of doctors on the basis of these qualifications, rather than whether or not they practice in an urban or rural environment."[90]

- "The College has developed a comprehensive graduate training program and professional development program for continuing medical education which will, if supported by Government and AMC recognition, enable enhanced delivery of primary care to Australian remote and rural communities."[91]

The submissions that put the contrary view that rural and remote medicine is based on the core of general practice are exemplified by the following:

"Review of the curricula and definitions of General Practice, Rural General Practice and Rural and Remote Medicine suggests more similarities than differences. Rural and Remote medicine does require different skills sets, but these are in addition to core General Practice skills as already defined in the RACGP curriculum. Flexibility and choices for additional training are necessary for registrars to gain the skills for the community context where they will practice… Additional medical skills may be acquired from a range of many other specialties e.g. anaesthetics, obstetrics, psychiatry, paediatrics. These knowledge areas are not geographically specific to rural and remote medicine. The geographical distinction is arbitrary. Rural, remote, urban fringe, inner city are all different environments with different community needs which therefore determine the skills needed by the primary care doctor. The common link is General Practice - GPs need a core of training and skills and then need additional skills according to the community context and the range of skills a General Practitioner chooses to develop." [92]

As noted above, the application for recognition describes the RACGP Graduate Diploma in Rural General Practice as achieving "some up-skilling for rural General Practice. This would cater for the needs of those practitioners who do not wish to undertake the full scope and depth of skills required for Rural and Remote Medicine."[93]

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[90] Professor G Solash, Head School of Rural Health, Monash University, Submission, AMC Internet Site
[91] Dr Andrew Perrignon, Chief Executive Officer, Northern Health, Submission, AMC Internet Site
[92] GPRA Submission, AMC Internet Site, p.2
[93] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine,* April 2004, pp. 47 and 48

The RACGP submission asserts: "It is not true that the RACGP Graduate Diploma in Rural General Practice lacks the **breadth and depth** (RACGP emphasis) of the FACRRM. It does allow the candidate to focus more specifically on the learning needs they identify for the rural and/or remote context in which they plan to practice, and is thus more learner-centred than the FACRRM, which seeks to comprehensively cover all skills and knowledge areas identified in the application. Both awards, however, are full postgraduate diplomas; although the RACGP's award has the distinction of being recognised within the Australian Qualifications Framework."[94]

The Review Group recognises that general practitioners in rural and urban environments may also acquire many of the skills identified above by ACRRM. In order to inform its assessment of the complexity and extensive of the knowledge and skills required to practice rural and remote medicine, and their difference to those required for general practice, at the request of the Review Group, the Recognition of Medical Specialties Advisory Committee commissioned a comparison of the curriculum for training leading to Fellowship of ACRRM with the curriculum for training leading to Fellowship of the Royal Australian College of General Practitioners and the Graduate Diploma in Rural General Practice. The Council engaged Professor David Prideaux of the Department of Medical Education, School of Medicine, Flinders University and Professor Brian Jolly, Director, Centre for Medical and Health Science Education, Monash University to undertake this curriculum comparison.

Their advice is provided at Appendix 6. This advice notes differences based on the two Colleges' views of practice and the specification of context, as well as differences in how the curriculum is specified. It also notes similarities in curriculum content. Concerning the two Colleges' approaches to specification of the curriculum, they advise:

"While there are similarities in the major curriculum documents of the two Colleges, quite different approaches have been adopted to the organisation and articulation of curriculum content. The RACGP's overall curriculum is based upon a framework related to:

- what GPs need to know ('the domains of general practice');
- why most people seek the services of a GP ('common patient presentations');
- the health needs and priorities of Australia's population ('national health priorities').

The resultant curriculum is organised according to five domains of general practice and 12 curriculum statements or priority learning areas. Each of these is underpinned by a clear set of learning objectives across the five domains.

The ACRRM Primary Curriculum has a theoretical basis in Skilbeck's 'situational model' which proceeds from an analysis of the situation or context in which the curriculum operates. As indicated previously, the principles and educational framework of the curriculum emphasise 'experiential learning in rural and remote settings' and a body of 'essential, knowledge, skills, behaviours and values which is unique to rural and remote practice'."[95]

Further, they indicate:

"The level of specification of content varies between the programs. The RACGP Training Program is driven by objectives set across the five domains and a set of 87 content topics. The ACRRM curriculum statements are specified in more detail with objectives and linked skills and abilities. The Graduate Diploma in Rural General Practice offered by the RACGP uses a similar format to the ACRRM approach.

[94] RACGP Submission, AMC Internet Site, p. 25
[95] Professors Prideaux and Jolly, AMC commissioned document, Section 4.1

In summary while, as expected, there is much common ground and overlap in the two approaches they do derive from different fundamental premises which relate, as indicated previously, to the different views of practice.

The differences are most apparent in the specification of content where the ACRRM program, and to a certain extent, the RACGP Graduate Diploma program use a more discipline-based and detailed approach. The Enhanced Rural Training Framework sets out three levels of Knowledge and Skills for Rural General Practice and/or Rural and Remote Medicine. It is the second Level (B) that demonstrates the major differences between the programs. Here the ACRRM approach involves studies across more disciplines and a more detailed exposition of knowledge and skills.

The Enhanced Rural Training Framework is a positive development. It does provide clear pathways for registrars and guidelines for trainers and there is evidence of flexibility. Above all it points to the possibility of choice between the two approaches to preparation for rural general practice or rural and remote practice which can be handled within the RTPs of GPET."[96]

The Review Group agrees with the support expressed for choice and educational diversity in vocational training.

Concerning overlap and difference in the curriculum content, they advise: "Given the above discussion and associated caveats it is difficult to place a precise quantitative judgement on the degree of overlap. Notwithstanding the previously highlighted similarities in much of the practice represented by the two programs it is not unreasonable to expected a degree of overlap and the authors claim this would approximate 65%. While there are one or two additional areas in the RACGP program it is largely the ACRRM program that specifies additional content and expresses it in more traditional discipline orientated forms. This largely accounts for the remaining 35% difference."[97]

Professors Prideaux and Jolly add: "It is important to point out in conclusion however, that in making quantitative judgements, many of the qualitative differences in the programs could be ignored. Issues such as the conceptual organization of the RACGP program compared to the discipline orientation of the ACRRM program, the emphasis on rural and remote context in the ACRRM program or the well defined examination of the RACGP compared to the emergent assessment of the ACRRM program need to be kept firmly in mind. In the end these issues may go a long way in defining curriculum difference irrespective of quantitative assessments of content."[98]

The Review Group notes the differences that result from the two Colleges' views of practice and their different approaches to curriculum organisation and specification. In terms of overall content, the Review Group considers that there is substantial overlap between the written curriculum of the RACGP and ACRRM. It notes that the additional curriculum domains outlined by ACRRM, particularly the Rural and Remote Practice domain, give additional explicit emphasis to the rural and remote context and the claim that rural and remote practice requires greater responsiveness to the milieu in which it is undertaken than other forms of medical practice. It notes that the RACGP Graduate Diploma in Rural General Practice includes a specific module on Rural General Practice, which introduces trainees to the unique characteristics of rural general practice.

The overlap is compounded by the delivery of both training leading to Fellowship of ACRRM and training leading to Fellowship of the RACGP through the framework provided by Australian General

[96] ibid
[97] op cit, p. 3
[98] op cit, p 3. The two caveats cited are: the study is limited to statements of content in official programs, and that content is only one dimension of a curriculum or program… The models stress that there must be consistency between the elements of curriculum; aims, objectives, content, pedagogy and assessment pattern. To base judgements about the programs based on only one of the elements is a best a partial analysis. Simply curriculum programs must be judged in context. To consider alone out of context again presents only part of the picture.'

Practice Training; the two programs share training providers and share training supervisors. Training providers and training supervisors interviewed by the Review Group largely considered that there was not and would not be substantial differences in the training delivered to registrars following the FACRRM pathway and those following the FRACGP, and the FRACGP and the Graduate Diploma in Rural General Practice program.

The Review Group notes the roles of the Joint Consultative Committees (JCCs), described in section 5.4, which set standards, identify the training and skills needs in areas of special interest, advise on the content of the vocational training curriculum and continuing professional development activities, and are involved in the accreditation of Advanced Rural Skills Posts. The joint participation by the RACGP and ACRRM in these standards setting exercises again indicates commonality. The Review Group notes there are some separate initiatives to develop curricula for rural practice, involving ACRRM and the relevant specialist medical college but not the RACGP, most notably the initiative between ACRRM and the Royal Australasian College of Surgeons.

At this stage, a comparison on the skills and knowledge required for Fellowship of the RACGP and Fellowship of ACRRM as evidenced by the summative assessment of the RACGP and ACRRM is not possible, since ACRRM's approach to assessment is still developing. The Review Group understands that as yet no ACRRM trainee has been assessed by the proposed assessment process. The College Executive outlined to the Review Group a plan for piloting the Multiple Choice Question component of the examination, later in 2005. It did not have a firm timeline for administering its first examination.

The Review Group noted the following statement by the RACGP: "…the FRACGP examination is well established, well evaluated and well validated. At least 25% of its examiners are experienced rural and remote GPs, and over the last 6 years the RACGP National Rural Faculty has assisted the Exam Panel in developing a range of rural exam questions and question extensions. "[99]

6.2.3 The program or programs for the continuing professional development and maintenance of professional standards of practitioners in rural and remote medicine

The ACRRM professional development program, described in section 4.3.2 of the report, has been established since 1998. Participation in the professional development program developed by ACRRM is mandatory for Fellows of the College. The program is available to all vocationally registered practitioners including FRACGP holders who can use the PDP as an alternative mechanism for maintenance of vocational registration.

As noted previously, the Review Group's discussions with rural and remote practitioners confirmed that many practitioners choose the continuing education activity which they see as most fitting their needs, rather than choosing exclusively from the ACRRM PDP or the RACGP QA&CPD activities. This indicates to the Review Group a major overlap in accreditation frameworks and in the educational needs being addressed.

6.2.4 The professional body (bodies) responsible for training, assessment and certification in the discipline and for setting standards of medical practice in the discipline, and engaging stakeholders in standards development

Medical practitioners in regional and remote Australia have praised the collegial role of ACRRM, the integrated education and workforce support provided in collaboration with rural organisations and stakeholders, and ACRRM's political role in advocating for rural and remote practitioners.

[99] RACGP, Submission, AMC Internet Site, p. 33

These sentiments are expressed in a large number of supportive submissions to the Review Group that did not address the criteria for recognition. Typical of such submissions is: 'I fully support the submission to recognise ACRRM as a specialist college. Rural and remote medicine is a distinct medical specialty and the accreditation of ACRRM will ensure that this unique knowledge and skill set is given the formal recognition it deserves.'

The RACGP notes: "ACRRM's application demonstrates its capability of engaging stakeholders, particularly medical stakeholders in setting standards. This is evident in its membership growth, occurring at a time when ACRRM has limited capacity to confer either vocational status or financial benefit to its fellowship."[100]

In discussions with the Review Group, practitioners, trainers, and training providers frequently expressed the view that the existence of a body such as ACRRM, with a strong mission to support and advocate for rural and remote practitioners and rural and remote training, had encouraged other training providers to consider and respond to the needs of rural and remote practitioners. Innovations in training appear to have resulted from the diversity in approaches to training.

A number of medical practitioners and training providers, however, believed that considerable additional benefits would derive from ACRRM and the RACGP working more closely together to continue to build the knowledge and practice bases for rural and remote medical practice.

ACRRM has presented considerable evidence of its capacity to set requirements and standards for training and practice. This evidence is reinforced by the acceptance of other bodies of ACRRM's training role, by its partnerships with other colleges, other rural agencies, State and Federal governments, and its participation in General Practice Education and Training Ltd.

The Review Group noted that there has been no independent assessment of the validity of ACRRM's requirements and standards.

It not clear from the application for recognition how ACRRM has engaged health consumers in setting standards.

The guidelines and procedures used by the professional body for determining who will be foundation members

The processes for awarding Fellowship to foundation members of ACRRM was a major issue for the Review Group. The Review Group accepts that there must be a process to determine who will be accepted as the foundation members of any new professional body. The Guidelines for Recognition, however, indicate clearly that in determining who should be foundation members of the professional body representing the specialty, 'The level of knowledge, skills and competence of foundation members should be no lower than the level of those who will complete its training program.'

ACRRM has stated: "FACRRM qualifications recognise attainment of a skills set that extends beyond that ordinarily encapsulated in primary care and includes many skills that in 'General Practice' would be routinely the purview of a specialist. All Fellows have a common set of skills based on the ACRRM Primary Curriculum."[101]

[100] ibid, p. 75

[101] Australian College of Rural and Remote Medicine, *Supplementary information in support of the application to have Rural and Remote Medicine Recognised as a Medical Specialty*, p. 5

696 (52.1%) of ACRRM Fellows were admitted under a 'Grandfather' provision that ended on 31 December 1999. These included:

- Rural practitioners with five years experience in rural practice and supportive testimonials from two peers as to the quality of their practice.
- Rural practitioners with three years in rural practice and support from two peers as to the quality of their practice and one of the following:
  - FRACGP and equivalent
  - Vocational registration
  - Three years of other relevant training and experience.
- Former rural practitioners with five years in rural practice and supportive testimonials from two peers as to the quality of their practice and who, since leaving rural practice have, in the opinion of their peers, made a significant contribution to ACRRM, &/or rural medicine &/or rural health.

An additional 598 (44.7%) were admitted to Fellowship through a 'Pioneer' pathway. Criteria for success in this pathway included rural practitioners who completed/will complete bona fide rural training under the auspices of:

- Rural Doctors of Australia Association (or a constituent State or Territory RDA); and/or
- Rural Health Training Units; and/or
- RACGP Faculty of Rural Medicine/Rural Faculty/Rural Training Stream; and
- Three years in rural practice, inclusive of training time spent in rural posts and with two supportive testimonials from supervisors.

The level of knowledge, skills and competence of foundation Fellows issue was addressed in a number of submissions to the Review Group. Comments included:

- "…the ACRRM's articulation of an independent vocational training program is inconsistent with RACGP experience. The ACRRM's Fellowship has been assessed to date by the signature of 2 peers. Where it has been awarded through vocational training, this has been vocational training leading primarily to the FRACGP and, additionally, to the RACGP Graduate Diploma in Rural General Practice. In the Pilot Remote Vocational Training Stream, the ACRRM has been awarding its Fellowship to Registrars who undertake no advanced rural skills training and attain only the FRACGP. It informed GP registrars at a GP registrar forum in 2003, however, that the FACRRM would be awarded to registrars who attained an FRACGP and an RACGP Graduate Diploma in Rural General Practice. It further informed a rural forum at the RACGP's Annual Scientific Convention in 2004 that the FACRRM could be awarded to a Registrar who completed the FRACGP, the RACGP Graduate Diploma, and some further activity that met the FACRRM criteria. In the FACRRM criteria released in 2004, a combination of the FRACGP and the RACGP Graduate Diploma attracts only 10 of the 16 points required for FACRRM eligibility."[102]

- "ACRRM describes how foundation members were determined and its current criteria for Fellowship on page 68. The majority of current FACRRM holders were awarded this based on grandfather and pioneer criteria prior to there be[ing] a detailed curriculum and assessment process. Current holders of FACRRM include 382 holders of FRACGP and 22 holders of other Specialty college Fellowships e.g. general surgeons, physicians, radiologists, obstetricians and gynaecologists. The current criteria for FACRRM require enrolling in some sort of training – vocational preparation, independent or RVTS pathways. The ACRRM submission states that there will be an examination pathway introduced in 2004 (p 68). Assessment is well recognized as a driver of education and learning, yet the details of the examination process are not yet widely available even though 2005 rapidly approaches. It is not known if the exam will be validated by having current holders of FACRRM sitting it. Those doctors not in a training program will also be able to apply for Fellowship using an experience-based Recognition of Prior Learning process

[102] RACGP, Submission, AMC Internet Site, p. 33

(Appendix 7). A points system is utilised, requiring applicants to gain 16 points minimum and also submit referee reports. Of note, up to 8 points can be awarded for passing the 1st and 2nd part (or equivalent) of another specialty colleges' exam. Points are also awarded for CPD, number of years in rural practice, further post graduate studies e.g. masters, graduate diplomas, and completion of specific courses, publications and teaching. This process would allow for medical practitioners with Fellowship qualifications from another specialist college in Australia or overseas to be awarded FACRRM. ACRRM also states that a 'Rural and Remote Medicine specialist delivers primary, secondary and tertiary care' (p14). It not clear how medical specialists in another field awarded FACRRM via the RPL process would be assessed for their ability and knowledge in primary care as defined by the ACRRM primary care curriculum."[103]

"Standards for award of FACRRM and how this translates to access to a Vocational Register are of concern. Significant differences in knowledge and practice patterns would exist between holders of FACRRM who achieved this via a training pathway versus the experience based Recognition of Prior Learning pathway. The former has a strong focus on training in primary care. The latter allows for specialists already recognised by another college e.g. a general surgeon to be awarded FACRRM and therefore practice 'unreferred primary care' and access a vocational register to bill for this care."[104]

As indicated earlier, about 94 per cent of the present Fellowship entered through either the grandfather or pioneer portal. The Review Group explored these processes with the College and with Fellows. It has not been presented with evidence that assessment through these pathways ensured that the 'level of knowledge, skills and competence of foundation members should be no lower than the level of those who will complete its training program'.

Concerning the processes for determining the equivalence of the standard of education, training and experience of medical practitioners trained overseas to that articulated by ACRRM, the application for recognition indicates:

"Australia leads the world is the development and support of this discipline and, as such, there no overseas qualifications are recognised as equivalent to FACRRM in Australia. For eligibility to FACRRM training pathways candidates must be registered medical practitioners within Australia, and meet all of the standard eligibility requirements. To qualify for award of FACRRM (in addition to other standard requirements) candidates must qualify and be assessed against the standard eligibility criteria and have a minimum of 3 years experience of rural and remote practice in Australia. Overseas trained rural doctors may apply for Recognition of Prior Learning (i.e. award of credit for learning that has resulted from previous work experience, courses of study or other life experiences). Due to the considerable career diversity among candidates (particularly OTDs), ACRRM's recognition of prior learning assessment process is designed for maximal flexibility while maintaining academic rigour."[105]

Page 72 of the application for recognition outlines the process for recognition of prior learning. As described, this appears an appropriate process.

Queensland Health indicated: "one concern related to international medical graduates has been identified. In its application, the Australian College of Rural and Remote Medicine advises that it will require international medical graduates to have a minimum of three years experience in Australian rural and remote practice to qualify for the award of FACRRM. This appears inconsistent with the College's recognition of prior learning process for international medical graduates. Queensland

[103] GPRA, Submission, AMC Internet Site, p. 9
[104] ibid, p. 2
[105] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 72

Health acknowledges it may not be appropriate to address this issue in the context of AMC's recognition process."[106]

6.2.5 Implications of the provision of rural and remote medical services by a single specialty for the standard of health care

The Review Group notes that 'first access non referred' medical services in rural and remote Australia are provided by a wide range of practitioners: Fellows of ACRRM, Fellows of the RACGP, Fellows of the RACGP who hold the Graduate Diploma in Rural General Practice, and practitioners who hold none of these qualifications.

The application for recognition (Section 3.5) states: "There are no negative consequences for existing specialties arising from the emergence of the specialty of Rural and Remote Medicine. In fact, there is evidence to demonstrate that the specialty has made a significant and positive impact on the range, quality and general support available for education and skills development in generalist training." The application for recognition[107] lists a number of benefits that are stated to have derived from the establishment of ACRRM and the emergence of Rural and Remote Medicine as a discipline, including.

- education modules on rural practice management;
- education modules for population health for clinicians that are able to be modified for other allied health professions;
- advocacy and representation;
- communication and peer support;
- guidelines and clinical protocols for best practice in rural medicine;
- integrated education and workforce support through collaboration with rural organisations and stakeholders;
- training opportunities and facilitated pathways for vocational trainees in the specialty;
- facilitated collaboration with specialties including general practice has resulted in mutually beneficial educational process and professional relationships; and
- programs have been developed for students and junior doctors.

The Review Group agrees that ACRRM contributes significantly to the range and quality of education and training available for rural and remote practitioners. The Review Group is not convinced that, using the recognition criteria, that defining a separate speciality of rural and remote medicine will enhance the quality of medical care.

The ACRRM application indicates:

"It is anticipated that recognition of Rural and Remote Medicine as a specialty will positively impact on other (non-medical) health professions in a number of ways.

- Recognition of specialist expertise in the medical profession is likely to positively influence professional attitudes toward 'rural' expertise and career pathways in other professions.
- As outlined above, it will contribute to increasing the number, and improving the confidence and special rural skills, proficiencies and attitudes of the medical professionals with whom other rural and remote health professions work.
- Other rural and remote health professionals can benefit in particular from the fact that Rural and Remote Medicine training incorporates cultivation of knowledge, skills and attitudes development for effective interdisciplinary teamwork.

[106] Queensland Health, covering letter, Submission, AMC Internet Site

[107] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 31

- Further development and advancement of the specialty, extending from recognition will add to the critical mass of academic, professional and support resources available to all health professionals working in rural and remote Australia.
- Provide a model for the development of rural and remote curriculum and professional development for other health disciplines."[108]

The Review Group supports the claim that recognition of specialist expertise in the medical profession is likely to influence positively professional attitudes toward 'rural' expertise and career pathways in other professions.

GPRA indicates: "Existing training structures already exist which is supported by data showing an increase in the level of healthcare provided. The Grad Dip Rural program has been running since 1997 and has now graduated over 250 candidates (Richard Lawrence, personal communication). 70% of these candidates are still practising in rural locations (RRMA 3-7) and 60% are practising in RRMA 4-7 post graduation. (http://www.racgp.org.au/document.asp?id=8820). ACRRM advises that 32 of its Fellows also hold a RACGP Grad Dip Rural qualification (p 84). ACRRM has only recently been offering a training pathway to FACRRM and has not presented any data on whether training towards FACRRM increases rural retention rates and thus improves levels of healthcare."[109]

6.3 Is recognition of rural and remote medicine as a specialty in keeping with wise use of available health care resources?

The Guidelines for Recognition list the following points that should be addressed by the case for recognition:

(a) that the proposed specialty or sub-specialty is of public health significance as demonstrated by burden of disease, incidence, prevalence or impact on the community. Evidence of support for the recognition of the medical specialty or sub-specialty in the community may also be taken into consideration;

(b) that where the specialist medical services are already provided or could be provided by practitioners in an existing specialty or sub-specialty or a combination of specialty groupings, the provision of these services by a single specialty or sub-specialty would provide improved levels of care;

(c) that, on balance, the resource implications for both public and private sector health care providers are justified on the basis of the benefits to the community of the recognition of the specialty or sub-specialty, e.g. through attracting practitioners to an under-subscribed field of medical practice;

(d) that the enhanced expertise that follows from the recognition of this medical specialty or sub-specialty would provide community benefits that justify progressive limitations on the ability of other medical practitioners to provide some or all of the services within the province of the new specialty or sub-specialty.

6.3.1 Community benefit

The application for recognition indicates:

"Recognition and growth of the specialty will ensure reduced costs of unnecessary retrieval, referral and transportation for patients as a consequence of more comprehensive training and increased confidence of practitioners to manage appropriate complex conditions in situ. Coordinated

[108] ibid, pp. 47-48
[109] GPRA, Submission, AMC Internet Site, p. 12

development of the most effective rural medical workforce service models (medical and allied health) and increased utilisation of already existing rural facilities will lead to more effective use of resources. Recognition will facilitate resource and administration sharing amongst training programs and allow for streamlining of training and accreditation arrangements for specialists in Rural and Remote Medicine, including arrangements for supervisors and medical educators. Speciality recognition will internalise Rural and Remote Medicine as an officially endorsed player within the medical profession training and accreditation system. Thus recognition provides the only self-sustaining mechanism for ensuring the concerns of Rural and Remote Medicine continue to be addressed and appropriate resources provided to support its outcomes.

It will also create clear and facilitated career paths and continuity of education in Rural and Remote Medicine from undergraduate to postgraduate practice. This allows agencies and educational organisations to better facilitate and coordinate high quality and relevant professional support in the form of education, peer networks, family networks, and in collaboration with rural organisations such as RDAA, Rural Workforce Agencies and Rural Divisions, provide a conduit to address financial and industrial issues.

The specialty status of Rural and Remote Medicine would assist to attract skilled doctors to rural practice who can effectively provide a broad range of comprehensive services. In so doing, it would also provide an impetus for the continued growth of intellectual and service infrastructure capacity in rural and regional areas."[110]

The evidence provided by ACRRM in the application for recognition amply documents the major health and health care needs of rural and remote Australians. This is supported by public submissions to the Review Group, especially those from rural and remote communities.

The Government's recognition of these problems is evidenced by the commitment in the 2004-2005 Federal Budget of $830.2 million over four years to the 2004 Rural Health Strategy to fund a range of initiatives including rural health services, programs to support the recruitment and retention of GPs and long-term measures to increase the rural workforce. This builds on the Regional Health Strategy - *More Doctors, Better Services*, announced in the 2000-2001 Federal Budget.

The Review Group is not convinced that the creation of a new specialty of rural and remote medicine would address these problems, however.

The Review Group accepts that recognition of rural and remote medicine as a specialty would enhance the prestige and visibility of the area of practice, and that it would influence professional attitudes toward rural expertise. As noted above, there is some support for the view that this would have a positive influence on recruitment for rural practitioners, as well as some support for the view that doctors in training are seeking the flexibility to train in a variety of urban and rural settings rather than by committing to a geographical area.

There appear to be many other factors that influence practitioner retention. For example, 2002 AARWG data indicated that the length of time a GP was in a practice decreased with increasing remoteness; it also indicated difference in the length of time in current practice across the States and Territory, with more doctors being at a practice for over 10 years in NSW, South Australia and Tasmania and more being at a practice for less than three years in the Northern Territory, Queensland, Victoria and Western Australia.[111]

The Review Group acknowledges the evidence presented concerning the importance of appropriate professional and educational support for retention of rural doctors. It accepts that acknowledgement

[110] Australian College of Rural and Remote Medicine *Application for recognition of the Specialty of 'Rural and Remote Medicine' by the Australian College of Rural and Remote Medicine*, April 2004, p. 10
[111] ARRWAG Reality Bites

of the work of rural doctors is also important. As outlined in section 5 of this report, there is a range of education and training initiatives and financial incentives for rural and remote practitioners. ACRRM plays an important role in advocacy for these initiatives. The likely effect of recognition of rural and remote medicine as a medical specialty over and above these initiatives is unkown.

The RACGP notes: "Potential costs also include additional **costs in retention of GPs** (RACGP emphasis) who would seek to spend some time in rural general practice and may be denied this opportunity because they do not have the FACRRM. There are a great many rural GPs who currently have the FRACGP and, increasingly, the RACGP Graduate Diploma in Rural General Practice, and do not see the clinical and professional need to transfer to Rural and Remote Medicine; yet this is what the ACRRM submission suggests will be required of doctors practising in rural and remote Australia, particularly those wishing to access any of the benefits pertaining to a Rural and Remote Medicine Register."[112]

A flexible generalist workforce is essential in Australia, and barriers to the movement of practitioners to rural and remote practice would not be in the community's interest. ACRRM indicates that it does not support geographic provider numbers or limitations on the locations where FACRRM or FRACGP could work. In addition, it indicates that if rural and remote medicine were recognised, general practitioners would still be able to work unhindered anywhere in Australia. These are matters relating to the development of a separate Rural and Remote Medicine Register which would need to be considered further.

Some concerns were expressed that recognition of a separate specialty of rural and remote medicine would lead to other colleges reducing their focus on providing training designed to meet the needs of rural and remote communities, since they might assume that ACRRM would look after these needs.

There are other strategies to respond to the health care needs of rural and remote communities, notably the provision of improved services.

Victorian WorkCover Authority writes:

"The VWA believes that ACRRM has yet to make the case that rural and remote medicine is a distinct medical specialty, as:

- It involves a multidisciplinary approach, rather than a distinct set of medical skills and knowledge. For example, the radiological skills and knowledge required in a rural and remote community are the same as those required in an urban setting;
- The range of disciplines that are envisaged within the specialty cover a range of the types of practitioners, including general practitioners, nurses and allied health providers. This raises questions as to who the 'specialist' designation would cover;
- The type of practice and its location determine the practice role. There are, for example, significant differences between practicing as an individual and as a member of a practice group, and between practising in a regional centre and a remote location;
- It is not appropriate to use recognition as a medical specialty to achieve other social policy objectives, such as encouraging rural doctors to remain in communities in order to slow the rate of rural decline;
- Unique ways of working, such as teamwork and in isolation, are not medical skills and knowledge and are therefore not an appropriate basis for recognition as a medical specialty; and
- Many of the problems that form the basis for seeking recognition of rural and remote medicine as a specialty are structural (as indicated by the research) and the case is not yet made as to how recognition will address these structural issues.

Conclusion: The health care needs of rural and remote communities would appear to be driven by the need for an accessible range of medical services, rather than a need for a distinct medical discipline.

[112] RACGP Submission, AMC Internet Site, p. 36

Greater assurance is required from the ACRRM that the aggregation of diverse expertise into a single discipline would not pose unacceptable risks to both patients and practitioners and represents a superior strategy to the current focus on improving the accessibility of a range of medical services."[113]

The RACGP asks: "How will 'recognition and growth of the specialty' lead to 'reduced costs of … retrieval and transportation for patients' –improved services are more likely to do this. Improved services result from a combination of workforce and infrastructure. It is true that 'more comprehensive training and increased confidence of practitioners' will assist practitioners in providing such services, once resourced to do so, but the RACGP is already well prepared to provide such training for rural and remote GPs through its FRACGP and Graduate Diploma in Rural General Practice, and its QA&CPD Program and JCCs. Who, in addition to GP specialists, does the ACRRM propose to provide such training for? This is not made clear in the application."[114]

6.3.2 Costs of recognition

ACRRM is seeking recognition of rural and remote medicine as a generalist speciality with vocational registration (or an equivalent government recognised status). ACRRM intends that its vocational training pathways leading to Fellowship of ACRRM would be an independent means for rural doctors to attain access to a generalist vocational register, a separate Rural and Remote Medicine Register, recognised for the purposes of the Medicare Benefits Schedule. ACRRM has also indicated that it is seeking fully transferable access to A1 item numbers anywhere in Australia from both the proposed Rural and Remote Medicine Register and the Vocational Register (i.e. under this proposal a Fellow of ACRRM could work in the city and a Fellow of the RACGP in the country whilst retaining access to the higher A1 items).

The Review Group notes that 77 per cent of the Fellows already hold vocational registration, and that all or most of the remaining 300 Fellows already have access to higher consultation rebates through the ROMPs Program, which provides for practitioners in RRMA 4 to 7 to bill A1 Medicare Benefits Schedule items and for their patients to receive the higher Medicare rebate. Assuming these figures are correct, the additional immediate cost of recognition would be small.

Rebates for procedural items would not be expected to change as a result of recognition unless there is an increase in demand or the number of rural practitioners increased. It should be noted that ACRRM states:

"51% of all ACRRM Fellows are practising proceduralists… Assuming that with recognition, the entire Rural and Remote Medical workforce would eventually comprise FACRRM holders, and that these practitioners would reflect current FACRRMs' practice patterns, the number of procedural practitioners could be expected to increase considerably."[115]

The application for recognition states that recognition of rural and remote medicine will reduce the costs of retrieval, referral and transportation of patients to metropolitan or provincially based specialists. In response to a request for more information concerning this claim, ACRRM contended that costs to the health system of provision of enhanced medical facilities in rural and remote locations would be more than balanced by lower recurrent costs. The Review Group was not persuaded that the scenarios advanced had taken account of the likely rise in acute care expenditure in rural and remote hospitals should the range of services be expanded.

There are several potential costs of recognition that are difficult to estimate, but overall are likely to have a small impact on costs:

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[113] Victorian Workcover Authority, Submission, AMC Internet Site, p. 4
[114] RACGP Submission, AMC Internet Site, p 60
[115] ACRRM *Supplementary Information in Support of the Application to Have Rural and Remote Medicine Recognised as a Medical Specialty*. April 2005, p. 19

1. Non-VR urban general practitioners who decide to train for Fellowship of ACRRM as a result of recognition, who would not otherwise have made that decision.

2. Seventeen per cent of current Fellows of ACRRM practise in metropolitan areas. If in future all FACRRM were regarded as vocationally registered, and the same proportion of vocationally registered and non-vocationally registered Fellows were in urban areas, the cost would be 17 per cent of the potential maximum of $14m which would be the additional cost if all current non VR ACRRM fellows moved from item A2 to item A1 rates, i.e. $2.4m per annum (based on average number of services per year, and estimated average difference between non-VR and VR of $10.50 per service).

3. Fellows of ACRRM, who did not previously have vocational registration, who decide to leave the rural sector and who would continue to be able to bill at the higher rebates, if FACRRM were recognised for the purposes of vocational registration. The Review Group notes that this change could remove an incentive for generalist practitioners to remain in rural areas. ?? This has policy implications, particularly for Government initiatives to recognise the workforce requirements of rural areas by geographic incentives. The net cost only relates to those Fellows who would have moved to urban areas in either scenario: those Fellows who would have remained in rural areas would have retained higher rebates; there are no costing implications for those who would not have moved without the incentive.

    - Based on a maximum of 300 practitioners, average number of services per year, and estimated average difference between non-VR and VR of $10.50 per service, the maximum possible cost that would apply to practitioners who would claim FACRRM as their qualification for vocational registration would be $14M. In reality, it is more likely that a small percentage of FACRRM would return annually to urban practice at lower rebates. For instance, if this were 20 per cent of 300 per annum it would cost approximately $2.8M per annum.

      The Review Group notes that there are currently other restrictions on many of these doctors, particularly the five and ten year moratoria on international medical graduates.[116]

    - Longer term this will not be an issue as those members retire and are replaced by new Fellows (as the costings fundamentally relate to non-VR GPs who were grandfathered into ACRRM, and there will be no more such grandfathering). The base cost will now include all Fellows paid at the higher rate.

The Review Group does not consider that recognition would create significantly increased costs related to pharmaceuticals or health technology compared to current costs. It should, however, be noted that there is insufficient information to predict whether recognition will:

1. increase pressure on government from Fellows for additional public hospital appointments in rural and remote areas, and/or

2. increase pressure on government for technology and support staff in rural public hospitals that may not be currently available.

A number of submissions to the Review Group raised the possibility of increased costs of vocational education and training from the recognition of a specialty of rural and remote medicine. These

[116] Section 19AB of the Health Insurance Act (the Act) provides that Medicare benefits are not payable for professional services provided by overseas-trained doctors (including those trained in New Zealand) and international doctors trained in Australia, for a period of 10 years from the time they first become registered with a state or territory medical board or from when they first became permanent residents of Australia. This restriction is sometimes referred to as the 10-year moratorium.

submissions describe the cost of infrastructure necessary to deliver a vocational training program, such as trained supervisors, practices appropriately resourced for training, accreditation of training practices.

Training towards FACRRM through the Vocational Preparation Pathway currently occurs through Australian General Practice Training. It is assumed that these arrangements would continue if rural and remote medicine were recognised as a medical specialty.

GPET's submission to the Review Group indicates that GPET is required to ensure that vocational training is well structured and produces doctors that are capable of meeting community needs, in particular those of rural and remote Australia. In its submission, and in discussions with the Review Group, GPET officers have outlined GPET's investment in educational infrastructure in rural areas. It is clear that this infrastructure is available for training and education for the FRACGP, and for other colleges or institutions, including ACRRM.

The Review Group notes that GPET has already committed additional funding to the Enhanced Rural Training Framework.

In these circumstances, it is difficult to see how recognition would create significantly increased costs related to education and training.

The General Practice Registrars Association (GPRA) raises some concerns regarding other costs: "… GP registrars may incur financial and social costs to relocate for their rural training. GPRA RLOs [Registrar Liaison Officers] also report difficulties in funding and accessing procedural training to prepare them for rural practice. There is an opportunity cost for GP registrar training as funding is utilised to ensure standards and assessment development for FACRRM are met, while funding to provide support and training of GP registrars for their rural placements can be inadequate."[117]

6.3.3 Community benefits and limitations on the ability of other medical practitioners to provide services within the province of rural and remote medicine

Procedural rural general practitioners and any future specialists in rural and remote mwould, in the view of the Review Group, continue to work as do Fellows of ACRRM now. The Review Group visited several practices comprised of FACRRM and other practitioners. These practices appeared to work as do other group practices. Hospital administrators indicated that decisions about credentialing, for instance credentialing for obstetric practice would be conditional on holding the Diploma of Obstetrics (DRANZCOG) rather than FACRRM or FRACGP.

GPRA argues:

"As evident from AIHW data, there are a number of rural medical practitioners who do not hold FACRRM but are providing a primary care or working as another specialist. Similarly, there are many GP registrars training with view to rural general practice who are not completing the vocation training pathway to FACRRM. Current **and future** (GPRA emphasis) rural GPs who choose not to obtain FACRRM will be unable to access the proposed RRMR possibly resulting in a two-tier system like the current VR non-VR situation in General Practice. Such a limitation on practice would result in further divisions within the profession which are unlikely to provide community benefits."[118]

ACRRM states that its training program encompasses general practice training and that its Fellows are qualified for general practice in urban areas. For this claim to be confirmed, the ACRRM training and assessment program would need to be externally assessed by the Specialist Education Accreditation Committee of the AMC.

[117] op cit, p. 12
[118] op cit, p. 12

6.4 Specific requirements

In addition to the core criteria, the Guidelines for Recognition indicate that applications with certain features would need to make a particularly strong case for recognition:

- Fields of medical practice based on particular requirements, such as geographic or demographic delineation, a single disease, or a single modality of treatment would need to demonstrate that the benefits of recognition of the specialty to the targeted population group would substantially outweigh any disadvantages to the broader community.

- An application for recognition of an area of practice substantially recognised under a different name would need to be based on a very strong case. The option exists for the body seeking recognition to apply to the AMC for accreditation as a provider of training and professional development programs for the existing specialty or sub-specialty.

The importance of geography in the case for recognition is a complex issue. Whilst ACRRM's application for recognition emphasises the importance of the rural and remote context to rural and remote medical practice and the different skills and knowledge that are required of practitioners because of this context, as noted earlier the scope of practice of rural and remote practitioners is very wide, and the specific requirements of rural and remote communities vary.

A number of the submissions that do not support recognition raise the issue of geography, for example:

"Although ACRRM's submission is not limited to a specific geography, the submission is very strongly based on recognition of rural and remote geography and its influence on provision of medical care.

Review of definitions, curriculum content, training requirements and practitioner characteristics suggests that holders of FACRRM would have much in common with holders of FRACGP + Grad Dip Rural. An evaluated training structure already exists to prepare GP registrars for rural practice. Recognition of ACRRM as a specialty college and provider of training for rural and remote practice would not necessarily result in improved safety or standards of healthcare that utilises resources more efficiently than the current structure. Rural and Remote Medicine should be considered as a discipline within General Practice rather than **completely distinct specialty.** A standardised, yet flexible training pathway resulting in a single primary endpoint is necessary for the future of General Practice."[119]

A number of submissions suggest that the health care needs of rural and remote Australians are such that a special case exists in relation to the assessment of the case for a specialty of rural and remote medicine, in spite of the importance of geographical context in the application. The Review Group notes that successive Australian and State Governments have committed significant funding to initiatives to recruit and retain medical practitioners in rural and remote Australia. This has included using ACRRM to implement a number of these initiatives.

An example of a submission that argues that there is a special case is: "Although you could classify rural Australia as a specific geographic area, I would again raise the issue of workforce shortage and the fact that Government initiatives now aimed at increasing the number of medical places, for example rural bonding, will take some 15 years to have an effect…..While I do not have the statistics for practitioners leaving rural area in front of me the average length of stay by a practitioner in a rural area is between 5 and 7 years. Thus any collegial networks or ability to enhance research or procedural

[119] GPRA Submission, AMC Internet Site, p. 13

skills that would keep a practitioner in rural Australia will greatly alleviate the workforce distribution issues."[120]

The Review Group considers that although the geographic context is important to the case for recognition, the applicant's targeted population of the application is sufficiently wide for this not to be of concern in assessing the application.

Earlier in the report, information is provided on the submissions that are directed towards the point of view that rural and remote medicine is already recognised as general practice. The RACGP for example states: "Definition of Rural and Remote Medicine, where the ACRRM describes a 'specialty that takes a broad range of consulting room practice responsibilities … and combines them with … skills and expertise from a number of relevant specialities' such as Obstetrics, Emergency Medicine, Surgery, Psychiatry, Public Health, Internal Medicine, Paediatrics, Radiology, Anaesthetics, and Aboriginal and Torres Strait Islander Health. From an RACGP perspective, this specialty is general practice – particularly general practice in rural and remote contexts."[121]

As indicated earlier, the Review Group considers that applying a broad definition of general practice, the practice of rural and remote medicine is largely general practice, with the addition of a variable set of advanced skills that are usually procedural. In these circumstances, ACRRM might apply for accreditation as a standards body and provider of specific training and professional development programs for the specialty of general practice.

Training leading to Fellowship of ACRRM is already delivered through the Australian General Practice Training framework, and the new Enhanced Rural Training Framework provides funding for the four years of ACRRM Vocational Preparation Pathway.

The Review Group notes that despite their similarities, there are also differences in the training of the RACGP and ACRRM, and in their views of the core competencies required to practice. ACRRM has indicated very clearly that it is seeking an opportunity to define practice and training standards, provide independent support to the profession and award a qualification that relates to the educational outcomes it has defined and assessed, rather than training to standards defined by the RACGP. It has indicated: 'Since the formation of the General Practice specialty and legislative arrangements tying all non-referred care providers to General Practice and its training programs, General Practice is the mandatory filter from which Rural and Remote Medical Practitioners can be recruited.'[122] It argues that this is barrier to recruitment to rural and remote medicine, since a different cohort of junior doctors is attracted to training for rural and remote medical practice.

There is as yet no other instance in Australia of two organisations defining the standards of medical practice and the standards for training and assessment for the one medical specialty, although in developing the model for the recognition of medical specialties and accreditation of specialist medical training programs the AMC had agreed this should be possible.

[120] Professor D De Witt, Professor and Head of School of Rural Health, The University of Melbourne, Submission, AMC Internet Site

[121] RACGP Submission, AMC Internet Site, p. 45

[122] Australian College of Rural and Remote Medicine *Supplementary Information in Support of The Application to have Rural and Remote Medicine recognised as a Medical Specialty* July 2004, p. 30

7 Next stages of the Assessment

The process for recognition of medical specialties is a two-stage process. The assessment completed by the Rural and Remote Medicine Recognition Review Group, which is assessing the case for recognition of the specialty, occurs in Stage 1.

The Review Group is not responsible for advising on whether or not rural and remote medicine should be recognised as a specialty. To conclude Stage 1 of the process, the Review Group's assessment is considered through the Australian Medical Council's committee processes, and advice is provided to the Minister for Health and Ageing.

The Review Group's report provides the information on which the Recognition of Medical Specialties Advisory Committee develops recommendations to the Australian Medical Council. Taking account of these recommendations, the Council itself decides on the advice to be given to the Minister about the recognition of rural and remote medicine as a specialty.

Should the Minister consider that a case for recognition has been made, Stage 2 of the recognition process is assessment of the training programs in the specialty. These assessments are conducted by AMC accreditation teams, which operate within the policy and process described in the AMC Guidelines *Accreditation of Specialist Medical Education and Training and Professional Development Programs*.

Recognition of Medical Specialties and Sub-Specialties

4 CRITERIA FOR THE RECOGNITION OF MEDICAL SPECIALTIES AND SUB-SPECIALTIES

In developing criteria for recognition of medical specialties and sub-specialties, the AMC has considered the criteria used in similar processes overseas, particularly those of New Zealand, Canada and the United States of America, and the criteria of the National Specialist Qualification Advisory Committee. It has also taken account of the valuable feedback of stakeholder organisations provided over a series of consultations.

The account of the evolution of medical specialties and sub-specialties in section 3 indicates that medical specialties and sub-specialties emerge in response to different factors. Thus the recognition of two specialties may be regarded as in the best interest of the community but for different reasons. Whilst three core criteria for recognition are described, this does not necessarily imply that equal weighting will be given to the three criteria.

4.1 Safer health care

Under this criterion the case must be made that the recognition of the medical specialty or sub-specialty will improve the safety of health care.

To satisfy this criterion, a case must be made addressing the following:

(f) that the medical specialty or sub-specialty is based on substantiated and major concepts in medical science and health care delivery and that it represents a well-defined[*] and distinct field of medical practice, both here and in comparable countries;

(g) that the practice of the specialty or sub-specialty requires the possession of a defined body of knowledge, and specific clinical skills or specific aggregations of clinical skills or expertise;

(h) that a demonstrable link exists between patient safety and competence in the skills and expertise required of the practitioners;

(i) that where the specialist medical services are already provided or could be provided by practitioners in an existing specialty or sub-specialty or a combination of specialty groupings, provision of these services by a single specialty or sub-specialty would enhance the safety of health care;

(j) that the development and recognition of this medical specialty or sub-specialty will not adversely affect safety for example through the deskilling of other practitioners.

4.2 Improved standards of health care

Under this criterion, the case must be made that recognition of the area of medical practice as a specialty or sub-specialty will or is likely to improve the standards of health care and that the data, where available, demonstrate better outcomes.

To satisfy this criterion, a case must be made addressing the following:

[*] In general, single treatments and techniques would not be regarded as a field of medical practice.

(a) that the medical specialty or sub-specialty has a demonstrable and sustainable base in the medical profession, indicated by some or all of the following:

- practitioners who possess the knowledge and skills to practise in the specialty, and who practise predominantly in the specialty
- projections of the future need for special skills and knowledge in this area
- sufficient practitioners to sustain academic activities such as vocational training and assessment, continuing medical education and maintenance of professional standards
- academic journals in the specialty area
- a substantive body of research in the area that meets international standards
- the status of the area of practice and of training in the area in comparable countries;

(b) that the specific body of knowledge and skills is sufficiently complex or extensive to require a comprehensive and complete training program, and that there is a program of education, training and assessment that will develop the knowledge and skills necessary to practise safely and competently in the specialty or sub-specialty*;*

(c) that there is a program or programs for the continuing professional development and maintenance of professional standards of practitioners in the specialty or sub-specialty;

(d) that there is a professional body or professional bodies:

- responsible for setting the requirements and standards for training, assessment and certification in the specialty
- capable of defining, promoting and maintaining standards of medical practice to ensure high quality health care and capable of engaging stakeholders, including health consumers, in setting standards
- with guidelines and procedures for determining who will be foundation members of the specialist body. The level of knowledge, skills and competence of foundation members should be no lower than the level of those who will complete its training program
- with appropriate processes for determining the equivalence of the standard of education, training and experience of medical practitioners trained in the discipline overseas;

(e) that where the specialist medical services are already provided or could be provided by practitioners in an existing specialty or sub-specialty or a combination of specialty groupings, the provision of these services by a single specialty or sub-specialty would improve the standard of health care.

4.3 Wise use of available health care resources

Under this criterion, the case must be made that the recognition of the medical specialty or sub-specialty will result in health care that uses available resources wisely and/or that the community benefits justify the increased costs of health care**.**

To satisfy this criterion, a case must be made addressing the following:

(e) that the proposed specialty or sub-specialty is of public health significance as demonstrated by burden of disease, incidence, prevalence or impact on the community. Evidence of support for the recognition of the medical specialty or sub-specialty in the community may also be taken into consideration;

(f) that where the specialist medical services are already provided or could be provided by practitioners in an existing specialty or sub-specialty or a combination of specialty groupings, the

provision of these services by a single specialty or sub-specialty would provide improved levels of care;

(g) that, on balance, the resource implications for both public and private sector health care providers are justified on the basis of the benefits to the community of the recognition of the specialty or sub-specialty, eg through attracting practitioners to an under-subscribed field of medical practice;

(h) that the enhanced expertise that follows from the recognition of this medical specialty or sub-specialty would provide community benefits that justify progressive limitations on the ability of other medical practitioners to provide some or all of the services within the province of the new specialty or sub-specialty.

4.4 Specific requirements

Taking into account the criteria listed above and the statements in section 3 concerning increasing specialisation, the AMC considers that applications based on any of the following:

(a) an area of practice limited to a specific geographic area or narrow demographic group;

(b) an area of practice limited to the treatment of a single disease;

(c) an area of practice based on a single modality of treatment.

would need to demonstrate that the benefits for the targeted population group of recognition of the proposed specialty would substantially outweigh any disadvantages to the broader community.

An area of practice not directly involved in clinical care would have to provide evidence that its recognition will have substantial benefits to the clinical care of the community.

Similarly, an application for recognition of an area of practice substantially recognised under a different name would need to be based on a very strong case. The option exists for the body seeking recognition to apply for accreditation as a provider of training and professional development programs for the existing specialty or sub-specialty.

Members of the Rural and Remote Medicine Recognition Review Group

Dr Robin Mortimer, MBBS *Qld* FRACP (Chair)
Chair AMC Recognition of Medical Specialties Advisory Committee and
Director of Endocrinology
Royal Brisbane Hospital

Associate Professor Steven Doherty; MBBS *NSW* FACEM,
Emergency Physician Tamworth Base Hospital NSW

Dr Martha Finn; BSc MBBCH MD MRcog MRCPI Master of Med Science FRANZCOG
Snr Lecturer in Obstetrics and Gynaecology
Northern Territory Clinical School Flinders University

Professor Nicholas Glasgow; BHB MBChB Grad Dip Fam Med *Monash* MD Grad Cert Ed Studies *Syd* FRNZCGP FRACGP FAChPM
Professor and Director,
Australian Primary Health Care Research Institute,
Australian National University

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Acting Executive Director of Medical Services,
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GMO Mt Isa 1994 -2002

Ms Kathleen Sanders; BA M Social Work Dip Soc Studies Leadership & Mgt in Health Care Cert *Mt Sinai Med School* NY
Member Medical Practitioners Board of Victoria
Member, Australian Medical Council
Veterans' Review Board

Mrs Robin Toohey AM,
Consumer Health Forum Representative
AMC Recognition of Medical Specialties Advisory Committee

Professor Alan Walker AM, MBBS *Syd* FRCP FRACP FRACMA
Paediatrician
Royal Darwin Hospital

Public Submission on
The Case for Recognition of Rural and Remote Medicine

SUMMARY OF SUBMISSIONS ON THE APPLICATION

The Submissions are listed by comment type, these are:

1. ***AMC Stakeholders*** – bodies approached by the AMC seeking comment on the application

2. Submissions ***with substantive comment*** – unsolicited from interested bodies

3. Submissions ***with substantive comment*** – unsolicited from interested individuals

4. ***Written or E-mail submission*** **without substantive** comment – unsolicited from interested individuals/bodies not lodged to the AMC internet, largely testimonials

5. ***E-mail and/or Written submission received post closing date (12 Nov 2004)*** – most refer to the AMA submission not supporting the ACRRM case.

The AMC has taken substantive comment to mean that the submission addressed at least *one* of the assessment criteria for recognition of medical specialties.

Numerical Summary of Submissions:

Submission Type	Total	Grand Total
1 AMC Stakeholders	35	
2. Substantive comment from Bodies	51	
3.Substantive comment from individuals	90	
4.E-mail without substantive comment	81	
5.E-mail/Written post closing date	69* Includes 10 duplicate submitters	**326**

List of all Submissions:

SUB NUMBER	SUBMITTER	SUBMISSION TYPE	SUBMISSION TOTALS
1.	The Australasian College of Dermatologists	1	
2.	Australian National University School of Medicine	1	
3.	Comcare Australia	1	
4.	Medical Council of New Zealand	1	
5.	South Australian Dept of Human Services	1	
6.	Royal Australasian College of Dental Surgeons	1	
7.	Queensland Health	1	
8.	The Royal Australian & New Zealand College of Ophthalmologists	1	
9.	The Royal Australasian College of Physicians	1	

SUB NUMBER	SUBMITTER	SUBMISSION TYPE	SUBMISSION TOTALS
10.	The University of Melbourne School of Medicine	1	
11.	The University of Western Australia School of Medicine	1	
12.	Workcover Queensland	1	
13.	Workcover Western Australia	1	
14.	Workcover South Australia	1	
15.	Australian Nursing Council	1	
16.	The University of NSW Faculty of Medicine	1	
17.	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists	1	
18.	Australian and New Zealand College of Anaesthetists	1	
19.	Health Insurance Commission	1	
20.	Australian Doctors Trained Overseas Association	1	
21.	Australian College of Emergency Medicine	1	
22.	Department of Health Western Australia	1	
23.	Medical Board of Queensland	1	
24.	School of Medicine James Cook University	1	
25.	ACT Health	1	
26.	Victorian Workcover Authority	1	
27.	Medical Council of Tasmania	1	
28.	Department of Health & Human Services, Tasmania	1	
29.	The Royal Australian College of General Practitioners	1	
30.	General Practice Education & Training (GPET)	1	
31.	Australian Medical Association	1	
32.	Royal Australasian College of Surgeons	1	
33.	NSW Health		
34.	Australian Rural Health Network	1	
35.	Workcover Authority NSW	1	
		Sub Total	**35**
36.	Australian Rural Health Network	2	
37.	New England Area Training service	2	
38.	Health Workforce Queensland	2	
39.	School of Rural Health University of NSW Wagga	2	
40.	Central Australian Division of Primary Health	2	
41.	Tara Shire Council, Queensland	2	
42.	Barwon Division of General Practice, Moree	2	
43.	Rural Doctors Association of Victoria	2	
44.	Queensland Farmers Federation	2	
45.	The Yorke Division of General Practice, SA	2	
46.	Kempsey Shire Council	2	
47.	Victoria Felix Medical Education	2	
48.	Rural & Remote Medicine University WA, Kalgoorlie	2	
49.	Rural Workforce Agency, Victoria	2	
50.	National Rural Health Network	2	
51.	West Aust. Centre for Rural & Remote Medicine	2	
52.	Tara & District Family Support Committee	2	
53.	NSW Country Women's Association	2	
54.	General Practice Registrars Australia Ltd	2	
55.	North East Victoria Division of General Practice	2	

SUB NUMBER	SUBMITTER	SUBMISSION TYPE	SUBMISSION TOTALS
56.	National Farmers Federation	2	
57.	Otway Division of General Practice, Victoria	2	
58.	Rural Doctors Association of Australia	2	
59.	Northern Territory General Practice Education Ltd	2	
60.	Rural Doctors Association of Queensland	2	
61.	School of Rural Health, Monash University	2	
62.	Rural Doctors Association of Tasmania	2	
63.	Australasian Faculty of Rehabilitation Medicine	2	
64.	School of Rural Health, University of Sydney	2	
65.	Mid West Division of General Practice, WA	2	
66.	North West Slopes Division of General Practice, NSW	2	
67.	Far North Queensland Rural Division of General Practice	2	
68.	North and West Queensland Primary Health Care	2	
69.	Health Consumers of Rural & Remote Australia Inc	2	
70.	Centre for Rural Health, Flinders University	2	
71.	NSW Central West Division of General Practice	2	
72.	The Australian Rural Centre for Addictive Behaviours	2	
73.	Rural & Regional Queensland Consortium	2	
74.	Rural Doctors Workforce Agency, SA	2	
75.	Combined Universities Centre for Rural Health, University of WA	2	
76.	Eyre Peninsular Division of General Practice	2	
77.	Rural Clinical School, Flinders University	2	
78.	Rural & Remote Health Journal	2	
79.	Bogong Regional Training Network, Victoria	2	
80.	Murray Plains Division of General Practice, Vic/NSW	2	
81.	Kempsey Shire Council NSW	2	
82.	Monsour Clinic, Maryborough Qld	2	
83.	Leonora Shire Council WA	2	
84.	Greater Bunbury Division of General Practice WA	2	
85.	Rural Doctors Association (NSW)	2	
86.	Tara Shire 60 & Better Program	2	
		Sub Total	**51**
87.	Dr Wilden-Constantin – Goulburn NSW	3	
88.	Dr S Shah- Leonora WA	3	
89.	Dr T Smith- Culburra Beach NSW	3	
90.	Dr J Williams – Inverloch Vic	3	
91.	Mr G Muller – Tara Qld	3	
92.	Dr J Walters – Clifton Hill Vic	3	
93.	Dr P Coughlin – Taralgon Vic	3	
94.	Dr N Theris – Merimbula NSW	3	
95.	Dr N Beaton – Atherson Qld	3	
96.	Dr P Arvier – Tasmania	3	
97.	Dr D Manahan – Stanthorpe Qld	3	
98.	Dr G Kokar – Yorketown SA	3	
99.	Dr E Kertez – E-mail	3	
100.	Dr El Ashrey – Esk, Qld	3	
101.	Dr B Sadler – Ayr Qld	3	
102.	Dr J Lock – Springshore Qld	3	

SUB NUMBER	SUBMITTER	SUBMISSION TYPE	SUBMISSION TOTALS
103.	Dr W Wahby – Kangaroo Ground Vic	3	
104.	Dr J Hammond – Newcastle NSW	3	
105.	Dr B Coulson – Colerain Vic	3	
106.	Dr E Rensberg – E-mail	3	
107.	Dr N Birch – E-mail	3	
108.	Dr E McPhee – E-mail	3	
109.	Dr J Dascalu – E-mail	3	
110.	Dr G Somers – E-mail	3	
111.	Dr D Bowley – E-mail	3	
112.	Dr M Rice – E-mail	3	
113.	Dr N Castle – E-mail	3	
114.	Dr S Adebiyi – E-mail	3	
115.	Dr L Sherriff – E-mail	3	
116.	Dr D Costigan- Jandacot WA	3	
117.	Dr M Perason – Tennant Creek NT	3	
118.	Drs Keenan, Swan Moss 7 Kirk, Northam WA	3	
119.	Dr J Davies – Manjimup WA	3	
120.	Dr F McConnel – Katherine NT	3	
121.	Dr R Byrne – Leeton NSW	3	
122.	Dr R Thompson –Thursday Island NT	3	
123.	Dr C Thompson – E-mail	3	
124.	Dr J Robinson – E-mail	3	
125.	Dr M Kerrigan – E-mail	3	
126.	Dr W Lang – E-mail	3	
127.	Dr E McLeod – E-mail	3	
128.	Dr I Mottarelly – E-mail	3	
129.	Dr C Turner – E-mail	3	
130.	Dr J Robinson – E-mail	3	
131.	Dr K Yastrebov – Davenport Tas	3	
132.	Dr E Dodd – E-mail	3	
133.	Dr T Wellinham – E-mail	3	
134.	Dr J Delima – E-mail	3	
135.	Dr J Borwn – E-mail	3	
136.	Dr S Jain – E-mail	3	
137.	Dr G Wood – E-mail	3	
138.	Dr P Leal – E-mail	3	
139.	Dr P Crawford – E-mail	3	
140.	Dr C Hegarty –- E-mail	3	
141.	Dr J Van Dyke – E-mail	3	
142.	Dr P MacNeil – E-mail	3	
143.	Dr R Lloyd – E-mail	3	
144.	Dr K Mackey – E-mail	3	
145.	Dr C Loy – E-mail	3	
146.	Dr J Lee – E-mail	3	
147.	Dr S Kolera – E-mail	3	
148.	Dr H Islam – E-mail	3	
149.	Dr T Doolan – E-mail	3	
150.	Dr J Briss – E-mail	3	
151.	Dr S Holmes – E-mail	3	
152.	Dr J Stace – E-mail	3	
153.	Dr G Helmy – E-mail	3	

SUB NUMBER	SUBMITTER	SUBMISSION TYPE	SUBMISSION TOTALS
154.	Dr J Wray – E-mail	3	
155.	Dr E Van Opstal – E-mail	3	
156.	Dr L De Frenza – E-mail	3	
157.	Dr L Jefferies – E-mail	3	
158.	Dr G Nelson – E-mail	3	
159.	Dr R Martin – E-mail	3	
160.	Dr S Adebiyi – E-mail	3	
161.	Dr K Hood – E-mail	3	
162.	Dr A Thakur – E-mail	3	
163.	Dr R Howard – E-mail	3	
164.	Dr G White – E-mail	3	
165.	Dr A Bennett – E-mail	3	
166.	Dr A Perrington – E-mail	3	
167.	Dr G Pereria – E-mail	3	
168.	Dr D Wilson – E-mail	3	
169.	Dr S Strasser – E-mail	3	
170.	Dr E Colquhoun – E-mail	3	
171.	Dr S Ballard – E-mail	3	
172.	Dr A Stevenson – E-mail	3	
173.	Dr S Roberts – E-mail	3	
174.	Dr W Walker – E-mail	3	
175.	Dr E McPhee – E-mail	3	
176.	Dr T Lian-Lloyd – E-mail	3	
		Sub Total	**90**
177.	Dr P Chhabra	4	
178.	Rural Doctors Association (NSW) Inc	4	
179.	Tara Health Services	4	
180.	Dr A J Egan – Mudgee NSW	4	
181.	Dr D Heap – Atherton Qld	4	
182.	Dr I Hoyle – Latrobe Tas	4	
183.	Dr P Krige – Port Lincoln SA	4	
184.	Dr N Pal – Katherine NT	4	
185.	Dr T Leeuwenberg – Kangaroo Island SA	4	
186.	Dr R Bond – E-mail	4	
187.	Dr J Moran – Murwillumbah, NSW	4	
188.	Dr P Corey – Glenn Innes NSW	4	
189.	Dr D Rimmer – E-mail	4	
190.	Dr I Budiarto – Bowral NSW	4	
191.	Dr C Say – E-mail	4	
192.	Dr I Toogood – E-mail	4	
193.	Dr St John Marsden – Urunga NSW	4	
194.	Dr D Joseph – E-mail	4	
195.	Dr C Hopgood – Dunedoo NSW	4	
196.	Dr F Weir – McMillians Vic	4	
197.	Dr de Jong – E-mail	4	
198.	Dr R Chowdhury – E-mail	4	
199.	Dr Amponn-Nyamekye – E-mail	4	
200.	Dr Pedlow – E-mail	4	
201.	Dr C Harris – E-mail	4	
202.	Dr M McDonnell – Email	4	
203.	Dr J James- E-mail	4	

SUB NUMBER	SUBMITTER	SUBMISSION TYPE	SUBMISSION TOTALS
204.	Mr M Schlenckner – E-mail	4	
205.	Dr H Lane – E-mail	4	
206.	Dr M Fairleigh – E-mail	4	
207.	Dr A Burk – E-mail	4	
208.	Dr M Leslie –E-mail	4	
209.	Dr F Antonio – E-mail	4	
210.	Dr D Simmonds – E-mail	4	
211.	Dr S Baillie – E-mail	4	
212.	Dr L Malzinskas – E-mail	4	
213.	Dr D Halder – E-mail	4	
214.	Dr I McCormack – E-mail	4	
215.	Dr M Griffies – E-mail	4	
216.	Dr T Sikivou – E-mail	4	
217.	Dr J Buckley – E-mail	4	
218.	Dr G Higgins – E-mail	4	
219.	Dr C Smith – E-mail	4	
220.	Dr M Golding – E-mail	4	
221.	Dr C Leahy – E-mail	4	
222.	Dr A Daniel – E-mail;	4	
223.	Dr G Bertuch – E-mail	4	
224.	Dr M Rehmann	4	
225.	Dr Panegyres	4	
226.	Dr K Olatunbosun	4	
227.	Dr E Pringle	4	
228.	Dr J Lamb	4	
229.	Mr N Naidoo	4	
230.	Dr I Scott	4	
231.	Dr A Bleaney	4	
232.	Dr A Shikrani	4	
233.	Dr M Ailzart – E-mail	4	
234.	Dr S Issa – E-mail	4	
235.	Dr A Faa – E-mail	4	
236.	Dr A McMahon	4	
237.	Dr Williamson – E-mail	4	
238.	Dr van Hennekeler – E-mail	4	
239.	Dr K Gell – E-mail	4	
240.	Dr T Dissanayake – E-mail	4	
241.	Dr R Faint – E-mail	4	
242.	Dr A Walley – E-mail	4	
243.	Dr L Venter – E-mail	4	
244.	Dr G duPreez-Wilkinson – E-mail	4	
245.	Dr J Outridge – E-mail	4	
246.	Dr H Alkazali – E-mail	4	
247.	Dr P Burrell – E-mail	4	
248.	Dr P Dowd – E-mail	4	
249.	Dr G Springhill – E-mail	4	
250.	Dr P Reynolds – E-mail	4	
251.	Dr L Henderson – E-mail	4	
252.	Dr J Streethouse – E-mail	4	
253.	Dr G Whittaker – E-mail	4	
254.	Dr L Marsh – E-mail	4	

SUB NUMBER	SUBMITTER	SUBMISSION TYPE	SUBMISSION TOTALS
255.	Dr C Vijayakumar – E-mail	4	
256.	Dr G Young	4	
257.	Dr J Azzopardi – E-mail	4	
		Sub Total	**81**
	Total of Submission received by closing date		**257**
	Submission received post closing date 12 November 2004 Some of these submissions are from earlier submitters, some are additional. ***** identifies repeat submitters		
258.	*****Dr E McPhee – E-mail	5	
259.	*****Dr T Lian-Lloyd – Quorn SA	5	
260.	Mid West Division of General Practice – Geraldton WA	5	
261.	*****Dr E Dodd – E-mail	5	
262.	Dr A McDevitt – E-mail	5	
263.	Dr J Steyn – E-mail	5	
264.	Dr M Frankish – E-mail	5	
265.	Dr C Mark – E-mail	5	
266.	Dr R Haron – E-mail	5	
267.	Dr I Taylor – E-mail	5	
268.	Dr R McQueen-Thompson – E-mail	5	
269.	Dr P Carter – E-mail	5	
270.	Dr M Zagorski – E-mail	5	
271.	*****Dr G duPreez-Wilkinson – E-mail	5	
272.	Dr D Dubetz – E-mail	5	
273.	Dr G Roux – E-mail	5	
274.	Dr S Iassa – E-mail	5	
275.	Dr A Slutzkin – E-mail	5	
276.	Dr N Chorley – E-mail	5	
277.	*****Dr A Bleaney – E-mail	5	
278.	Dr L Abas – E-mail	5	
279.	Dr W Gunn – E-mail	5	
280.	Dr T McLellan – E-mail	5	
281.	The McCarthy Trust – E-mail	5	
282.	Dr S Ross – E-mail	5	
283.	Dr A Coltzau – E-mail	5	
284.	Dr R Warner – E-mail	5	
285.	Dr M Comparti – E-mail	5	
286.	Dr P Correy – E-mail	5	
287.	Dr R McGowan – E-mail	5	
288.	Dr Biing Lian Yin – E-mail	5	
289.	Dr Wan Sze Yin – E-mail	5	
290.	Dr A Iannuzzi – E-mail	5	
291.	Dr John Quayle – E-mail	5	
292.	Dr T Mikulin – E-mail	5	
293.	Dr P Coughlan – E-mail	5	
294.	Dr W Meagher – E-mail	5	

SUB NUMBER	SUBMITTER	SUBMISSION TYPE	SUBMISSION TOTALS
295.	Dr W Hlaing – E-mail	5	
296.	Dr J Mellor – E-mail	5	
297.	*****Dr P Dowd – Email	5	
298.	Dr G Quigley – E-mail	5	
299.	Dr C Rowan – E-mail	5	
300.	Dr P Reid – E-mail	5	
301.	Dr W Smolilo – E-mail	5	
302.	Dr D Larcombe – E-mail	5	
303.	Dr M Thomas – E-mail	5	
304.	Dr C Homan – E-mail	5	
305.	Dr N Aalders – E-mail	5	
306.	Dr Andrew Egan – E-mail	5	
307.	Dr M Guerin – E-mail	5	
308.	Dr M Percival – Moree NSW	5	
309.	*****Dr S K H Shah – Leonora WA	5	
310.	Dr G Sparkes – E-mail	5	
311.	Dr D Atkinson – E-mail	5	
312.	Dr M Mears – E-mail	5	
313.	*****Dr A McMahon – E-mail	5	
314.	Dr L Roberts-Thompson – E-mail	5	
315.	Dr L Venter – E-mail	5	
316.	Dr P McInerney – E-mail	5	
317.	Dr D Mildenhall – E-mail	5	
318.	Dr J Heinrich – E-mail	5	
319.	Dr C Muecke – E-mail	5	
320.	Dr R Kurtzer – E-mail	5	
321.	Dr J Pollard – E-mail	5	
322.	*****Dr C Leahy – E-mail	5	
323.	Foster Medical Centre – E-mail	5	
324.	Dr A De Gabriele – Portland Vic	5	
325.	*****Dr J Heinrich – E-mail ***re GPRA submission***	5	
326.	Dr P Botha – E-mail		
		Sub Total	**69**
	Duplicate submitters		**10**
		Grand Total	**326**

SUMMARY OF KEY ISSUES RAISED IN SUBMISSIONS
RECOGNITION OF
RURAL AND REMOTE MEDICINE AS A MEDICAL SPECIALTY

Submitter Numbers	Summary of Key Issue Comments	Notes
Positive support/comments from stakeholders		
15	Rural and remote medicine has a distinct knowledge and practice base and patients require higher quality care.	
2	Supportive of a subsidy for rural and remote practitioners	
7	ACRRM supports doctors in rural and remote Australia (ADVOCACY ROLE)	
1	Application meets assessment criteria	
18	Approval of specialty may promote recruitment and retention of doctors in rural and remote Australia and ACRRM needs a dedicated college to do this.	
3	More complexity requires additional remuneration this may attract more doctors to R & R Medicine.	
2	ACRRM provides environment of rural research	
6	Approval will provide streamlined VR pathway	
22	Rural and remote doctors treat a wide range of conditions, therefore require higher skill set	
3	The FACRRM equals FRACGP	
Positive support/comments from stakeholders:		
3	ACRRM offers a multidisciplinary approach to R & R medicine	
6	ACRRM promotes required standards of R & R health and provides educational support for Doctors needs.	
13	Recognition may overcome rural workforce shortages by enticing new graduates and by retaining existing doctors.	
11	Rural and remote doctors do more procedural works than city counterparts	
22	Broader range of skills required to work in R & R Australia with diverse and specialised demands.	
4	ACRRM curriculum supports R & R medicine as promotes standards of rural health in cost effective manner	
3	Training of urban GPs and R & R GPs must be different to reflect different skill set needed.	
1	RACGP fails to provide enough 'specialist' training for R & R GPs. ACRRM makes up for this.	
142	**Sub total (minus general comments)**	
79	Generally supportive	No detailed comment lodged.
221	**POSITIVE COMMENTS TOTAL.**	

SUMMARY OF KEY ISSUES RAISED IN SUBMISSIONS
FOR RECOGNITION OF
RURAL AND REMOTE MEDICINE AS A MEDICAL SPECIALTY

Submitter Numbers	Summary of Key Issue Comments	Notes
Negative support/comments from stakeholders:		
1	Application does not meet assessment criteria	
3	No separate specialty is required, viewed as a sub-set to GP	
1	Concerns expressed if separate specialty approved, other specialist Colleges may not commit to R & R health	
1	Application clearly describes General Practice	
1	Concerns at a geographic/location specific specialty	
1	Concerns at training numbers	
1	ACRRM has not provided formal guidelines for assessing equivalence of IMGs qualifications	
1	Concerns at the "grand-parenting" of FACRRMs	
1	Application demeaning to General Practice	
2	Current VR training provides for R & R doctors with skill set required for R & R medicine	
2	Concerns at safety outcomes – R & R doctors overreaching	
1	Approval may limit "non-specialists" to practice in R & R Australia	
1	Concerns at limiting OTDs to working in R & R Australia	
6	Application indicates no differentiation between R & R medicine and General Practice	
1	RACGP model reflects the need of Rural Practise.	
1	Recognition of R & R as a specialty will not address workforce issues.	
1	Establishment of FACRRM has potential to divide profession	
26	**Sub total (minus general comments)**	
6	Generally not supportive	No detailed comment lodged
32	**NEGATIVE COMMENTS TOTAL**	
168	**TOTAL DETAILED COMMENTS**	
257	**TOTAL OF ALL RECORDED COMMENTS**	

Rural and Remote Medicine Recognition Review Group

Overview of Site Visits

The Australian Medical Council Recognition of Medical Specialties Advisory Committee, Rural and Remote Medicine Recognition Review Group undertook site visits and stakeholder meetings in the course of its assessment of the application by the Australian College of Rural and Remote Medicine for recognition of Rural and Remote Medicine as a medical specialty. The site visits were to assist the review group develop its understanding of the application.

The sites visited are listed below:

- April 2005 - Site visits and stakeholder meetings in the Northern Territory (Darwin and Katherine) western Victoria (Koroit, Warrnambool and Camperdown), and central Victoria (Echuca, Bendigo and Gisborne)
- May 2005 – Stakeholder meetings in Brisbane and site visits in south east Queensland (Toowoomba, Warwick, and Beaudesert) and northern Queensland (Atherton), and central New South Wales (Scone, Muswellbrook and Newcastle) 25 May 2005 Meeting with GPET officials
- August 2005 - stakeholder meetings in Perth

The conduct of the visits:

The total program of site visits aimed to maximise input from the following groups and/or individuals:

- the local hospitals, in the area visited
- the local education and training providers (rural clinical schools, Divisions of General Practice, regional training providers)
- the community
- rural and remote medical practitioners.

The key issues explored in the visits were:

- how medical practitioners work in rural and remote areas, and the knowledge and skills that are required for practice
- how these skills and this knowledge influence patient safety and standards of care
- the interactions between rural and remote medicine practitioners and other medical and health practitioners,
- the training and experience that prepared the practitioners for rural and remote medicine
- practitioners' roles as supervisors of trainees
- continuing professional development, support and advocacy for rural and remote medical practitioners.

The key issued discussed during the visits

Generally, practitioners in the practice visits commenced with the history of the dissatisfaction with the RACGP in providing support for the doctor working in rural and remote Australia, leading to the formation of the RACGP Rural Faculty and eventually ACRRM.

All sites visited were concerned about the workforce shortages in rural and remote Australia. A flexible model to address workforce problems is sought.

Commonalties of information from site visits

1. Medical practice in rural and remote Australia

- the claimed **unsupported** nature of rural and remote practice (distance from tertiary hospitals, specialists etc)
- the complexity and severity of conditions encountered in rural and remote Australia
- statement that rural and remote doctors must deal with **uncertainty** (risk management approach) due to lack of tertiary and specialist support
- the view that "General practice is a **sub-set** of rural and remote medicine and not an add-on at the end of general practice training"
- general feeling (of local practitioners) of lack of recognition of the value and dedication that rural and remote practitioners contribute (by their self directed skill sets) to the rural and remote community health care delivery requirements (complexity and severity of conditions encountered)
- rural and remote medicine as a horizontal specialisation (some parallels were drawn with emergency medicine - although this focuses on the acute presentation of illnesses and is episodic hospital based care); and as cross specialty paradigm (elements of medicine, surgery, paediatrics etc)
- the overwhelming issue of **workforce shortage** in rural and remote Australia: a high percentage of people interviewed were more concerned with solving workforce problems (in rural and remote Australia) rather than the justification of the case for recognition of rural and remote medicine as a medical specialty. The focus was on the future of medicine in the bush "who will replace the current dedicated set of rural and remote doctors?" and "where are the locums coming from?"
- the view that the stoic country patient is rapidly changing; patients now seeking best possible care irrespective of location and expect to have those services provided locally.

2. There was a major emphasis on the need for appropriately trained practitioners for rural and remote Australia

- to meet community expectations of the delivery of health services, the rural and remote doctor is expected/required to practice in procedural areas (**restricted choice of practice** as compared to urban practice)
- training providers would adapt to teaching both ACRRM and RACGP curricula as required
- similarities were recognised between the training curricula from both Colleges and it was accepted that procedural training is undertaken in both the rural and urban contexts

- claims that ACRRM training pathway more engaged in rural and remote skills requirements and would if it became an approved specialty, more clearly define rural and remote medicine roles and lessen possible confusion for students/graduates when choosing career direction

- while many were confident that creation of a distinct specialty would positively influence recruitment and retention, a significant number, which included more junior doctors were concerned creation of a distinct specialty may have an adverse impact on recruitment and retention, due to the need to commit early and exclusively to practice in rural and remote areas and the questionable flexibility and portability of the qualification to work in all areas of Australia.

3. The review group noted practitioners providing high quality medical service but their training for rural and remote practice was very variable

- very favourable impression of the highly professional manner of medical services provided to local communities and dedication of rural and remote doctors, both in their clinics and the provision of services as VMOs at local hospitals

- a high level of appreciation among nursing, non-medical and Aboriginal health workers for the commitment, skills and attitudes of the doctors working in rural and remote health centres and hospitals. A high quality service was provided by the doctors in the units visited

- the rural and remote doctors providing procedural skills (e.g. obstetrics, anaesthetics, general surgery) had developed these skills through self organised Australian clinical rotations overseas or in the case of recent graduates, through the graduate diploma of the RACGP

- concerns expressed by practitioners at government policies in closing small community hospitals thus requiring patients to travel to large tertiary hospitals in urban areas

- possible confusion for student/graduates about which College program to choose

- limited response by RACGP to the needs/concerns of rural and remote doctors

- claims there is need for flexibility and portability (urban ↔ rural/remote) but rigidity and length of training may deter potential rural practitioners

4. The perceived role of ACRRM

- claims that ACRRM provides a strong and dedicated **advocate** for rural and remote doctors and communities in Australian

- claims some doctors see ACRRM as a **standards body** with provision of on-line education programs (RROMEO) assisting with the provision of appropriate professional and educational support and provides and **end-point** for rural and remote training

- some practitioners consider ACRRM a **solution to workforce** issues arguing for economic efficiencies created by up-skilling to meet community health needs, facilitating the development of procedural skills would equip the doctor to work in unsupported areas of medical practice.

Australian Medical Council Briefing on the Curriculum Mapping Project

TRAINING IN GENERAL PRACTICE AND TRAINING IN RURAL AND REMOTE MEDICINE

Background

The Australian Medical Council is assessing an application for recognition of a new medical specialty, rural and remote medicine. The AMC has a standard application process and core criteria against which applications for recognition are assessed. Applications are assessed by expert review groups, which report to the AMC's Recognition of Medical Specialties Advisory Committee, which in turn reports to the Council. The Council decides on its advice to the Minister for Health and Ageing on the case for recognition, and the Minister makes the decision on recognition.

The criteria which applications are assessed against are:

1. Recognition of the medical specialty will improve the safety of health care

2. Recognition of the area of medical practice as a specialty will or is likely to improve the standards of health care and that the data, where available, demonstrate better outcomes

3. Recognition of the medical specialty will result in health care that uses available resources wisely and/or that the community benefits justify the increased costs of health care.

The application for recognition lodged by the Australian College of Rural and Remote Medicine describes rural and remote medicine as a generalist specialty. Presently, the only recognised generalist specialty in Australia is general practice. The Guidelines for Recognition indicate that the arguments for recognising general practice as a specialty relate to the requirement for a specific training program of supervised general practice experience for unsupervised general practice, and the requirement for ongoing continuing professional development in general practice.

The key questions for the AMC rural and remote medicine recognition review group concerning training are:

1. Does the practice of rural and remote medicine require the possession of a defined body of knowledge, and specific clinical skills or specific aggregations of clinical skills or expertise?

2. Are the knowledge and skills sufficiently complex or extensive to require a comprehensive and complete training program? Is there a program of education, training and assessment that will develop the knowledge and skills necessary to practise safely and competently in the specialty?[123]

The ACRRM application states "Rural and remote medicine is a broad discipline that includes skills sets that overlap with many specialties including general practice. In these areas the specialist in rural and remote medicine must have a broader and deeper understanding of these areas as he/she will be required to deal with greater complexity in the management of the presenting conditions and with more professional isolation. There are also additional areas of practice that are not incorporated or considered integral to the skill set required for fellowship of general practice: procedural skills; hospital practice; population health; indigenous health; emergency medicine, and extended skills in areas such as psychiatry. The curricula for training in rural and remote medicine and general practice have been mapped and contain substantive difference in areas of content[124]."

[123] See section 3 of the Guidelines for Recognition, *Recognition of Medical Specialties and Sub-specialties.*
[124] ACRRM application for recognition, page 21

Advice sought by the AMC

In view of such claims, to assess the case for a generalist specialty of rural and remote medicine, the AMC is seeking an independent comparison of the training required for rural and remote medicine and that required for the recognised generalist specialty, general practice. This would entail comparison of education and training leading to Fellowship of the Royal Australian College of General Practitioners (RACGP) and the post-Fellowship one year Graduate Diploma in Rural General Practice and the training leading to Fellowship of ACRRM, addressing the differences between them in relation to:

- The educational objectives of training
- The content of training (as described in curriculum documentation and as assessed)
- The context of training (location, placements)
- The complexity of training (as described in curriculum documentation and as assessed).

Both the RACGP and ACRRM provide alternate pathways to Fellowship. The pathways that have educational content (development of learning plans etc) and a defined assessment process are the ACRRM experience-based pathway and the RACGP practice-based assessment pathway. The AMC is also seeking comparison of the content requirements and assessment requirements of these pathways.

Both the RACGP and ACRRM participate in a series of Joint Consultative Committees (JCC). These tripartite committees have representatives from the relevant specialist college, the RACGP (nominated by the National Rural Faculty) and the Australian College of Rural and Remote Medicine. The JCCs focus primarily on GP education and training, particularly in relation to the Advanced Rural Skills Posts[125]. JCCs set standards, identify the training and skills needs in areas of general practice special interest, advise on the content of the vocational training curriculum and continuing professional development activities, and are involved in the accreditation of Advanced Rural Skills Posts. There are detailed statements of the objectives and formative and summative assessment requirements of each post. The AMC is also seeking comparison of the requirements of the Advanced Rural Skills Posts endorsed/accredited by the RACGP and ACRRM.

The AMC is aware that the RACGP is planning to undertake a review of the RACGP curriculum in 2005 in consultation with key stakeholders. It is intended that the curriculum review will incorporate a reassessment of all the RACGP statements on the goals of education and training including the hospital and rural terms as well as action on the recommendations in the AMC Accreditation Report *Accreditation of Training Leading to Fellowship of the Royal Australian College of General Practitioners* in relation to the structure and duration and content of the RACGP curriculum. The AMC is seeking comparison of the ACRRM curriculum and the current RACGP curriculum.

Definitions of general practice and rural and remote medicine

The RACGP defines general practice as:

> General practice is part of the Australian health care system and operates predominantly through private medical practices, which provide universal unreferred access to whole person medical care for individuals, families and communities. General practice care means comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health[126].

[125] Both the ACRRM curriculum and the FRACGP Graduate Diploma in Rural General Practice include Advanced Rural Skills posts.
[126] Viewed RACGP website 29 November 2004

The RACGP defines a general practitioner as: "… a registered medical practitioner who is qualified and competent for general practice in Australia. A general practitioner:

- Has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care; and
- Maintains professional competence for general practice.[127]"

The ACRRM application for recognition of rural and remote medicine as a medical specialty argues that, like general practice, rural and remote medicine is principally a primary care specialty (although operating on a unique paradigm of primary, secondary and tertiary medical care), but that it is "more than" general practice, with knowledge, skills and attitudes that differ to a large extent in depth and complexity from the other major generalist specialty, **general practice**[128].

On page 14 of its application, ACRRM defines the specialty of rural and remote medicine as: 'The specialty that focuses on securing optimum patient and community health outcomes utilising a particular range and depth of knowledge, skills and attitudes not common to any other medical craft group to achieve the desired outcomes within the parameters of practice imposed by rural and remote environments.' The following features are also mentioned:

- A unique paradigm of primary, secondary and tertiary care, with increased individual responsibility owing to relative professional isolation, geographic isolation, limited resources and special cultural and sociological factors

- Ability to adapt and build skills in response to the health needs of a diverse range of rural and remote community settings

- Defining characteristics of specific content, context and consequent complexity of the discipline.

Outline of training for general practice and rural and remote medicine

Delivery of general practice training in Australia is the responsibility of General Practice Education and Training Limited (GPET), which is a company established by the Commonwealth. Attainment of the Fellowship of the RACGP (FRACGP) remains the end point of vocational training, the FRACGP remains the requirement for vocational registration under The Health Insurance Act, and general practice training is required to meet standards set by the RACGP.

General practice training

The Royal Australian College of General Practice has developed statements on the role of general practice and primary care in health care systems and on the characteristics of high quality general practice and general practitioners. This work and the documents describing general practice, predicate the goals and objectives and the curriculum for training.

The RACGP has a curriculum framework (www.racgp.org.au/folder.asp?id=709) based on patient presentations, national health priorities, curriculum statements relating to particular population groups, aspects of general practice or new issues of national significance, and the Five Domains of General Practice, which are:

- communication skills and the patient-doctor relationship;
- applied professional knowledge and skills;

[127] Viewed RACGP website 29 November 2004
[128] ACRRM application for recognition page 13.

- population health and the context of general practice;
- professional and ethical role;
- organisational and legal dimensions.

Learning objectives are specified for each Domain.

The RACGP is planning to undertake a review of the RACGP curriculum in 2005 in consultation with key stakeholders. The curriculum review will incorporate a reassessment of all the RACGP statements on the goals of education and training including the hospital and rural terms as well as action the AMC recommendations in relation to the structure and duration and content of the RACGP curriculum.

The key elements of general practice training are:

- one year of hospital-based training (or equivalent) subsequent to the intern year;

- six months of basic GP terms, including basic education release of one half-day session per week (or equivalent) and one session per week of one-to-one teaching by the practice GP supervisor;

- six months of advanced GP terms, including one half-day session per fortnight (or equivalent) of advanced education release and a half session per week of one-to-one teaching by the practice GP supervisor;

- one year of subsequent (mentored) GP experience, with the provision to spend up to six months of this year in special skills terms in clinical areas of particular relevance to general practice.

GP registrars may have the opportunity to undertake supplementary education activities such as education seminars for rural registrars to meet the specific needs of rural general practice.

The RACGP Vocational Training Standards and Requirements set out in detail the requirements for dedicated learning time, external educational activities, educational release, and requirements relating to breadth of clinical experience.

The RACGP also offers a Graduate Diploma in Rural General Practice (Grad Dip Rural). GP registrars or eligible general practitioners who wish to be awarded the FRACGP and the RACGP Grad Dip Rural need first to complete 12 months of rural posts for the FRACGP. They then complete a fourth year entailing 12 months in Advanced Rural Skills Posts and the relevant education requirements (720 hours) for the Graduate Diploma. Available posts include Aboriginal health, adult internal medicine, anaesthetics, emergency medicine, obstetrics, child and adolescent health, mental health and surgery. The College has produced detailed statements of the objectives and formative and summative assessment requirements of each post. Where possible, their curricula have been developed with, and approved by, Joint Consultative Committees.

Specified educational activities include: two mandatory modules: work in a rural general practice (150hr) and emergency medicine (50hrs) plus elective modules: Aboriginal health; Adolescent health; Aged care; Critical thinking and research; Is the child seriously ill; Practice management (520 hours collectively).

Other RACGP curriculum matters of note:

- In 2004, the RACGP reported that it had commenced the establishment of an Advanced Skills Training Initiative (ASTI) to provide more opportunities for registrars and general practitioners to train in procedural skills. The ASTI has representation from the National RACGP Rural Faculty and the General Practice Registrar Association. Collaboration with the Australian College of Rural and Remote Medicine (ACRRM) is anticipated and funding has been sought for the ASTI.

The RACGP and ACRRM have established a joint committee on continuing professional development and education and training policy for rural general practice.

Rural and remote medicine training

ACRRM states that it aims to support and train doctors who are safe, independent and confident generalist practitioners capable of working anywhere in Australia, including the diverse range of rural and remote settings. Seven domains have been identified for categorising the ACRRM vocational preparation program:

- Core clinical knowledge and skills
- Advanced clinical knowledge and skills
- Emergency care
- Population health
- Aboriginal and Torres Strait Islander health
- Professional and ethical practice
- Rural and remote context.

The curriculum document is available at www.acrrm.org.au/main.asp?NodeID=3665

The Vocational preparation pathway entails 48 months of vocational training in practices and posts approved by ACRRM.

- 12 months rotating clinical training in a hospital must include a paediatrics term;

- 12 months core rural and remote medical training, may include up to 6 months approved hospital or community based experience;

- 12 months specialty advanced rural and remote medical training may include up to 6 months approved hospital, Aboriginal medical service or community based experience;

- 12 months specialty rural skills training may include but is not limited to accredited Advanced Rural Skills Posts in Aboriginal health, adult internal medicine, anaesthetics, emergency medicine, obstetrics, psychiatry, population health, radiology/ultrasonography, ophthalmology and surgery or up to 6 months approved elective training. (Not clear if these ARSPs are the same as the RACGP ARSPs?)

Other training pathways include:

- The pilot remote vocational training stream. This is tailored to doctors already practicing in remote communities. It is a joint ACRRM/RACGP initiative.

- The independent pathway. Provides an opportunity for flexible training for experienced doctors and specialists who work in rural and remote Australia.

The Assessment Program

RURAL AND REMOTE MEDICINE
SUMMARY OF SITE VISITS

VICTORIA SITE VISITED	NOTES ON THE PRACTICE
Dr Brendan Kay The Jamieson St Medical Practice WARRNAMBOOL. And at Koroit Hospital, High St KORIOT	Number of ACRRM fellows in practice – 4 Warrnambool RRMA 4 Koroit RRMA 5 Provides GP training - Yes GP training provider: Greater Green Triangle GP Education and Training ***Who suggested this site – RACGP National Rural Faculty***
Dr Peter O'Brien Director of Medical Services South West Health Care Warnnambool Campus (Hospital)	Number of ACRRM fellows in practice – 4 Warrnambool RRMA 4 Provides GP training GP training provider: Greater Green Triangle GP Education and Training ***Who suggested this site – AMC***
Dr Eldon Lyon The Camperdown Clinic 56 Scott Street Camperdown Robinson St Medical Centre Dr John Menzies Dr Menzies has been requested to attend the Camperdown Clinic to save on two separate meetings	Number of ACRRM fellows in practice – 2 Provides GP training - Yes GP training provider: Greater Green Triangle GP Education and Training Camperdown RRMA 5 The Robinson Street Medical Centre is located on the campus of the Camperdown Hospital. Number of ACRRM fellows in practice – not known Provides GP training – no current registrar GP training provider: Greater Green Triangle GP Education and Training ***Who suggested these sites – ACRRM***

VICTORIA SITE VISITED	NOTES ON THE PRACTICE
Dr Peter Nesbitt Nish Street Medical Practice Nish Street ECHUCA	Number of ACRRM fellows in practice – 1 RRMA 4 Provides GP training – Yes 2 registrars GP training provider: Victoria Felix Medical Education Ltd ***Who suggested this site – AMC*** ACRRM accredited training site The Nish St. practice also provides medical services for the town of Moama in NSW, north of Echuca
Dr John Quayle Rich River Health Group 214 Ogilvie Ave ECHUCA	Number of ACRRM fellows in practice – 2 RRMA 4 Provides GP training - Yes GP training provider: Victoria Felix Medical Education Ltd ***Who suggested this site - AMC***
Eucha hospital ECHUCA	Victoria Felix can negotiate for a training place in this hospital. Review Group visited this facility in connection with the Nish St Practice
Dr John Togno Dr Tali Barrett Victoria Felix Medical Education 106 Wattle Street BENDIGO	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training: N/A GP training provider: N/A ***Who suggested this site – AMC***. RRG wished to speak to a training provider for view point on the application.
Prof Gordon Whyte Monash School of Rural Health 106 Wattle Street BENDIGO	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training GP training provider ***Who suggested this site – AMC*** RRG wished to discuss the application with a Rural School of Health.

VICTORIA SITE VISITED	NOTES ON THE PRACTICE
Dr Richard Bills Brooks St Medical Practice Brooks St Street WOODEND And The Central Highlands Division of General Practice 33 Brantome St GISBORNE Dr Bills is the Executive Officer	Number of ACRRM fellows in practice – 1 RRMA – 5 Provides GP training – Yes 3 registrars GP training provider: Victoria Felix Medical Education Ltd ***Who suggested this site – AMC*** The Division is located immediately to the North of greater Melbourne and, while it is mostly rural, contains an increasing proportion of 'urban fringe' areas. The Division contains a number of sizeable towns but no major regional centres. The largest hospital is located at Kyneton but most of the population would access Melbourne for tertiary care needs and a substantial proportion access accident and emergency services at Northern Health, Western Health and Royal Melbourne Hospital

NOTHERN TERRITORY SITES VISITED	NOTES ON THE PRACTICE
Dr Doug Lloyd Executive Director Northern Territory General Practice Education Ltd Charles Darwin University Building 39 Level 3 Ellengowie Drive Casurina NT	Number of ACRRM fellows in practice: N/A RRMA – N/A Provides GP training N/A GP training provider – N/A ***Who suggested this site - AMC***
Dr Tony Watson Medical Director Katherine District Hospital Gorge Road Katherine	Number of ACRRM fellows in practice - 2 RRMA 5 Provides GP training: N/A GP training provider: N/A ***Who suggested this site - ACRRM***
Mr John Paterson Director Wirli Wurlinjang Health Service 25 Third Avenue Katherine	Number of ACRRM fellows in practice - 0 RRMA 5 Provides GP training - yes GP training provider: Northern Territory General Practice Education Limited ***Who suggested this site - ACRRM***
Dr Jim Scattini Kintor Clinic Katherine	Number of ACRRM fellows in practice - 1 RRMA Provides GP training - yes GP training provider: Northern Territory General Practice Education Limited ***Who suggested this site - AMC***

NEW SOUTH WALES SITES VISITED	NOTES ON THE PRACTICE
Dr Richard Abbott (VMO) Ms Diane Lewis Hospital CEO Scott Memorial Hospital Stafford Street Scone Dr Richard Abbott Scone Medical Centre Surman Ave Scone	Number of ACRRM fellows in practice - 2 RRMA 5 Provides GP training - yes GP training provider: General Practice Training - Valley to Coast ***Who suggested this site - ACRRM***
Dr Mark Rikard-Bell Brook Medical Centre 64 Brook Street Muswellbrook	Number of ACRRM fellows in practice – 1+ RRMA 4 Provides GP training : Yes GP training provider: General Practice Training - Valley to Coast ***Who suggested this site - ACRRM***
Dr Kevin Sweeney (CEO) Dr Cathy Regan (Dir of Ed) General Practice - Training Valley to Coast Cnr Gavey & Firth Streets Mayfield Dr Kevin Mychael (Chair) Ms Caddie Marshall (CEO) Hunter Rural Division of GP Dr Ian Cameron (CEO) Dr Paul Collett Rural Doctors Network	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training N/A GP training provider – N/A ***Who suggested this site - AMC***

QUEENSLAND SITES VISITED	NOTES ON THE PRACTICE
Associate Professor Peter Baker Head of Region University of Queensland Rural Clinical School Level 1, Cossart House Toowoomba Hospital Pechey Street Toowoomba	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training – N/A GP training provider – N/A ***Who suggested this site - AMC***
Dr Peter Bristow Executive Director Medical Services Toowoomba Hospital	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training - Yes GP training provider – N/A ***Who suggested this site - AMC***
Dr Andrew Reedy (Chair) Ms Jennifer Willet (CEO) Rural and Regional Qld Consortium 213A Ruthven Street Toowoomba	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training – N/A GP training provider - Yes ***Who suggested this site - AMC***
Dr Lynton Hudson Dr Kiss Dr Hetherington Condamine Medical Centre & Warwick Medical Centre Combined meeting at 53 Wood Street Warwick	Number of ACRRM fellows in practice – 2 RRMA – 4 Provides GP training - Yes GP training provider – Rural and Regional Qld Consortium ***Who suggested this site - AMC***
Dr Chris Tracey-Patte Beaudesert Medical Centre 35A William Street Beaudesert	Number of ACRRM fellows in practice – RRMA – 5 Provides GP training - Yes GP training provider - Rural and Regional Qld Consortium ***Who suggested this site - AMC***

QUEENSLAND SITES VISITED	NOTES ON THE PRACTICE
Dr Neil Beaton (Med Superintendent) Atherton Hospital A teleconference with the following Rural and Remote practitioners was held to facilitate a wide as possible coverage of views. Janes Cook University • Professor Ian Wronksi Mt Isa Centre for Rural and Remote Health • Dr Denis Pashen • Dr Louis Peachy Mt Isa Base Hospital • Dr Gordon De Cean • Dr Peiter Nell RFDS Mt Isa & Cairns • Drs Carty & Chaulkey Far North Qld GPs • Dr Grant Manypenny - Mareeba • Dr Brian Connor – Charters Towers • Dr Kevin Zischke – Charters Towers • Dr Shaun Grimes - Proserpine • Dr John Douyere - Longreach Mt Isa Council Representative • Ms Helen Davis	Number of ACRRM fellows in practice – many Atherton - RRMA 5 Provides GP training - yes GP training provider – Tropical Medical Training ***Who suggested this site - ACRRM*** Mareeba – RRMA 6 Charters Towers – RRMA 5 Proserpine – RRMA 5 Longreach – RRMA 7

WESTERN AUSTRALIA SITES VISITED	NOTES ON THE PRACTICE
Dr Brian Lloyd Chief Medical Officer Western Australia Department of Health Dr Andy Robertson Dr Tim Lahey Dr Christine O'Farrell	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training N/A GP training provider – N/A ***Who suggested this site - AMC***
Mr John Nichols Manager Dr Denise Finlay Medical Educator WA General Practice Education and Training (WAGPET)	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training -Yes GP training provider – N/A ***Who suggested this site - AMC***
Dr Felicity Jeffries Director West Australian Centre for Remote and Rural Medicine (WACRRM) Dr Parbodh Gogna Deputy Director	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training N/A GP training provider – N/A ***Who suggested this site - AMC***
Ms Maxine Drake Health Consumers Council of WA	Number of ACRRM fellows in practice – N/A RRMA – N/A Provides GP training N/A GP training provider – N/A ***Who suggested this site - AMC***

Advice to the Australian Medical Council: Curriculum Mapping Project

TRAINING CURRICULA FOR RURAL GENERAL PRACTICE AND RURAL AND REMOTE MEDICINE IN AUSTRALIA

A comparison of programs offered by the

Royal Australian College of General Practitioners (RACGP) and the

Australian College of Rural and Remote Medicine (ACRRM)

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Report prepared for the Australian Medical Council

May 2005

EXECUTIVE SUMMARY

This report was commissioned by the Australian Medical Council (AMC) to provide an independent comparison of postgraduate training leading to the Fellowship of the Royal College of General Practitioners (FRACGP) and the Graduate Diploma in Rural Practice and training leading to the award of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM).

The differences were to be assessed in relation to the:

- objectives of training;
- context of training;
- content of training;
- complexity of training.

The review was informed by a model of curriculum developed by Michael Eraut and the *Enhanced Rural Training Framework* produced by General Practice Education and Training Australia (GPET) and was restricted to an investigation of the curriculum as stated in the relevant documentation provided by the Council.

Both the RACGP and ACRRM programs use a structure of defining aims followed by more specific objectives. The aims are highly contextual and relate to the context in which the Colleges define practice. The RACGP uses a conceptual approach based on a view of comprehensive care and unrefereed practice. The ACRRM program emphasises the essential and unique body of knowledge and skills claimed to be necessary for rural and remote practice.

Five domains of general practice are integrated across the RACGP program. The ACRRM program has seven domains which mark the essential characteristics of rural and remote practice. Content in the RACGP curriculum is organised into 12 priority learning areas, often with generic titles. There are eight curriculum statements in the Graduate Diploma course. There are 22 curriculum statements in the ACRRM program with a greater emphasis on disciplinary-focused statements.

The level of specification of content varies between the programs. The RACGP Training Program is driven by objectives set across the five domains and a set of 87 content topics. The ACRRM curriculum statements are specified in more detail with objectives and linked skills and abilities. The Graduate Diploma in Rural General Practice offered by the RACGP uses a similar format to the ACRRM approach.

The complexity of the programs was assessed in terms of time for completion, teaching and learning methods and assessment. Four years are required both for the FRACGP with Graduate Diploma route and the FACRRM route. The latter requires two years in rural and remote practice in addition to advanced skills while the former requires only one.

Both programs use experiential teaching and learning methods appropriate for postgraduate education. There is perhaps some more flexibility in the ACRRM program but given that curriculum delivery is the responsibility of Regional Training Providers (RTPs) it was not possible to examine this in great detail.

The RACGP has a well known and credible examination process. The examination is carefully blueprinted to the curriculum and appropriate tools selected. The ACRRM approach is still emerging and the College aspires to a different form of assessment using some of the approaches for assessing

specialist knowledge and skills. In both programs the Advanced Rural Skills component taken in the fourth year is assessed experientially.

In summary while, as expected, there is much common ground and overlap in the two approaches they do derive from different fundamental premises which relate, as indicated previously, to the different views of practice.

The differences are most apparent in the specification of content where the ACRRM program, and to a certain extent, the RACGP Graduate Diploma program use a more discipline-based and detailed approach. The Enhanced Rural Training Framework sets out three levels of *Knowledge and Skills for Rural General Practice and/or Rural and Remote Medicine*. It is the second Level (B) that demonstrates the major differences between the programs. Here the ACRRM approach involves studies across more disciplines and a more detailed exposition of knowledge and skills.

The Enhanced Rural Training Framework is a positive development. It does provide clear pathways for registrars and guidelines for trainers and there is evidence of flexibility. Above all it points to the possibility of choice between the two approaches to preparation for rural general practice or rural and remote practice which can be handled within the RTPs of GPET.

1 INTRODUCTION

This report was commissioned by the Australian Medical Council (AMC) to provide:

An independent comparison of the training leading to Fellowship of the Royal Australian College of General Practitioners (RACGP) and the post-Fellowship one year Graduate Diploma in Rural General Practice and the training leading to Fellowship of the Australian College of Rural and Remote Medicine (ACRRM).

The differences were to be assessed in relation to:

- The educational objectives of training;
- The context of training;
- The content of training;
- The complexity of training.

In compiling this report the first two issues have been combined. In the documentation on the programs provided by the Council these two issues are frequently interlinked. For example, ACRRM's position is that, to a very great extent, the educational objectives of training are derived from the rural and remote context as much as from any unique epistemology of clinical practice. It has been very difficult to separate these features out and make comments on each and hence they have been treated as part of the same issue. The content of training has been taken to include the framework and organisation of the curricula and statements of content. Complexity has covered the training arrangements, teaching and learning methods and assessment programs.

2. METHODS OF ANALYSIS

2.1 Background

There are very few explicit guidelines about what constitutes an appropriate scope of practice for medical disciplines. Indeed the scope of practice for health care professions such as nursing and physiotherapy, and so-called complementary professions such as chiropractic and osteopathy, as compared to medicine, are a matter of active and vigorous debate. Until recently, even at an international level the medical profession has not felt it necessary to define the scope of its practice. This dilemma has been recognised by the working group on Adult Internal Medicine of ACRRM. Other recent attempts to define the scope of practice[1,2] have been predominantly about broad attributes of exemplary practitioners, the values they should espouse and the behaviours they should exhibit. This lack of precise definition has led to apparent anomalies in some countries where, for example, physicians and radiologists carry out procedures that involve some degree of surgical invasion of patients.

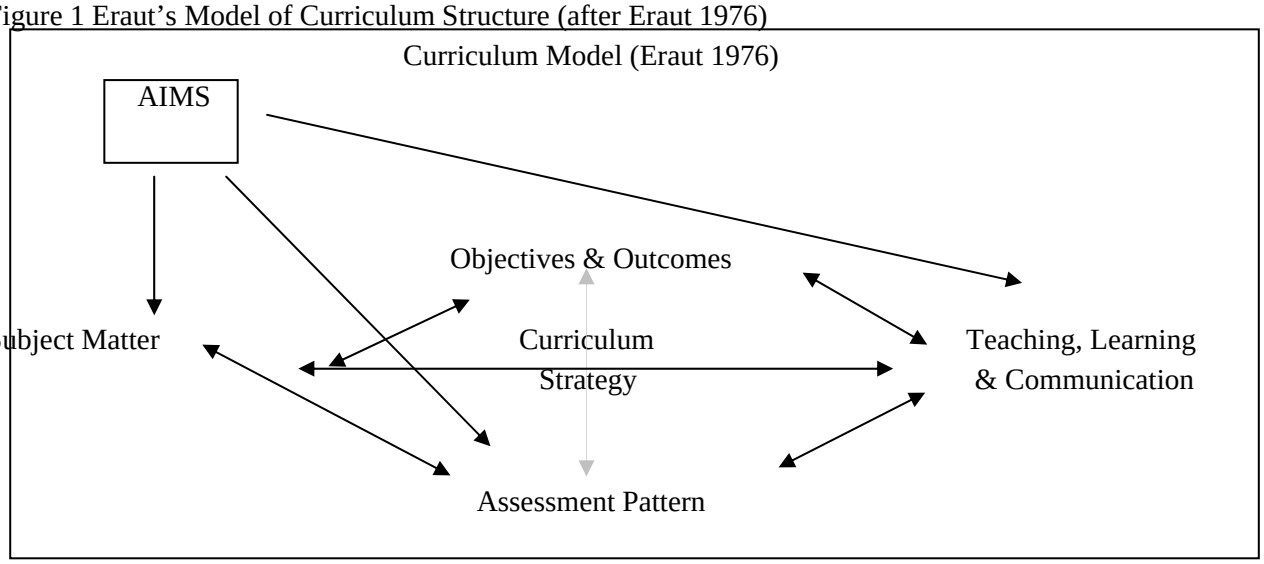
Hence, at post-registration level, there is very little capacity to compare new curricula against explicit standards for content, process and methods. Furthermore curricula are recognised as dynamic entities. They are no longer, nor should be syllabus-bound. Emphasis on instructional design in health care professions has meant that most training institutions pay considerable attention to creating symbiotic

and consistent relationships between the overall aims of the curriculum, the content, teaching methods and assessments.
One way to deal with this issue is to independently compare 'new' curricula with well established ones, and that seems the most appropriate way forward in the current application.

2.2 A model for analysis

The authors sought a structure for the comparison that has some educational credibility. One such framework is that derived by Eraut[3] and first described in 1976. It has been widely used in professional education and has also been used, for example, to compare different curricula in teacher education in developing countries[4]. It is based on two main ideas. First, the notion that a well developed curriculum strategy must involve consistency among aims, objectives, content, pedagogy and assessment patterns (see Figure 1).

Figure 1 Eraut's Model of Curriculum Structure (after Eraut 1976)



In this model the aims, or general strategic directions, for the curriculum and its trainees, infuse and steer one or more aspects of its delivery. Second, these aims are usually derived within an individualised clinical, social and educational context. Such contexts vary. Some disciplines share more than others. For example surgery and psychiatry are conducted in very different contexts. This idea is also reflected in the writings of other curriculum theorists such as Skilbeck[5] and, indeed, ACRRM has used Skilbeck's work as a platform for developing its own curriculum. As a consequence, professional education and development programs need to be analysed and comprehended within their contexts. Context can render some aspects of the curriculum model more salient than others. Dominant factors in these contexts include systems for guiding the programs, the quality of entrants, the types of practice for which the accredited practitioners are destined, and the historical and cultural matrix in which the whole process is embedded. Another constraint is that, as curricula are dynamic entities, the curriculum 'as delivered' may be different from the curriculum 'as intended'[6]. Unfortunately the assessment of many of these attributes, those that govern the 'curriculum as delivered' for example are beyond the scope of this project and hence it must remain at the level of analysis of documentation only.

Nevertheless, as a minimum requirement to act as a basis for any educational action, and to achieve consistency of delivery of a curriculum across different locations, curriculum documentation needs to be explicit, clear and capable of being implemented. As Stenhouse[6] put it, curricula cannot be described as being 'right', only as being 'intelligent'. This intelligence is manifested through curriculum documentation. In the present analysis, the main source has been documents and web site material.

However no matter how coherent, lucid and alike two sets of curricula might be, context might operate to render one or other insufficient for their purpose (the curriculum as delivered). For example, a number of questions arise at AMC visits to undergraduate schools that relate to the provision of appropriate clinical experience to afford an adequate skills base for students.

There is also a cogent argument about professional knowledge that suggests that much of it is socially constructed or derived. For example much professional expertise involves so-called 'tacit' or 'craft' knowledge[7,8]. This is knowledge that is derived from contextual experience and work as commonly done in clinical practice; bedside manner, for example. It is not always embedded in textbooks or journals but is nevertheless widely regarded as valid and useful. Examination of the patient, for example, is a method that has evolved substantially from clinical practice, as well as from scientific endeavour.

Despite these complexities the analysis has proceeded according to Eraut's model and the scope of the review provided by the AMC. While there is some ongoing comment on the differences between the two curricula in the text of the report the final concluding section provides an overall summary and outline of the major differences.

2.3 Documentation for the review

The inaugural brief from the AMC calls for a comparison of the Fellowship of the Australian College of General Practitioners (FRACGP) and the post-Fellowship one year Graduate Diploma in Rural General Practice with the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM). The FRACGP is normally of three years duration and prepares Fellows for work in general practice anywhere in Australia. However, as is indicated in this report, there is a recognition that additional skills and abilities are required for rural general practice which requires a further year of training. The FACRRM, which normally takes four years prepares Fellows for independent rural and remote practice anywhere in Australia. Thus it is important to keep the four years of the FRACP and Graduate Diploma and the four year FACRRM as the units of analysis.

Extensive documentation was provided by the AMC. Table I sets out the major documents consulted.
Table 1 Documents consulted in the review

RACGP	ACRRM
The RACGP Training Program Curriculum 1999 RACGP Training Program, Advanced Rural Skills Curriculum 1997 RACGP Graduate Diploma in Rural General Practice, Curriculum Guidelines 2002 Curriculum of the Royal Australian College of General Practitioners and the RACGP Graduate Diploma in Rural General Practice – The College Examination 2005 – Standards for General Practice Education and Training – Anaesthetics – Obstetrics – Practice Based Assessment – GP Supervisors' Manual – ECT Manual	ACRRM Primary Curriculum 2002 Vocational Preparation Handbook for Fellowship of the Australian College of Rural and Remote Medicine 2004 Provisional ACRRM Advanced Surgical Curriculum 2004 An Assessment Program for the Award of Fellowship of the Australian College of Rural and Remote Medicine ACRRM Prospectus 1997

In Australia neither the RACGP nor ACRRM are responsible for the delivery of general practice training. This is undertaken by Regional Training Providers (RTPs) through General Practice Education and Training Ltd (GPET). Recently GPET together with ACRRM and the RACGP have published an Enhanced Rural Training Framework 2004 document[9]. This document restates the view that rural and remote general practice requires additional knowledge and skills than that required for FRAGP. It provides a framework for preparation for rural and remote practice that brings together the RACGP and ACRRM approaches. In doing so it defines three levels of requirements.

- Level A, Core knowledge and skills for rural and remote practice and/or rural and remote medicine;
- Level B, Knowledge and skills for rural general practice and/or rural and remote medicine;
- Level C, Knowledge and skills for advanced rural general practice and/or rural and remote medicine.

Level A equates with hospital terms, Level B with core knowledge and skills to be gained in rural and remote contexts and Level C with advanced knowledge and skills that can be gained in rural, regional or metropolitan contexts. These three levels inform the final section of this report where the major similarities and differences between the two approaches are explained.

3. THE CONTEXT AND OBJECTIVES OF TRAINING

3.1 Introduction

Both the RACGP and ACRRM use a traditional approach of more broadly stated aims followed by more specific objectives. ACRRM also uses statements of outcomes in its individual curriculum statements but it does not constitute a full outcomes-based approach as is advocated in some of the contemporary medical education literature.[10] The statements of aims and objectives serve two functions. The aims, in particular, are focused on the overall intentions and directions of the programs and provide the contextual background for training. The objectives make specific what the trainees are expected to achieve.

3.2 RACGP

3.2.1 The context, the nature of general practice and rural general practice

In the most recent iteration of the RACGP definitions general practice is defined as:

> … part of the Australian health care system and operates predominantly through private medical practices, which provide universal unrefereed access to whole person medical care for individuals, families and communities. General practice care means comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health.[2]

A general practitioner is defined as

> A general practitioner is a registered medical practitioner who is qualified and competent for general practice in Australia. A general practitioner has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care; and maintains professional competence for general practice.
>
> [www.racgp.org.au/document.asp?id=6234]

By not using any qualifying statements, these definitions implicitly include all geographic and social dimensions of Australian practice. They also highlight the importance of 'comprehensive' care; implying that all specialty expertise could, if necessary, be accessed through initial contact with a general practitioner. They also avoid mention of the words 'primary care' and 'family practice', although substituting 'unrefereed', that are common in definitions of general practice in other countries and in the literature underpinning this specialty.

There is further elaboration of these statements in the curriculum statements on the Conceptual Basis of General Practice in the RACGP Training Curriculum Document. The purpose, in part, is to 'provide registrars with a coherent framework of philosophies, concepts, principles and reflective practice which describes the nature of general practice' (RACGP Training Curriculum 1999 pp 24-28).

As indicated previously, the RACGP has instituted additional professional qualifications for rural general practice and advanced rural skills that can be incorporated into a rurally focused training stream. In these the RACGP recognises that:

> There is a growing body of evidence to suggest that general practice in rural and remote communities has special characteristics which differentiate it from general practice in other contexts … Rural GPs … are more likely to be the sole source of medical advice for communities … tend to undertake a broader range of minor procedures (and) are more likely to be involved in providing emergency medical treatment …(Graduate Diploma in Rural General Practice 2002 p 4)

Furthermore the College maintains that:

> The Grad Dip Rural is based on a definition of Rural General Practice as a distinct field of practice within the discipline of general practice as a whole. (Graduate Diploma in Rural General Practice 2002 p 5).

These fields are also defined in functional rather than geographic terms.

> Rural practice is medical practice outside urban areas which requires some general practitioners to have … procedural and other skills not usually needed in urban practice.
> Remote rural practice is … practice in communities over 80 km or 1 hour by road from a centre (with specific specialist facilities). (RACGP Advanced Rural Skills Curriculum 1997 p ii)

3.2.2 The aims and objectives of the RACGP programs

In line with the above definitions, the RACGP basic vocational program aims to produce graduates who have the knowledge, skills and orientation necessary to:

- undertake competent, unsupervised general practice;
- meet their community's (sic) health care needs;
- support the current and future goals of the Australian health care system. (The RACGP Training Program Curriculum p 6)

Embedded within the training standards is also the statement that:

> The program must have a stated goal to train GPs who are competent for unsupervised general practice anywhere in Australia. (General Practice Education and Training, Programs and Providers p 2).

The aims are translated into trainee expectations through a set of learning objectives. The purpose is to:

> Describe the breadth and depth of the knowledge, skills and attitudes required for competent, unsupervised general practice. (RACGP Training Curriculum 1999 p 15)

Learning objectives are organised according to five domains of general practice which are discussed in more detail in the next section. The objectives are stated at two levels. The first level contains common learning objectives which relate to all patients and define 'minimum and essential knowledge and skills'. The second contains specific learning objectives which are included in individual curriculum statements. They relate to specific population groups or 'aspects of general practice'.

Again in the Graduate Diploma a set of learning objectives has been defined for the whole program according to the five domains. These are written in more specific terms than those of the Training Curriculum. Objectives in the individual curriculum statements are not organised by domains.

3.3 ACRRM

3.3.1 The context, the nature of rural and remote medicine

ACRRM concentrates on defining rural and remote practice per se while acknowledging that the purveyors of such practice should be generalists. Rural and remote practice is defined as:

> … a separate specialty based upon a unique model of practice. It is embodied in the concept of an 'extended generalist' doctor … and … encompasses an unique range of clinical roles and responsibilities (ACRRM Primary Curriculum 2002 Section 1, p 1)

The defining characteristics of rural practice include 'professional isolation and independence' remoteness from specialists and unique patterns both of health and of demographic features. ACRRM defines this constellation of professional expertise as a 'unique combination of knowledge and skills' but acknowledge that the skills themselves are all essentially drawn from other disciplines. However, it is the way that these skills:

> are practised within a defined set of professional values that marks rural and (remote) medical practice. (ACRRM Primary Curriculum 2002, Section 1 p 1)

These values centre on claims that there is an international scientific literature that defines rural and remote medicine as a distinct area of academic endeavour, and there is a need to pursue the mainstreaming of these issues across policy, education, training and research.

3.3.2 The aims and objectives of the ACRRM program

The values are elaborated through a series of principles for the curriculum and the educational framework underlying it. The distinguishing features of this framework are the need for:

- experiential learning in rural and remote contexts;
- developing independence in trainees' decision-making as a consequence of the rural and remote context;
- the involvement of rural and remote practitioners in those processes.

(ACRRM Primary Curriculum 2002, Section 1 p 2).

The elaboration of these values suggests that ACRRM is claiming to frame the curriculum around its concept of 'a separate discipline based upon a unique mode of practice'. At the same time it maintains that the clinical skills and disciplines frameworks are extracted from many disciplines which may imply that there is no such distinctiveness. Though not explicitly stated, the distinctiveness is likely to be found in the application of the 'knowledge, skills, behaviours and values' in particular rural and remote context[5] (ACRRM Primary Curriculum 2002, Section 1, p 2).

Nevertheless the distinctiveness of the discipline does not seem to be reflected in the specification of the main aims of the Primary Curriculum that is to 'produce graduates' (sic) who;

> can function as safe and independent doctors across a range of rural and remote settings in Australia [and] are prepared to begin advanced studies in selected subject areas which are relevant to the practice of remote and rural medicine in Australia.

(ACRRM Primary Curriculum 2002, Section 3, p 1).

The distinctiveness is more in evidence in the general objectives of the Primary Curriculum. They are couched in the language commonly used to describe the end points of curricula. However they stress a number of additional features, the comprehensiveness of practice, the extended nature of general practice, the isolation of such practice, the distinctiveness of rural communities, and an emphasis on personal and professional qualities. These cover some specific areas of practice not generally regarded as 'general' practice for example, transport, evacuation, retrieval and disaster management, which are frequently part of the training of emergency physicians, and secondary and tertiary care (ACRRM Primary Curricula 2002, Section 3 p 1).

There is further specification of the objectives in each of the 22 curriculum statements, first with a set of outcomes for each statement. The statements are then arranged into general instructional objectives and required skills and abilities. There is further elaboration of this in the next section. There is no attempt to use a domain structure nor highlight any particular aspects of the objectives. For example objectives classified as secondary and tertiary care or as extended practice are not identified as such in the text. Rather they are woven into the matrix of the topics.

4. THE CONTENT OF TRAINING

4.1 Overall Structure

While there are similarities in the major curriculum documents of the two Colleges, quite different approaches have been adopted to the organisation and articulation of curriculum content. The RACGP's overall curriculum is based upon a framework related to:

- what GP's need to know ('the domains of general practice');
- why most people seek the services of a GP ('common patient presentations');
- the health needs and priorities of Australia's population ('national health priorities').

(The RACGP Training Program Curriculum p 11)

The resultant curriculum is organised according to five domains of general practice and 12 curriculum statements or priority learning areas. Each of these is underpinned by a clear set of learning objectives across the five domains.

The ACRRM Primary Curriculum has a theoretical basis in Skilbeck's[5] 'situational model' which proceeds from an analysis of the situation or context in which the curriculum operates. As indicated previously, the principles and educational framework of the curriculum emphasise 'experiential learning in rural and remote settings' and a body of 'essential, knowledge, skills, behaviours and values which is unique to rural and remote practice'.

(The ACRRM Primary Curriculum p 2).

The curriculum is marked by seven domains and 22 curriculum statements each organised by general instructional objectives and required skills and abilities in a detailed approach to specifying content. The RACGP Advanced Rural Skills curriculum represents something of a hybrid of the two approaches utilising the five domains of general practice and learning objectives but with half of the eight curriculum statements using a two fold listing of conditions with associated clinical and other skills or a variant thereof in a manner broadly similar to the ACRRM statements.

4.2 Domains

Table 1 sets out the domains of the two curricula.

Table 1 Domains of learning in the RACGP Training Program and ACRRM Primary Curricula

RACGP Domains	ACRRM Domains
Communication skills and the patient-doctor relationship	Core clinical skills
Applied professional knowledge and skills	Extended clinical practice
Population health and the context of general practice	Population health
Professional and ethical role	Professional and ethical practice
Organisation and legal role	
	Aboriginal health
	Emergency care
	Rural and remote context

There are some immediate and obvious similarities between the sets of domains. Both contain a Population Health and Professional and Ethical domain. There is a match between the RACGP Communication Skills and Patient-Doctor Relationship and the ACRRM Core Clinical Skills domains. The Applied Professional Knowledge and Skills (RACGP) and Extended Clinical Practice (ACRRM) domains both define the core practices of the respective curricula.

There are also important differences. There is no equivalent of the RACGP Organisational and Legal Role domain in the ACRRM Curriculum. There are three ACRRM domains not represented in the RACGP Curriculum; Aboriginal Health, Emergency Care and Rural and Remote Context.

The domains do have different functions in the overall curriculum approaches. In the RACGP curriculum they have an integrating function. The learning objectives in the 12 priority learning areas are organised by domains with all five represented in all but a few statements. In the ACRRM curriculum only the Professional and Ethical Practice domain is explicitly represented across all 22 curriculum statements. Most of the content in the 22 ACRRM statements falls within the Core Clinical Skills and Extended Clinical Practice domains but it is not explicitly identified as such.

The ACRRM Aboriginal Health, Population Health and Emergency Care domains are represented as separate curriculum statements. The final ACRRM domain, Rural and Remote Practice, has a different purpose. It signifies ACRRM's claim that rural and remote practice requires greater responsiveness to the milieu in which it is undertaken than other forms of medical practice. This is justified, as indicated previously, by reference to the need for greater independence in practice, responsiveness to community needs, the requirement for rural and remote doctors to live and work in the communities they serve and limited patient choice which requires matching knowledge and skills with need. (The ACRRM Primary Curriculum 2002, Section 1 pp 3-4)

The RACGP domains do achieve the clear purpose of integrating content across the curriculum. This is explicitly the case for one of the ACRRM domains but only implicitly so for two others. It would appear that the prime function of the domains in the ACRRM curriculum is to define the essential dimensions of the body of knowledge, skills, values and attitudes that comprise rural and remote practice. They can then be represented in the curriculum through integration or as discrete curriculum statements but all must be implemented within a pervasive rural and remote context.

4.3 Curriculum Statements

As indicated previously, there are 12 curriculum statements or priority learning areas for the RACGP Curriculum with 22 such statements for the ACRRM Curriculum. The RACGP's Advanced Rural Skills Curriculum contains another eight statements. The RACGP curriculum has divided the Curriculum Statements into two main groups:

- Principles and methods of general practice;
- Population groups.

The latter is further subdivided into:

- Acute and chronic presentations;
- Age;
- Gender;
- Groups with special needs.

In order to facilitate comparison Table 2 sets out the Curriculum Statements in the RACGP Training Program and Advanced Skills Curricula and the ACRRM Primary Curriculum according to these groupings.

Table 2 Curriculum Statements in the RACGP Training Program, Advanced Rural Skills Curriculum and ACRRM Primary Curriculum

Principles and methods

RACGP Training	RACGP Advanced Rural	ACRRM Primary
Conceptual basis of general practice		Principles of rural and remote general practice
Critical thinking and research		Research and evidence based medicine
Practice management		Management
		Information technology and information management
		Strategic skills in rural medical practice

Acute and chronic presentations

RACGP Training	RACGP Advanced Rural	ACRRM Primary
Acute serious illnesses and traumatic conditions		
Chronic conditions		
Mental health	Mental health	Psychiatry/Mental health
	Adult internal medicine	Adult internal medicine
	Anaesthetics	Anaesthetics
	Emergency medicine	Emergency medicine
	Surgery	Surgery*
		Dermatology
		Musculoskeletal health
		Ophthalmology
		Oral health
		Palliative medicine
		Radiology
		Rehabilitation

* Advanced surgical curriculum statement also available

Age

RACGP Training	RACGP Advanced Rural	ACRRM Primary
Aged care		Aged care
Children and young people	Child and adolescent health	Child and adolescent health

Gender

RACGP Training	RACGP Advanced Rural	ACRRM Primary
Men's health		
Women's health	Obstetrics	Obstetrics/Women's health

Special needs

RACGP Training	RACGP Advanced Rural	ACRRM Primary
Aboriginal health	Aboriginal health	Aboriginal people and Torres Strait Islander health
Ethnic health		

In the initial Principles and Methods grouping there is equivalence between the RACGP's Conceptual Basis of General Practice, Critical Thinking and Practice Management statements and ACRRM's Principles of Rural and Remote General Practice, Research and Evidence Based Medicine and Management statements. There are two additional ACRRM statements in this grouping, Information Technology and Information Management and Strategic Skills in Medical Practice. The former is obviously of some importance to practitioners working at a distance. The latter includes core studies in sustainable rural practice, clinical care, representation and leadership with optional studies in support, management, research and gender and medicine.

The Age, Gender and Special Needs groupings reveal the existence of similar curriculum statements for at least the RACGP Training and ACRRM Primary curricula. The ACRRM Curriculum has no statements for Men's Health or Ethnic Health.

The Acute and Chronic Presentations grouping is the area of greatest difference between the three curricula. In the RACGP Training Program Curriculum more generic titles for curriculum statements dealing with Acute, Chronic and Mental Health conditions are preferred. Both the RACGP Advanced and ACRRM Primary programs have more specific and discipline-oriented statements with seven additional areas appearing in the ACRRM Curriculum; Dermatology, Musculoskeletal Health, Ophthalmology, Oral Health, Palliative Medicine, Radiology and Rehabilitation. While content from these areas is likely to be covered in the more generically titled curriculum statements of the RACGP, the existence of separate and detailed statements in the ACRRM Curriculum is some indication at least in the view of the curriculum developers, that additional skills and abilities are required for rural and remote doctors. The ACRRM Population Health Curriculum Statement was not able to be included in any of the groupings in Table 2. This is a stand alone statement for the ACRRM Primary Curriculum, while a more integrated approach is taken in the RACGP Curriculum through the Population Health and Context of General Practice domain.

4.4 Specification of content

4.4.1 RACGP

There are different methods for detailed specification of content for the three curricula. In the RACGP Training Program the priority learning areas are organised according to the following headings:

- Introduction/definition;
- Rationale;
- Learning objectives;
- Special conditions/curriculum requirements;
- Teaching and learning approaches;
- Resources.

The Practice Management, Chronic Conditions, Aged Care and Women's Health statements also include the heading Feedback and Assessment.

The key indicators of content are the learning objectives which are organised by the five domains of general practice. They are written as specific objectives with clear indications of trainee requirements in knowledge, skills and processes.

The content of RACGP Training Program Curriculum is also set out in a separate section of the document with alphabetic listing of 87 different topics to be covered (see Appendix 1). They include symptoms such as Abdominal Pain, conditions such as Diabetes Mellitus, disciplines such as Ophthalmology, key concepts such as Conceptual Models or skills such as Procedural Skills. There is not a clear link to the learning objectives in the priority learning areas and it is assumed that the topics act as an index or cross checking mechanism for the scope and coverage of the objectives. Each of the topics is elaborated through a series of dot points but there is not a common approach to this. Some, such as Anxiety, Arthritis and Asthma, include definition, diagnosis, treatment and management. Others, such as Infectious Diseases provide a list of common and important conditions. For Hypertension a combination of these two approaches is used. The topics reflect, as do parts of the ACRRM Curriculum, an attempt by the practitioners involved in the curriculum design process to define the scope of their diverse discipline.

This statement of content does provide further understanding of what is covered under the generically titled Acute and Chronic curriculum statements of the RACGP Training Program. For example three of the seven additional discipline areas defined in the ACRRM curricula are present in this list; Dermatology, Musculoskeletal and Ophthalmology.

The RACGP Advanced Rural Skills Curriculum initially follows the same format as the Training Program curriculum document. The eight curriculum statements use the following headings:

- Rationale;
- Learning objectives;
- Content;
- Teaching/supervision approaches;
- Prerequisites/assumed prior experience;
- Feedback and assessment methods;
- Evaluation methods;
- Time and learning resources;
- Acknowledgements.

There is no separate listing of content topics as in the Training Program Curriculum. There are, however, detailed content statements in each of the eight statements.

4.3.2 ACRRM

The statements in the ACRRM Primary Curriculum also follow a standard format using the headings below:

- Context;
- Outcomes;
- Content outline;
- Content;
- Acknowledgements.

As indicated previously, the content section is set out in a double column format with the general instructional objectives on one side and matching required abilities and skills on the other. In effect,

the latter represent a more detailed specification of the instructional objectives and, on occasions, it is difficult to discern large differences between the two. Nevertheless their linkage is a clear feature of this curriculum. The required abilities and skills contain a mixture of knowledge and skills in dot point form. There is much reference to diseases and conditions that rural and remote practitioners are likely to see together with their symptoms, treatment and management particularly in the discipline oriented statements such as Adult Internal Medicine. Again the approach reflects the curriculum development process whereby experienced practitioners define the scope of their practice rather than proceeding from a more schematic basis.

The greater emphasis on specific conditions and associated procedures in both the ACRRM and RACGP Advanced Skills Curriculum is readily apparent through examination of the curriculum statements and reflects the overall directions of the curriculum statements. For example the RACGP Training Program statement on Women's Health focuses on a wholistic and comprehensive approach to women's health. The Advanced Rural Skills Curriculum focuses more narrowly on skills and knowledge in managing obstetric conditions and emergencies. The ACRRM statement entitled Obstetrics/Womens' Health attempts to combine both with perhaps a greater emphasis on the former.

5. COMPLEXITY OF TRAINING

5.1 Time for training

Four years of training are required both for the rural general practice route of the RACGP via FRACGP and the Graduate Diploma and the FACCRM rural and remote medicine route.

The requirements for the FRACGP are:

- 12 months of hospital training after internship;
- 18 months general practice experience;
- six months extended skills training.

The above must include a rotation that includes care of 'acutely unwell children' (Standards for General Practice Education and Training, Requirements for Fellowship 2005). Trainees would normally sit for the Fellowship examination after these three years. To qualify for the award of the Graduate Diploma in Rural General Practice, 12 months rural training must be incorporated into the FRACGP with a further 12 months in an advanced rural skills post.

The FACRRM requirements consist of:

- 12 months rotating hospital clinical training (including a paediatrics term);
- 12 months core rural and remote medical training (could include six months in approved hospital or community-based service);
- 12 months advanced rural and remote medical training (could include six months hospital or community experience);
- 12 months specialty rural skills training.

(Vocational Preparation Handbook for FACRRM 2004 p 11).

There are current proposals for a Fellowship examination after three years.

The patterns reveal similar trends in the two approaches; the major differences being the additional twelve months in rural contexts in the ACRRM program prior to advanced skills training. The GPET Enhanced Rural Training Framework with its three levels of requirements as discussed in Section 1 has sought to further highlight similarities in the structure of the two approaches.

5.2 Teaching and learning, background

In most undergraduate medical education, regulatory bodies, such as the AMC or the General Medical Council in Britain, describe curriculum and standards in general terms, and then monitor the capacity of university owned and delivered courses to define and elaborate these curricula in more detail and to deliver them. In other health professions, such as nursing or physiotherapy, there is sometimes a higher specification of curriculum by the regulatory body.

At postgraduate level in medicine, mostly for historical reasons, specialist organisations are responsible for defining, mapping and setting standards both for curricula and trainees, and these organisations either own the curriculum delivery process in its entirety, or have very close control of or interaction with, those who do deliver it. So for example the Royal College of Surgeons in England has systems for curriculum design, courseware development, training for trainers and mentors, close relationships and interactions with training directors in hospitals and postgraduate deans, and for assessment and accreditation.

As indicated previously, currently, in Australian general practice education a different framework operates. For general practice a separate training body, GPET, has statutory responsibility for delivering the curriculum. This introduces a further complexity into any analysis of teaching and learning methods. It means, for example, that the very strong links between aims, objectives and teaching and learning methods, expected in Eraut's model and in most other models, may be compromised. This is so because, in effect, there are multiple owners of 'the curriculum'.

This also has direct consequences for the curriculum 'as delivered'. Even if two curricula were recognised as identical in frameworks in the Australian general practice rural or remote context, the training organisation might respond differently depending upon its own strengths and weaknesses. Conversely, were the curricula to be recognised as entirely different, some harmonisation could occur through the training process. This needs to be taken into account in any discussion of teaching and learning methods.

5.2.1 RACGP teaching and learning

Many of the RACGP teaching and learning activities are dealt with through a series of standards issued by the College for the training process, for example:

> Standard P5. The program must provide at least 125 hours of peer/group learning via face to face meetings, teleconferences, or videoconferences over 18 months in general practice. Of this, at least 48 hours must be by face to face meetings.

(Standards for General Practice Education and Training, Programs and Providers 2005 p 3)

In general, for trainees or registrars, these standards emphasise the need for training to have a coherent educational and theoretical underpinning, for registrars' needs to be addressed through experiential learning, for formative assessment, and for adequate resources. Furthermore some of the curriculum statements on the various components of general practice emphasise certain teaching/learning methods as particularly appropriate for that element of the training program, for example reflection on practice for the Aged Care component (RACGP Training Program Curriculum 1999, p 63).

For trainers, the standards include the experience and practice requirements of the trainer, the provision of adequate support, additional training, provision of Continuing Professional Development (CPD) for both registrars and trainees, together with a series of recommendations for assessment of registrars and evaluation and continuing quality improvement of the program. There are also specific guidelines on the training process, for example:

> The trainer must be available for teaching, support and discussion for three hours per week for the registrar's first six months of general practice training, and for two hours per week for the second six months …

(Standards for General Practice Education and Training, Trainers and Training Posts 2005 p 1).

There is also a GP supervisors' manual, developed in NSW, that details a large volume of information and guidance on attributes of the teaching practice, help with teaching activities, practice preparation and organisation, and advice on how other teaching and learning in the Graduate Diploma in Rural Practice is guided by a learning plan developed between the registrar and an educational mentor. In addition to experimental learning tutorials, case presentations, projects and reflective learning are encouraged.

5.2.2 ACRRM teaching and learning

The ACRRM Primary Curriculum indicates that candidates may have considerable discretion over what is and what is not learned. The curriculum:

> … outlines the range of knowledge and skills that … doctors can aspire to possess through the process of vocational training and lifelong learning. It is recognised that candidates … may be expected to exercise some choice in how and where the content will be acquired … it is not expected that all candidates … will necessarily be competent in all aspects of the Primary Curriculum at the end of their training.

(ACRRM Primary Curriculum 2002, Section 2 p 2)

The course is seen as an 'individually tailored' one such that the content, and appropriate lengths of training are negotiated between the registrar, the ACRRM Educator and the College Censor taking Recognition of Prior Learning (RPL) into account. This system is controlled through a sophisticated set of electronic tools, Rural and Remote Education On-line (RRMEO), that are used to record and monitor educational and supervisory activities. There is minimal discussion in the Primary Curriculum document about criteria for educational providers. However there is a comprehensive document on standards available on the ACRRM website that covers teachers' and posts' characteristics. There are separate criteria for posts in 'rural and remote medicine' and for posts in 'a

remote context'. Additionally, the Prospectus published in January 1997 outlines how practices can apply to be training practices, and by implication require certain attributes to be accepted for this status.

The ACRRM standards initially differentiate three levels of teaching and learning support; supervisor, mentor and rural or remote doctor teacher. Mentors are distinguished from supervisors by not including assessment or performance monitoring within their role.

The criteria appear comprehensive and challenging, but are flexible. Some are layered, such that mentors are required to have certain characteristics, and supervisors require additional ones. But the initially separated role of doctor teacher seems always to be treated as one of these two roles.

The specifications of roles include characteristics in the attitudinal, knowledge and skills domains. For example supervisors must be committed, willing to carry out video/web camera review of a registrar's consultations at least four times in the first 12 months of training and demonstrate skills in this and other areas, and undertake at least three days of training per annum. There is a list of equipment considered essential to teaching practices.

There is a separate list of criteria for teachers and posts in 'remote contexts'. These practices must be situated in a remote location. While these indicators are identical to those discussed above for clinical qualifications and experience, they are more specific for commitment as a teacher and focus on requirements to ensure face to face meetings with trainees on a regular basis. In terms of clinical opportunities there is considerable overlap, but 'remote context' should involve more opportunities to take on community advocacy and leadership.

5.3 RACGP assessment

5.3.1 Introduction

The RACGP assessment process has an international reputation, gained through extensive and informative publications. This standing is attributable to a long period of development within the College, addressing issues of reliability, validity, fairness and feasibility in a thorough and self-critical approach. It would probably be accurate to say that this element of the curriculum is the most carefully developed and has been marshalled to address and deliver very high standards of performance by candidates. The quality of this process is evident in the current, informative and well prepared handbook, The College Examination 2005.

Over the last five to eight years the College has offered a flexible pathway to candidature for the assessment process that involves RPL for certain types of experience, and acknowledges the variety of routes that doctors in Australia have taken in preparation for practice here. The assessment process offers both formal training routes and practice-based routes for some candidates. In addition, there is a practice-based route to Fellowship that has been prepared as an alternative to the examination, but it is not available to registrars in the training program.

5.3.2 The FRACGP examination

The examination consists of two written and one clinical papers. One written paper is a 150-item, one best answer and extended matching test, taken over a four-hour period, of applied knowledge carefully blueprinted on Australian general practice. The other comprises 26 key features cases designed to assess clinical decision-making.

The clinical examination is an objective structured clinical examination (OSCE) format, although the documentation carefully avoids labelling the examination as an OSCE. It stresses that two styles of encounter are used in combination; an eight minute focused encounter and a longer 19 minute encounter. However both are directed at whole patient care.

There are extensive activities dedicated to quality assurance of the examination process, including publicly available blueprinting on actual practice, attention to item design and analysis, item review, feedback from candidates and examiners, examiner training including at some stages, extensive engagement and collaboration with international experts and examining bodies. Calibration of examiners, processes for standard setting and weighting of components and extensive review of all the above procedures are also undertaken.

The examination is clearly presented by the RACGP as a central and important mechanism for the setting of clinical and educational standards for Australian general practice.

5.3.3 Practice-based assessment

This route is currently open only to those who qualify through the practice-eligible route to Fellowship or who are engaged in the alternative pathways program. In essence the practice-based assessment utilises a number of approaches to performance assessment that have been investigated in the educational research literature and have high validity for actual practice:

- A professional portfolio;
- A review of videotaped consultations;
- An oral examination;
- An educational visit (ECV) to the practice.

The portfolio contains a comprehensive reflective description of the candidate's practice, current certificates of competence for CPR, and identification of 25 peers capable of delivering 360° ratings from a number of professional perspectives on the candidate's clinical practice.

The video consultations comprise 90 consented encounters with patients and an accompanying logbook that may be analytical. Fifteen of these encounters are selected for scrutiny by examiners. The oral assessment is conducted during the ECV and involves observation of not less than eight patient encounters and 20 two-part questions based on the candidate's portfolio/declared practice. The ECV allows assessment of examination skills, whereas the videotapes are usually aimed at verbal interactions with patients.

These assessments are thoroughly described in available documentation and there are guidelines for candidates, examiners and censors.

5.3.4 Assessment in the Graduate Diploma of Rural Practice

Assessment in the Graduate Diploma comprises evidence of clinical 'experience and performance' and completion of education activities. These are recorded in a Learning and Educational Assessment Portfolio (LEAP). Completed modules of work are verified by the educational mentor and the completed portfolio submitted to the RACGP Rural Censor for eligibility for the award (RACGP Graduate Diploma in Rural General Practice Curriculum Guidelines 2002 pp 22-23).

5.4 ACRRM assessment

The assessment strategy for this training program is still in development. It takes as its starting point the alleged limitations of the RACGP curriculum and assessment process and aims to fully take account of the needs of rural and remote practitioners. For example it does not assess 'essential competencies' of general practice. The assessment consulting report commissioned by ACRRM emphasises the need to assess learners in 'a broader range of knowledge and skills' perhaps incorporating methods used by other Colleges more attuned to the assessment of specialist skills (Assessment Program for the Award of FACRRM p 11).

The Assessment Program document follows classic approaches to the development of assessment methods including defining content, the purpose of assessment, the choice of methods and standard setting. The purpose for ACRRM is to 'develop assessment programs that include a range of formative and summative tasks' so as not to demotivate learners but to 'inspire, measure and reward them'. The consultant report proposes two major streams of assessment; a Primary Assessment Pathway and a Practice-based Pathway. The former will involve a greater degree of commonality, and standardisation of assessment content, timing and sequencing if it is to be widely available, affordable, valid and reliable. The latter is 'not for those who are in the mainstream Training Program' (Assessment Program for the Award of FACRRM 25-26).

The report then discusses potential assessment methods and analyses the utility of each. The resulting formulae for assessment involve three blocks of summative assessment of the basic practice pathway, each of which has a potential choice between methods; for example, between a multiple choice and key-feature question paper or case studies, record review and audits all based on actual practice.
In summary, the ACRRM assessment strategy, as it stands, is yet to be decided, although final decisions are very close. It is striving to be more flexible than the RACGP, but is running into the realities that the demands of high quality assessment programs make on resources, assessors' time and infrastructure. In many respects the two assessment strategies share much in common. They are both aiming for state of the art systems. They are both well matched to the skills that they are aiming to assess.

ACRRM's approach to the Advanced Skills training like the RACGP Graduate Diploma will be practice-based. It is likely to include more intensive performance-based measures involving peer and supervisor ratings.

However the assessment consultancy document makes it clear that the final program is still somewhere between six months and two years away, depending on the resources devoted to its development. There are still considerable mode and item development challenges ahead, although overall framework looks very promising. Regulations, and guidelines for candidates, examiners and censors are still some way off.

6. CONCLUSION: MAJOR POINTS OF DIFFERENCE

6.1 Context, aims, complexity

Across all three curricula; the RACGP Training Curriculum, the RACGP Graduate Diploma in Rural Practice/Advanced Skills Curriculum and ACRRM Primary Curriculum there are school broad similarities and, at the same time, some important differences. This is not surprising on both counts. First there are substantial areas of overlap in the practice of those who receive training by one of the routes. Yet the RACGP and ACRRM have developed different and distinctive perceptions on the task and there is the recognition from both groups that rural practitioners do require additional knowledge and skills than those who work solely on metropolitan contexts.

The stated aims of the programs are both heavily influenced by the context from which they were derived. The aims for both the FRACGP and the Advanced Skills derive from a view that general practice is unrefereed comprehensive care for the whole of Australia with additional skills for those who choose to work outside metropolitan areas.

ACRRM's curriculum aims are derived from its concerns to define rural and remote medicine as a specialty with a distinct and unique body of skills and knowledge. This distinction does flow over into the specification of objectives and the overall curriculum frameworks. It is best seen in the use of domains. The RACGP program's domains provide an integrating and conceptual approach across the curriculum. In ACRRM's program they mark what is distinct and unique about rural and remote practice and demonstrate the importance of the rural and remote context in training.

The RACGP approach is conceptual and underpinned by considerations of 'what GPs need to know', 'common patient presentations' and 'national health priorities'. In this approach direct links between the objectives and specified content are less important given that the objectives are comprehensively written across all domains. The links between the more detailed specified content in the ACRRM curriculum with required skills and abilities are more explicit. This also applies to the Graduate Diploma/Advanced Skills program of the RACGP, giving further credence to the more procedural and defined orientation of those who label themselves as rural general practitioners (RACGP) or rural and remote practitioners (ACRRM).

Both programs require four years for completion of rural training. The ACRRM program provides for more direct experience in rural and remote settings which is compatible with the emphasis in gaining the distinct skills claimed as necessary for rural and remote practice.

Both colleges promote the use of experiential, apprentice-based teaching and learning activities, although, ultimately, the delivery of those teaching and learning methods is the responsibility of the

RTPs. There is, perhaps, more flexibility in the ACRRM program. Both Colleges have initiated on-line learning and support.

The RACGP has a well known and credible examination process leading to Fellowship. It is carefully blueprinted to the curriculum and uses an appropriate mix of best practice tools. The Graduate Diploma employs portfolio-based experiential methods for assessment of advanced skills. ACRRM's assessment approach is best described as 'emergent'. The College aspires to a different form of assessment using some of the modalities for assessing specialist skills and knowledge. Again advanced knowledge and skills are to be assessed experientially with an emphasis on performance-based assessment.

6.2 Content

The lack of standardisation in approaches to specification of content both within and between each of the curricula renders a detailed comparison of content difficult. There is overlap but, nevertheless it is in the area of content that the greatest differences between the two approaches emerge. It is important to reiterate that input for all three curricula has come from experienced practitioners representing a diversity of practice. Uniformity has not been given preference over capturing the essence of practice for curriculum design purposes.

The differences are more immediate in the curriculum statements. There are 22 in the ACRRM Primary Curriculum and 12 priority learning areas in the RACGP Training Program. The lower number may be accounted for in the use of generic terms by the RACGP such as Chronic and Acute Conditions but it also reflects the disciplinary organisation and commitment of the ACRRM approach. There is a body of knowledge to be learned and objectives are linked with skills and abilities. The Advanced Skills curriculum of the RACGP use an analogous approach.

The three levels of Enhanced Rural Training as espoused in the GPET document provide a framework for elucidating the differences. Level A, the Core Knowledge and Skills for Rural General Practice and/or Rural Medicine reside in the one year hospital experiences of the two Colleges' programs. These may be regarded as equivalent, albeit that ACRRM requires a paediatric rotation. These Level A knowledge and skills can be learned in metropolitan, provincial or rural and remote contexts.

There is some equivalence too in the Level C, Knowledge and Skills for Advanced Rural General Practice and/or Rural Medicine. The RACGP Advanced Rural Skills Curriculum of 1997 lists eight advanced skills areas, Aboriginal Health, Adult Internal Medicine, Child and Adolescent Health, Mental Health, Anaesthesia, Obstetrics and Surgery. All these are listed as options for specialty skills training in the ACRRM Vocational Preparation Handbook for the FACRRM, with the addition of Population Health, Radiology/Ultrasonography, and Ophthalmology. Only one ACRRM specialty curriculum statement, Surgery, was provided but it showed similarities with its RACGP Graduate Diploma counterpart.

It is at Level B, Knowledge and Skills for Rural General Practice and/or Rural Medicine that the clearest differences emerge. ACRRM registrars could expect to take this component for two years using up to 22 curriculum statements that have been designed to incorporate the knowledge and skills that are deemed imperative for rural and remote practice, while at the same time ensuring that they can

meet the requirements for FRACGP. This is the only qualification accepted for Vocational Recognition (VR). While the RACGP Graduate Diploma in Rural Practice predominantly focuses on Level C knowledge and skills, there is an expectation that registrars in this route will gain some Level B content as they complete requirements for the FRACGP and Graduate Diploma. They are required to take 12 months of rural training, although presumably it could be more. They must also complete a learning plan based on a series of education modules, of which Working in Rural Practice and Emergency Medicine are compulsory. In this way, both programs recognise and provide ways by which trainees can gain the extra skills and abilities for rural practice. At least on paper the intention of ACRRM is to introduce the additional skills and abilities earlier and encapsulate them in a wider range of curriculum statements.

The existence of the Enhanced Rural Training Framework document is a good sign. It provides clear pathways for the registrars and staff of RTPs. It would appear that registrars would be unlikely to undertake both programs, not withstanding that completion of the FRACGP is a requirement for VR. The framework does demonstrate that some flexibility is possible and both Colleges have procedures for RPL. Ultimately the Framework points to the possibility of choice. That choice will be dependent on registrar interest and direction, advice and mentoring of those who deliver the curricula discussed here within the RTPs.

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APPENDIX – CONTENT, RACGP TRAINING PROGRAM CURRICULUM 1999

Alphabetical Listing of Content for Teaching and Learning
Index
Abdominal Pain (also see gastro-intestinal)
Aboriginal (also see public health, communication and general practice)
Abuse (also see domestic violence)
Adolescence (see young people)
Aged care – specific
Alcohol (see also drugs/substance)
Altered mental state (also see psychiatric)
Anxiety
Arthritis
Asthma
Back and neck problems
Blood loss/bleeding
Cancer (also see breast, prostate, bowel, cervical cancer and prevention)
Breast (see also cancer/breast)
Cardiovascular disease (see also hypertension and lipid metabolism disorders)
Child health (see also paediatrics, genito-urinary, cardiovascular and emergency medicine)
Chest pain (see cardiovascular)
Chronic illness (see also general practice – role of the general practitioner in chronic illness)
Contraception
Consultation models (also see general practice)
Communication
Counselling
Deafness (see also injury prevention)
Depression
Dermatology
Diabetes mellitus
Disability
Disaster management (also see trauma)
Domestic violence (see also abuse)
Drug/substance abuse
Ear, nose, throat and mouth problems (ENT)
Emergency medicine in children and adults (also see emergency resuscitation skills checklist in the Curriculum Companion)
Endocrine problems in children and infants
Eye problems
Gastro-intestinal problems (also see abdominal)
General practice (also see practice organisation and consultation models and self care legal issues)
Genetic
Genito-urinary (also see prostate)
Gynaecology (also see menopause and sexual health)
Haematology
Health Promotion – (see prevention and occupational health and safety)

HIV/AIDS
Hypertension (also see cardiovascular disease and lipid metabolism disorders)
Infectious diseases (also see HIV, Hepatitis, STIs)
Hepatitis – A B C
Immunisation
Immunological/rheumatological problems in children/infants
Injury prevention (see occupational health & safety)
Legal issues
Lipid metabolism disorders
Men-specific
Menopause (see also gynecology) (sic)
Mental illness/psychiatry (also see altered mental state)
Musculo-skeletal
Neurological problems
Nutrition
Occupational health and safety
Ophthalmology (also see eyes)
Orthopaedic
Paediatric (see also child development, specific diseases, ie asthma, respiratory)
Poisoning
Practice management
Practice organisation
Pregnancy
Prevention (includes health promotion)
Procedural skills (see checklist in Curriculum Companion)
Psychiatric – (also see mental illness/altered mental state/depression)
Public Health (also see general practice)
Rational Prescribing
Research
Respiratory disease
Schizophrenia
Self-care (also see general practice)
Sexual health (also see sexuality)
Sexuality
Sexually transmitted infections (STIs)
Shock (also see trauma and cardiovascular)
Skin (also see dermatology)
Sleep disorders
Stroke – (also see cardiovascular disease)
Suicide – (also see mental health)
Surgical skills (see wound care and the essential procedural skills list in the Curriculum Companion)
Trauma
Women – specific (also see gynaecology, pregnancy, communication)
Wound care (also see surgical skills)
Young people (also see communication and sexuality

TRAINING CURRICULA FOR RURAL GENERAL PRACTICE AND RURAL AND REMOTE MEDICINE IN AUSTRALIA

A comparison of programs offered by the

Royal Australian College of General Practitioners (RACGP) and the

Australian College of Rural and Remote Medicine (ACRRM)

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Additional Information

July 2005

1. Introduction

This statement is provided in response to the request from the AMC for further information on overlap in the programs of the RACGP and ACRRM. This has essentially been interpreted as a question of content; of determining what content is the same in each program and what is distinctive or unique about each of the programs.

There are, however, two caveats that must be addressed in any such consideration. The first is that this study is limited to statements of content in official programs. As indicated in Section 2.2 of the substantive report there is a difference between curriculum statements as they are intended and as they are actually delivered. Much of the determination of content in the two programs occurs as they are implemented in the Regional Training Programs. This is beyond the brief of this study.

The second is that content is only one dimension of a curriculum or program as is represented in Eraut's or the other models referred to in Section 2.2 of the substantive report. The models stress that there must be consistency between the elements of curriculum; aims, objectives, content, pedagogy and assessment patterns. To base judgements about the programs based on only one of the elements is at best a partial analysis. Similarly curriculum programs must be judged in context. To consider content alone out of context again presents only part of the overall picture.

2. Content overlap

Notwithstanding the discussion above it is clearly stated in the concluding section of the report (Section 6.1) that there are broad similarities in the two programs. This is not surprising given the substantial areas of overlap in practice in those who undertake and graduate from the programs. But it is also pointed out that there are some differences and that these are more evident in the area of content.

The three levels of knowledge and skills set out in the Enhanced Rural Training Framework document are used to highlight the differences in content. Level A content, Core knowledge and Skills for Rural General Practice and/or Rural Medicine resides in the hospital experiences of the two programs. These are regarded as equivalent although the ACRRM program requires a paediatric rotation.

Similarly equivalence is reported in Level C, Knowledge and Skills for Advanced Rural General Practice and/or Rural Medicine. There are eight areas in common, Aboriginal Health, Adult Internal Medicine, Child and Adolescent Health, Mental Health, Anaesthesia, Obstetrics and Surgery. There are three additional areas in the ACRRM program; Population Health, Radiology/Ultrasonography and Ophthalmology. Only one ACRRM advanced statement, Surgery, was supplied which makes further comparison difficult.

Level B, Knowledge and Skills for Rural General Practice and/or Rural Medicine is the area of greatest difference. Registrars in the ACRRM program follow 22 curriculum statements in rural and remote contexts over two years. The RACGP program is less explicit about Level B. The Graduate Diploma in Rural General Practice focuses largely on Level C knowledge and skills with a

requirement of one year rural training although more could be taken. Some Level B knowledge and skills could be included in this and as a part of FRACGP studies.

The content differences are more evident when the direct comparisons are made (see Section 4.3, Table 2). The groupings used in the RACGP curriculum are used to highlight differences between the two programs;

- Principles and methods of general practice
- Population groups
  - Acute and chronic presentations
  - Age
  - Gender
  - Groups with special needs

For most of the categories there is a great deal of equivalence. For the Principles and Methods of General Practice ACRRM has additional statements in Information Technology and Information Management and Strategic Skills in Medical Practice. The major differences in Age, Gender and Special Needs are the absence of Men's Health or Ethnic Health statements in the ACRRM program. Acute and Chronic Presentations is identified as the area of greatest difference. Generic and conceptually designated areas are defined in the RACGP program while the ACRRM program uses a discipline-based approach. There are seven additional areas in the ACRRM program:

- Dermatology;
- Musculoskeletal Health;
- Ophthalmology;
- Oral Health;
- Palliative Medicine;
- Radiology; and
- Rehabilitation.

The statements in the ACRRM program are more detailed and prescriptive generally with lists of required knowledge and skills as defined by rural and remote practitioners. This represents the basis of the two years that ACRRM Registrars spend on Level B studies. On paper, at least it would appear that they are likely to spend a longer time dealing with more specifically defined knowledge and skills. Again, however, this needs to be tested out in the realities of practice.

3. Estimating the overlap

Given the above discussion and associated caveats it is difficult to place a precise quantitative judgement on the degree of overlap. Notwithstanding the previously highlighted similarities in much of the practice represented by the two programs it is not unreasonable to expected a degree of overlap and the authors claim this would approximate 65%. While there are one or two additional areas in the RACGP program it is largely the ACRRM program that specifies additional content and expresses it in more traditional discipline orientated forms. This largely accounts for the remaining 35% difference.

It is important to point out in conclusion however, that in making quantitative judgements, many of the qualitative differences in the programs could be ignored. Issues such as the conceptual organization of the RACGP program compared to the discipline orientation of the ACRRM program, the emphasis on rural and remote context in the ACRRM program or the well defined examination of the RACGP compared to the emergent assessment of the ACRRM program need to be kept firmly in mind. In the end these issues may go a long way in defining curriculum difference irrespective of quantitative assessments of content.