

Chapter 2.1.8

THE ACRRM: ADVANCING THE DISCIPLINE OF RURAL AND REMOTE MEDICINE IN AUSTRALIA

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The Australian College of Rural and Remote Medicine (ACRRM) was formally established in 1997, following a national plebiscite of rural doctors in 1995 which overwhelmingly voted for recognition of rural and remote medicine as a separate discipline.

Rural and remote medicine as a discipline

While various medical schools around the world promote rural and remote education in a range of ways (as seen in other chapters in this guidebook), the ACRRM is the world's first and, currently, only college dedicated to the representation and advancement of the *discipline* of rural and remote medicine – the distinct characteristics of which include:

1. a rural / remote context – often entailing extreme professional and geographical isolation;
2. a comprehensive generalist scope of clinical practice – primary, secondary and often tertiary care (including advanced procedural, i.e. surgery, obstetrics and gynaecology, emergency medicine, anaesthetics);
3. a unique body of learning and research – which includes national vertically-integrated rural training programmes; dedicated scientific journals;
4. peer acknowledgement – from other specialist colleges;
5. national and international recognition – both academic and from government.

ACRRM's mandate and relationships

The ACCRM gets its brief from the rural medical profession and the scope of clinical practice needed to service rural and remote communities in Australia. The College is accountable to those doctors and communities through its constitution and by virtue of its accreditation by the Australian Medical Council (AMC) for its educational programmes and its close linkages with related organisations.

The College is represented on an extensive range of organisations and committees regionally and nationally - including the Committee of Presidents of Medical Colleges, Australian General Practice Training Programme, Remote Vocational Training Scheme (RVTS), Regional Training Providers, university rural clinical schools, university departments of rural health, the National Rural Health Alliance, National Aboriginal Community Controlled Health Organisation and a plethora of national committees relevant to the discipline.

At the international level, the College has developed relationships with rural educational bodies in Canada, South Africa, New Zealand and Ireland with a view to mutual standard-setting and mutual recognition of those standards.

A national office of ACRRM was established in Brisbane and provides extensive facilities and support for the College membership.

ACRRM's roles and achievements

The **roles** of the College are as follows:

1. To define the body of knowledge of the discipline of rural and remote medicine.
2. To establish and maintain standards for rural and remote medicine in Australia.
3. To provide and support educational programmes for students, doctors undertaking vocational preparation, and College fellows undergoing professional development (PDP).
4. To assess candidates and award certification for attainment of the Fellowship and ongoing PDP (with oversight by the AMC).
5. To represent the interests of education/training and of standards of rural and remote medical practice amongst the profession, to government and other stakeholders, both nationally and internationally.

6. To represent and support rural and remote communities in their endeavours to acquire a suitably trained medical workforce and the health infrastructure necessary to meet their clinical service needs.

The **achievements** of ACRRM are numerous. Since May 1996 when the first author of this chapter, Tom Doolan, delivered the original paper on the establishment of the College at the First International Conference on Rural Medicine in Shanghai, China, ACRRM has come a long way. Some of its significant achievements are as follows:

- **Membership:** The ACRRM now has 3 350 fellows and members and is experiencing steady growth.
- **Undergraduate training:** This highly successful federally-funded initiative – managed by John Flynn and Rural Bonded Student programmes and administered by ACRRM - enables large numbers of medical students to undertake high quality rural and remote immersions at early stages of their careers.
- **Early postgraduate training** – the Pre-vocational General Practice Placement Programme introduces doctors in their first and second postgraduate years to rural and remote medicine and general practice via 10 to 12-week rotations in rural or urban practice. This highly successful programme was originally developed as a collaboration between Flinders University in South Australia, ACRRM and the federal government but has now widened to include other stakeholders.
- **Vocational preparation** – the Fellowship of ACRRM has been recognised by the federal government and the Australian Medical Council as an accredited pathway for general practice training leading to vocational recognition – which enables these practitioners' patients to access full Medicare benefits (national health insurance).
- **Professional Development Programme (PDP)** - ACRRM has also developed a comprehensive triennial process which ensures that its Fellows have access to a high quality, relevant and accessible PDP – again recognised by the federal government for Medicare purposes.

ACRRM Fellowship

Attainment of the Fellowship of ACRRM (FACRRM) involves undertaking a four-year vocational preparation programme which requires training in and satisfactory assessment of knowledge and skills outlined in

1. the ACRRM Primary Curriculum (see below); and
2. one of ten Advanced Curricula (see below).

Fellowship can be achieved via one of three pathways:

1. The Australian General Practice Training Programme (AGPT) – funded by the federal government and delivered in accredited training positions by a number of Regional Training Providers in collaboration with ACRRM.
2. The ACRRM Independent Pathway – a self-funded programme wherein the education is provided by ACRRM directly and the candidates also undertake training in ACRRM accredited posts.
3. The Remote Vocational Training Scheme (RVTS) – a federally-funded programme which enables doctors to train in ACRRM-accredited posts under remote supervision in isolated communities with a remotely-delivered educational programme.

The Rural Generalist Programme

The Rural Generalist Programme is a dedicated training programme for rural medical staff with specialist recognition. All candidates train to the FACRRM or equivalent and have an individually tailored training pathway with preference for high quality posts, particularly procedural. All candidates are required to be registrars in the AGPT during training.

The programme was established through an exciting collaboration with the Queensland government – and upon successful completion, candidates are recognised (industrially) as specialists by Queensland Department of Health. The programme has been very successful in attracting applicants and will have an entry cohort of approximately 80 in 2015. It is serving as a model for national consideration with commitment to similar programmes from other states, including the Northern Territory and Victoria.

In 2014 the Australian Government commissioned the ACRRM to undertake a scoping study for the potential establishment of a national Rural Generalist Programme.

Curricula

The ACRRM has developed a series of curricula as the educational blueprints for its four-year vocational preparation programmes. Being outcomes based, these also serve as useful tools in the assessment of candidates for recognition of prior learning purposes.

- **Primary curriculum:** This describes the essential knowledge and skills required by doctors across all clinical areas for the safe and comprehensive practice of the discipline of rural and remote medicine. Candidates are assessed on their acquisition of this scope of practice during completion of the first three years of the ACRRM four-year vocational preparation programme. The primary curriculum has gone through a number of iterations and process changes without significant variation to content and is now available in searchable format online.
- **Advanced curricula:** These are available in ten disciplines from which a candidate can choose for their Advanced Specialised Training year. The disciplines include adult internal medicine, surgery, anaesthetics, obstetrics, emergency medicine, mental health, indigenous health, remote health and population health. Paediatrics is currently under development. Candidates undertake their advanced training in ACRRM-accredited posts and are assessed according to advanced curricula requirements. In certain areas this is in collaboration with other specialist colleges.

Rural and Remote Medical Education Online (RRMEO) – ACRRM's online learning website – provides a distance education facility for all levels of learning.

Assessment

ACRRM recognised the importance of designing an assessment system that would align with the commitments and directions of the curriculum as well as provide the important function of certifying competence for the Fellowship. To this end the College commissioned a consultancy comprising a team of assessment experts from Australia and New Zealand to design the assessment. They recommended a 'programmatic' (1) approach, such that the strengths of a programme of assessment

tools could be combined to enable decision-making about the competence of potential Fellows.

The ACRRM had some clear priorities for its assessment programme - which included:

- a strong contribution from practicing rural doctors in the design and construction of assessment tools;
- the inclusion of workplace-based approaches which would involve assessment by rural doctors of the actual performance of rural registrars in their day-to-day work;
- a commitment to implementing as much of the assessment as possible in situ so that candidates do not have to travel long distances to be assessed. (This was judged to be important not just to reduce travel by candidates but also to avoid depriving rural communities of key workforce personnel at examination time.)

The resulting ACRRM assessment programme has four major elements:

1. multiple choice question (MCQ) examination;
2. structured assessment using multiple patient scenarios (StAMPS);
3. mini-clinical examination (Mini-CEX); and
4. multi-source feedback (MSF).

1. **Multiple choice question (MCQ) examination**

The items have been developed by rural doctors and are anchored in contemporary rural practice. Regular writing workshops were conducted and a high level of expertise in item-writing has been developed. Psychometric analyses of tests were undertaken and items reviewed. High levels of reliability have been achieved in tests, with non-performing items having been removed. An item bank has been constructed. The test is taken in the candidate's home town via the internet.

2. **Structured assessment using multiple patient scenarios (StAMPS)**

This is an innovative variant of the traditional objective structured clinical examination (OSCE) and has been described in the literature (2). It is undertaken by videoconference so that candidates do not have to leave their own communities. StAMPS has been designed to test higher order functions in a contextually organised framework where candidates have the opportunity to explain what they do and demonstrate clinical reasoning in specifically designed rural practice cases.

3. **Mini-clinical examination (Mini-CEX)**

This approach was first developed in the United States and has gained wide international acceptance (3). Its focus is the assessment of history-taking, physical examination and patient management in situ. In the ACRRM approach, structured assessment of the candidate's performance is undertaken in the training post by supervisors and visiting external clinical teachers.

4. **Multi-source feedback (MSF)**

In this mode of assessment registrars receive ratings from peers, other staff in the practice and from patients. It represents ACRRM's commitment to ensuring that key rural stakeholders are involved in the assessment of future independent rural practitioners. ACRRM has been able to engage the services of the international best practice CFEP (Client Focused Evaluation Programme) system to initially provide norms for the MSF and subsequently to develop a system adopted for the realities of Australian rural medical practice.

Together these elements provide a robust assessment programme to promote learning of the curriculum and to certify competence for unsupervised practice. They have been refined and developed further according to psychometric analyses and examiner and candidate feedback and will continue as the underpinning backbone of the educational programme for rural practice.

Conclusion

The creation of ACRRM arose out of the recognition by doctors in Australia of the distinct discipline of rural and remote medicine, as defined above. It was also a response to the dearth of recognition of the discipline more broadly, however, and a consequent absence of structured education programmes at vocational and professional levels which addressed the full scope of rural and remote generalist clinical practice.

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The Rural Doctors Association of Australia (RDAA) deserves full credit for its vision and initiative in commissioning the Taskforce for the Establishment of ACRRM in 1996 which led to the birth of the College in 1997. RDAA's ongoing support for ACRRM's principles and its close relationship with the College have been most facilitatory.

ACRRM's staff, and in particular the College's CEO since inception, Marita Cowie, have made an enormous contribution to the College's development through their unwavering energy, creativity and commitment.

Finally, the voluntary contribution of the fellows and members to this first in the world College of Rural and Remote Medicine has been outstanding. Without their intellect in terms of curriculum and educational programme development, delivery and assessment; and without their generous donations of time to innumerable governance meetings; and without their resolve against considerable odds during the establishment phase, there wouldn't be an ACRRM.

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