Royal Australasian
College of Surgeons

RACS Remote, rural and regional professional skills curriculum

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Acknowledgement

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1 Executive summary

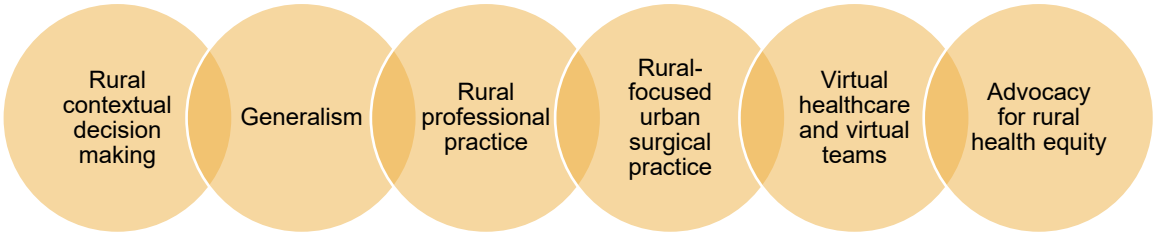
1.1 Purpose

The purpose of the RACS Remote, Rural and Regional Professional Skills Curriculum (RACS Rural PSC) is to define the knowledge, skills, values and behaviours required to care for rural people within remote, rural and regional (RRR) practice, rural-focused urban surgical (RUFUS) practice, virtual healthcare, and collaboration in virtual and/or geographically dispersed healthcare teams.

1.2 Curriculum domains

There are six domains of competence within the RACS Rural PSC.

1. Rural contextual decision making
2. Generalism
3. Rural professional practice
4. Rural focused urban surgical practice
5. Virtual healthcare and virtual teams
6. Advocacy for rural health equity



1.3 Strategic alignment

Twenty-eight percent of Australians(1) and thirty-eight percent of Aotearoa New Zealanders(2) live in remote, rural and regional areas (RRR, hereafter collectively referred to as 'rural'). People living in rural areas experience barriers in accessing healthcare, have lower healthcare utilisation, lower per capita health expenditure and worse health outcomes compared to people living in urban areas.(3,4) The surgical workforce is maldistributed, with undersupply in rural areas.(3) Trainees and younger Fellows report feeling unprepared for rural practice.(5)

Achieving rural health equity requires dedicated focus, including

- identifying barriers to accessing care, and developing solutions to address these barriers, for individual patients and in the design of health systems.
- ensuring specialist training programs deliver a workforce with
    - appropriate geographical distribution, and
    - the skills to care for rural people.

These skills include rural surgical practice, rural focused urban surgical practice (RUFUS), virtual healthcare and collaborative practice in geographically dispersed healthcare teams.

The WHO Global Policy Recommendations for rural health workforce development and retention(6) include a recommendation for rural training experience to be combined with a rural-relevant curriculum. The recommendation was incorporated into the RACS Rural Health Equity Strategic Action Plan 2020.(7) The RACS Rural PSC was developed in three phases from, including qualitative research, stakeholder evaluation and the creation of an eLearning course. The project was funded by the Australian Government Department of Health, Disability and Ageing Specialist Training Program.(8)

1.4 Relationship with internal and external curricula

The RACS Rural PSC contributes to the longitudinal development of the rural and RUFUS medical workforce, by building on the Australian Medical Council Primary Medical(9) and Prevocational Graduate(10) domains and outcome statements and the Better Culture Curriculum,(11) and by preparing Trainees to practice in line with national standards and codes of conduct for medical practice, including the Medical Board of Australia Good Medical Practice – a Code of Conduct for Doctors(12) and the Medical Council New Zealand Practice Standards.(13)

The RACS Rural PSC was designed to integrate with the RACS Professional Skills Curriculum (PSC)(14) and the RACS and AOA specialty specific Surgical Education and Training (SET) curricula.

Appendix 2 contains further information to demonstrates how the RACS Rural PSC domains, behavioural markers and graduate outcomes map to internal and external curricula and standards for medical practice.

1.5 Teaching, learning and assessment

The RACS Rural PSC is designed to accompany remote, rural or regional training experience, and/or RUFUS training experience. It presents a standardised guide to the development of skills for Trainees and Supervisors to optimise surgical training experience in rural, RUFUS, virtual and collaborative care settings.

The RACS Rural PSC is supported by the RACS Remote, rural and regional professional skills eLearning course, available on the RACS website for Trainees, Specialist International Medical Graduates and Fellows. The eLearning course includes formative and summative assessment activities. There is no cost associated with enrolling in and completing the course.

The course can be accessed via this link: https://elearning.surgeons.org/course/view.php?id=683

A Guide for Supervisors is attached (Appendix 1) and is included within the course shell.

1.6 Future actions

Engagement with the RACS Rural PSC and eLearning course is optional for Trainees, Specialist International Medical Graduates and Fellows. In the longer term, there are opportunities for the curriculum domains to be incorporated into future iterations of the RACS Professional Skills Curriculum and the specialty specific Surgical Education and Training and AOA Curricula.

2 Curriculum domains, behavioural markers and graduate outcomes

DOMAIN 1 RURAL AND CONTEXTUAL DECICION MAKING

Rural and urban contexts differ in ways that are significant for health outcomes, healthcare services, surgical training and surgical practice. Each rural context is unique.

Context comprises three inter-related elements.

- Place: geography, topography, natural resources, climate, climate change, transport, industry, disasters and disaster preparedness.
- People: First Nations People, demography, culture, community, health and welfare.
- Healthcare system: health facility resources and capability level and connections to other facilities in the healthcare network.

The ability to analyse context and engage in contextual decision making is essential to delivering appropriate health services, and optimising outcomes for patients.

Considerations in rural contextual decision making include whole-of-person care, patient and family/whānau values and preferences; community need; resource variability or limitation; capacity and capability of surgical team and healthcare facility; community integration and boundaries; fatigue prevention, mitigation and response; transport, retrieval and balancing potential benefits and risks of transferring a patient for care in another facility.

Rural surgeons may need to respond to uncommon high-stakes emergencies outside their usual scope of practice, in RRR contexts where other surgical specialties or subspecialties are not available, and/or there is no more suitably qualified surgeon available and the time for transfer to definitive care would result in loss of life or limb (e.g. neurotrauma, vascular injury).

Behavioural markers	Graduate outcomes
1.1 Develops detailed rural contextual knowledge.	Analyses the context of RRR practice and RRR patients: place, people and healthcare system Evaluates strengths, enablers and barriers to healthcare access and delivery.
1.2 Incorporates rural contextual knowledge into clinical decision making.	Applies rural contextual decision making in remote, rural and/or regional practice. • Describes contextual considerations in rural clinical decision making. • Adapts to new RRR training and practice context, to become an effective member of the healthcare team and deliver healthcare. • Communicates contextual knowledge to other members of the healthcare team to develop a shared understanding of context. Applies rural contextual decision making in response to emergencies. • Develops strategies for responding to emergencies outside scope of practice. • Anticipates and prepares self and team for managing uncommon high stakes emergencies outside usual scope of practice. • Recognises the need to act in an emergency, at the limit or outside your scope of practice, in the absence of another suitable practitioner.

	• Remains calm under pressure while taking suitable and prompt action. • Mobilises local and distant resources and works methodically towards stabilisation and transfer or definitive management. Activates or supports emergency patient transport, evacuation or retrieval.
1.3 Develops strategies for safe practice in resource-limited environments.	Develops strategies for safe practice in environments where resources are limited. • Identifies resources, resource variability and resource limitation. • Demonstrates effective use of available local and distant resources to maximise safety and patient outcomes. • Demonstrates flexibility, adaptability and innovation in developing and delivering place-based models of healthcare • Evaluates the benefits and disadvantages of local treatment and transfer for treatment. • Recognises situations when the absence of local resources can't be compensated for and referral or transfer is necessary. Develops and maintains a local and distant professional network, for advice, remote decision support, referral and transfer.
1.4 Incorporates rural contextual knowledge into leadership, teamwork and collaboration.	Demonstrates integration of contextual knowledge in leading and managing junior staff, and in end-of-rotation handover to, and orientation of peers.
1.5 Optimises training experience in the rural context.	Develops strategies to optimise training experience in RRR context, matching SET program requirements and professional goals to opportunities available.

DOMAIN 2 GENERALISM

The Royal College of Physicians and Surgeons of Canada defines the philosophy and practice of generalism in three domains:(15) broad scope of practice, response to community need and advocacy

A generalist practices across a broad spectrum within their discipline. Developing an extended scope of practice is a response to community need. Advocacy includes coordinating patient care and assisting patients and their families/whānau with health system literacy and health system navigation.

The philosophy of generalism applies to medical, nursing and allied health practice, and to general practitioners and non-GP specialists, for example a generalist urologist practices across a broad spectrum of the discipline of Urology.

Ideal health systems include a balance of generalist and subspecialist practitioners, with effective collaborative relationships and networks.

Generalist models of healthcare become increasingly important when caring for patients with undifferentiated or complex, multisystem disease, in remote, rural and regional practice, and in resource limited and austere environments including GRiD contexts (Global, Remote/Rural/Regional and Deployable – humanitarian, disaster, military).

GRiD surgery is of particular relevance to general and orthopaedic surgeons. The Operational Clinic Skill Set (OCSS) is a proposed list of skills expected of deployed Australian Defence Force general

surgeons developed by RACS Fellows (Bender et al.).(16) The Operational Clinical Readiness Pathway (OCRP) is a process of defining and rectifying any skill deficiencies of general surgeons prior to operational deployment; 'an individualised plan for development arising from a process of facilitated reflection on their current skill set (readiness review) and supported by a compendium of recognised learning experiences'.(17)

The OCSS and OCRP are examples of responding to a specific community need and the reflective practice skills involved are relevant for all surgeons engaging in generalist, rural and RUFUS practice.

Behavioural markers	Graduate outcomes
2.1 Engages with the philosophy and practice of generalism.	Describes broad, subspecialist and extended scopes of practice. Conducts a broad scope of practice. Maintains core generalist elective and emergency skills within their discipline. Discusses the strengths and limitations of generalist and subspecialist models of surgical practice. Evaluates generalist and subspecialist models of care, incorporating patient, disease, procedural and contextual factors. Justifies which patients/conditions/procedures necessitate treatment by subspecialists or within subspecialist settings. Advocates for and/or designs and delivers evidence-based subspecialist surgical care, to ensure equitable access to subspecialist care, and to minimise the social and financial cost for RRR people of travelling for centralised subspecialist care.
2.2 Scope of practice is contextualised to the needs of the local community. Safely adapts scope of practice for different and evolving environments.	Responds to rural community need. • Identifies rural community need, including unmet need. • Adapts scope of practice in response to community need. • Develops strategies to safely and effectively acquire and maintain an extended scope of practice, or subspecialist scope of practice • Develops local surgical team and facility capability in response to community need. Describes the concepts of operational clinical skillset and operational clinical readiness in the context of global, humanitarian or military deployment. • Demonstrates insight in self-assessment of operational clinical readiness. • Develops strategies for maintenance of operational clinical skill set and addressing gaps in operational clinical readiness. • Discusses professional and ethical considerations in global, humanitarian and military service.
2.3 Advocates effectively for rural patients, families/ whānau and communities.	Responds to the complexity of accessing healthcare for remote, rural and regional people. Takes responsibility for coordinating members of dispersed or virtual teams. Assists patients to access healthcare and navigate the healthcare system.

DOMAIN 3 RURAL PROFESSIONAL PRACTICE

RRR surgeons are uniquely positioned as both providers for, and members of, their communities. RRR doctors have a depth and breadth of clinical responsibility and reciprocal relationships with community that urban doctors don't necessarily have. The considerations and implications of community integration become increasingly important with increasing rurality and remoteness.

Rural surgeons must balance

- the benefits of community integration and the need to maintain professional boundaries.
- responding to community need and maintaining a healthy and sustainable personal and professional life.
- knowing your own limits and having the courage to act in an emergency, at the limit or outside your scope of practice, in the absence of another suitable practitioner.

Rural medical culture describes the unique values and attitudes demonstrated by RRR doctors, which enable them to successfully meet community need, practising across a broad and/or extended scope of practice, in environments of resource limitation or variability and at a distance from other specialist or subspecialist teams. Rural medical culture intersects with the philosophy of generalism, and includes the concepts of rural self-efficacy, rural practice capability and rural clinical courage.

The formation of professional identity as a rural doctor involves the development of rural self-efficacy,(18,19) which is an individual's belief in their capabilities to practise in rural settings.

Rural practice capability describes the intersection of competence, capacity and performance in a specific rural professional and social context, or the ability to live and work effectively in a rural context.(20) This requires contextual knowledge and the ability to optimise your performance within a given context.

Rural clinical courage involves practising outside your usual scope of practice to provide access to essential (including emergency) medical care in the absence of a more suitable practitioner.(21–23) There are six elements:

1. A strong sense of belonging to and seeking to serve your community.
2. Accepting clinical uncertainty and persistently seeking to prepare for clinical challenges
3. Deliberately developing detailed contextual awareness, knowing what resources are available, how best to use them and how to advocate for more.
4. Humbly seeking to know the limits of your own clinical practice
5. Needing to clear a cognitive hurdle when deciding to act, the courage to act when necessary.
6. Developing and maintaining professional networks to support your practice.

Behavioural markers	Graduate outcomes
3.1 Delivers effective healthcare in rural practice.	Discusses the components of rural medical culture, including generalism, rural self-efficacy, rural practice capability and rural clinical confidence. Demonstrates rural self-efficacy, rural practice capability and rural clinical confidence Demonstrates a strengths-based, flexible and problem solving- approach to achieving health outcomes in RRR practice. Demonstrates resourcefulness, independence and self-reliance, while also being an effective collaborator, communicator and team member.
3.2 Balances dual roles of being a provider for and member of your community	Practises in a manner that recognises the realities of RRR health and community life. Manages privacy, confidentiality and professional boundaries while integrating into the community. Balances service to community with health, wellbeing and vitality of self and family.

	• Advocates for and has strategies to meet, your own need for social connection, healthcare, privacy and confidentiality. • Maintains healthy lifestyle to benefit personal health and be a positive role model for the RRR community. • Develops strategies for connecting with sources of personal and professional support. • Develops and maintains a diverse local and distant professional network to access professional and personal support.
3.3 Effectively balances duty of care and risks of overwork, fatigue and burnout. whānau and communities.	Implements strategies to ensure safe hours, fatigue risk mitigation, recognition of and response to fatigue for self, colleagues and trainees. Advocates and collaborates with stakeholders, for flexible and innovative approaches to managing 24-hour healthcare services in human resource-limited RRR environments. Plans and implements appropriate work-life integration. Takes regular breaks to strengthen resilience for sustainable practice.

DOMAIN 4 RURAL FOCUSED URBAN SURGICAL PRACTICE (RUFUS)

Rural focused urban surgeons engage in activities that support rural patients, surgeons, Specialist International Medical Graduates, Trainees, healthcare teams and healthcare facilities.

RUFUS actions include

- Inreach: providing care for rural people in an urban setting, including caring for RRR patients who travel to urban centres for care and/or providing virtual healthcare/telehealth for rural people in their home or community
- Outreach and locum practice: travelling to provide services in rural facilities.
- Collaborative healthcare: care in geographically dispersed teams including urban and rural practitioners
- Professional and personal peer support for rural colleagues.
- Application of rural health equity and Indigenous equity principles to specialty and subspecialty training, healthcare delivery and health system design, research, management and leadership.

RUFUS practice includes whole-of person care. The AMC defines whole-of-person care principles as the ‘consideration of a patient’s physical, emotional, social, economic, cultural and spiritual needs and their geographical location, acknowledging that these factors can influence a patient’s description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources-Australian Medical Council’(24)

Quality outreach services are responsive to community need, contextually sensitive, culturally appropriate and culturally safe. They integrate with and add value to existing services. They are viable and sustainable.

Domain 5 Virtual healthcare and virtual healthcare teams addresses collaborative healthcare in geographically dispersed teams.

Domain 6 Rural Health Equity addresses health system design.

Behavioural markers	Graduate outcomes
4.1 Engages in effective inreach practice for RRR people.	Demonstrates rural contextual decision making in caring for RRR people in urban facilities. • Engages in whole-of-person care. • Investigates and analyses the RRR context of rural patients and their families. • Incorporates contextual knowledge into clinical decision making to deliver whole-of-person care for rural people and their families.

- Demonstrates a flexible problem-solving approach to achieve outcomes for RRR patients.
- Upholds the individual's right to receive healthcare and to self-determine where and when to access care.

Provides cost-conscious care.

- Assesses the impact of management plans on the patient's social and economic context.
- Investigates ways to increase accessibility and affordability for individual patients.

Develops strategies to increase access to care for rural people and their families.

- Responds promptly and effectively for requests for advice, referral or transfer from RRR colleagues.
- Develops strategies to deliver care closer to home and/or reduce the burden of travelling for care, including virtual healthcare, outreach and/or collaborative care with RRR healthcare teams.

See also Behavioural maker 2.3 Advocates effectively for rural patients, families/whānau and communities.

- Responds to the complexity of accessing healthcare for remote, rural and regional people.
- Takes responsibility for coordinating members of dispersed or virtual teams.
- Assists patients to access healthcare and navigate the healthcare system.

4.2 Engages in effective outreach practice when caring for RRR people.

Incorporates RRR contextual knowledge into clinical decision making in RRR outreach practice.

- Discusses features of quality outreach
- Plans and implements systems of specialist and subspecialist outreach surgical services for RRR and geographically isolated communities.
- Collaborates effectively with rural communities, healthcare and administrative teams to design and deliver outreach services.
- Conducts risk management assessments and develops risk management plans for outreach services.
- Negotiates and engages in a contextually appropriate scope of practice.
- Supports rural facilities by maximising use of local resources and building the capacity of local healthcare teams through outreach practice.
- Advocates for rural outreach services to be incorporated into health systems.

Delegates shared care including after-care effectively within geographically dispersed healthcare teams.

- Ensures delegates have the skills to recognise and respond to clinical deterioration.
- Ensures safe and effective clinical handover.
- Documents plans for delegation, escalation and transfer.

4.3 Engages in effective locum practice when caring for RRR people.	Demonstrates rural contextual decision making in RRR locum practice. • Demonstrates insight into own scope and recency of practice, and RRR experience. • Investigates the RRR context and scope of practice of the locum position. • Compares own skills and experience to ensure an appropriate match to the locum position. • Describes key requirements of locum orientation to RRR practice context. Ensures timely and effective clinical handover at commencement and conclusion of locum service.

DOMAIN 5 VIRTUAL HEALTHCARE AND VIRTUAL TEAMS

Technology-enabled healthcare can increase access to care, enhance value and reduce the costs of healthcare for RRR people.

Telehealth modalities include primary, secondary, synchronous, asynchronous, text, telephone and video consultations, as well as wearable devices and applications that support virtual healthcare and remote monitoring of patients.

Rural patients may need referral, transfer or retrieval for necessary care. The risks inherent in clinical handover are elevated when transitions of care are associated with significant distance between healthcare facilities and when discharging rural people into the care of their GP.

Technology-enabled communication facilitates collaboration in virtual and geographically dispersed healthcare teams.

Examples of collaborative models of healthcare include remote decision support, shared care, secondary telehealth, virtual multidisciplinary meetings, virtual quality assurance and quality improvement activities (e.g. surgical audit) and continuing professional education.

Behavioural markers	Graduate outcomes
	Discusses technological solutions for improving access to quality care, close to home for RRR people. • Describes telehealth modalities. • Evaluates strengths, benefits and risks of each modality. • Discusses patient and clinical barriers to using telehealth. • Discusses principles of consent, collection, storage and transmission of electronic patient information, including protecting patient privacy and confidentiality.
5.1 Uses technology to provide healthcare services.	Demonstrates effective use of technology in providing healthcare services. • Identifies patients and clinical encounters suitable for telehealth. • Selects the most appropriate modality to achieve the goals of the consultation. • Assesses patient digital health literacy. • Teaches patients to use telehealth platforms. • Conducts surgical consultation by telehealth. • Demonstrates compliance with regulatory and health facility protocols for telehealth, including conducting, recording and billing telehealth consultations. Engages in virtual collaborative care arrangements with patient's RRR healthcare team. • Delegates and directs physical examination effectively, during secondary telehealth consultations.

	• Investigates and facilitates access to local patient-end virtual healthcare assistance services for RRR people, when needed.
5.2 Demonstrates safe and effective clinical handover in geographically dispersed healthcare teams.	Demonstrates safe and effective clinical handover over distance, including transfer between facilities and when discharging patients into the care of their GP. Develops strategies to manage risks in clinical handover over distance. Develops safety strategies for transfer of information, transfer of responsibility and transport or retrieval of the patient. Implements strategies for safe discharge into low resource healthcare environments, including remote communities.
5.3 Engages in effective collaborative practice within geographically dispersed teams.	Engages in collaborative models of healthcare in geographically dispersed teams. • Develops and maintains diverse local and distant professional networks to facilitate communication and collaborative care, and to receive and offer professional and personal support. • Uses existing and emerging technology to communicate and collaborate in geographically dispersed teams. • Collaborates with local healthcare teams to enable patients' access to care closer to home, including shared care, secondary telehealth and outreach. • Negotiates collaborative care arrangements, clearly communicating the responsibilities of each team member. Responds effectively to requests for advice, remote decision support or transfer/retrieval from rural facilities. • Assesses context of referring rural facilities to identify resources and capability, evaluate risks of treatment locally and of delayed care during transfer, provide remote decision support or coordinate patient transfer or retrieval or transfer when needed. • Demonstrates insight into the context, skills, knowledge and experience of practitioners working in remote and austere environments. Engages in collaborative models of training and supervision, including hybrid models of on-site and remote supervision.

DOMAIN 6 ADVOCACY FOR RURAL HEALTH EQUITY

Remote, rural and regional people have poorer access to healthcare and poorer health outcomes compared to people in urban areas.

Advocacy for rural health equity can occur in multiple domains: whole-of-person care, cultural competence and cultural safety, health system design, quality assurance and quality improvement, reflective practice and research.

Utilising national geographic classification systems for health ensures consistency and comparability in communication, quality assurance and quality improvement, research, health policy and advocacy. Disaggregating data is necessary in quality improvement activity and research to understand and develop solutions for inequity in health status and health outcomes.

Whole-of-person care, cultural competence and cultural safety

Rural culture is a subculture of national culture, with impacts on individual and collective values, attitudes, lifestyles and ways of doing things, including patient's experience of health and accessing healthcare.

Rural people are disproportionately affected by climate change and climate disasters.

Whakapapa (connection to iwi, hapu and family/whānau and to land/whenua family/whānau) is a cultural determinant of health for Māori. Family, mob/kinship relationships and Country are cultural determinants of health for Aboriginal and Torres Strait Islander Peoples. The intersection of rurality and Indigeneity results in poorer health outcomes for remote/rural and regional dwelling Māori and Aboriginal and Torres Strait Islanders compared to non-Indigenous rural people and urban people. First Nations people value family/whānau-centred care provided as close to home as possible. Travelling to access necessary healthcare can reduce access to cultural determinants of health.

Health system design

An ideal health system has a primary purpose of health equity, with the following principles.

- Delivery of quality care as close to home as possible, with support for patients and families who must travel for care.
- Efficient and effective use of limited resources, with equitable, rational, transparent allocation of resources.
- A health workforce with appropriate geographic distribution to meet community need,
- A balance of generalist, subspecialist and extended scope practitioners, in medicine, nursing and allied health.
- Place-based models of healthcare. Meeting community need using a variety of care models tailored to context. This includes an evidence-based balance between centralisation and geographically dispersed/distributed models of healthcare and systems to enable access to centralised care for defined patient/conditions/procedures where evidence demonstrates superior health outcomes with centralisation.
- Formal networks to enable collaboration across distance, in dispersed teams, and transfer and transport of patients when needed.

Quality assurance and quality improvement

Quality assurance and quality improvement activities include clinical audit, risk management, incident reporting, peer review of performance and reflective practice.

RRR people value care delivered as close to home as can be done well. Rural people may receive care in multiple sites and from multiple providers during a course of care. Assessment of healthcare quality includes the whole course of care, and includes patient context, health service context, access to care (and the burden on patients and families of accessing care), the outcomes of care, and patient and provider perspectives. The value of healthcare encompasses the total cost of the whole cycle of care, including costs to the health system, as well as to the patient and their family/whānau.

The context of practice should be considered when surgeons engage in peer review of self and of others.

Research

RRR people and researchers are under-represented in health and medical research. Research relevant to rural communities can contribute to improving access, healthcare delivery and health outcomes. Collaborating with rural people in the design and conduct of research can reduce barriers to participation, contribute to building RRR research capacity and generate evidence to inform system and service improvement.

Behavioural markers	Graduate outcomes
6.1 Recognises and responds to Remote, Rural and Regional (RRR) residence and	Identifies RRR people as an equity group with unequal access to resources, including healthcare, and who experience poorer health outcomes compared to urban people.

geography as social determinants of health at a systems level.	• Utilises national geographic classifications for health to ensure consistency and comparability in communication, quality assurance and quality improvement, research, health policy and advocacy. • Recognises that advocacy is necessary to ensure equitable access to healthcare. Considers to the impacts of climate change and climate disasters for RRR communities • Describes the importance of weather and climate to rural communities, industries, and infrastructure, including transport. • Identifies physical and environmental determinants of health for individuals and communities, including factors relevant to the impacts of climate change. • Discusses the impact of climate change and climate disasters on rural people, healthcare workers, communities, industries, infrastructure and economies. • Describes disaster preparedness and disaster response principles. Describes the principles of mental health first aid and trauma informed care.
6.2 Recognises and responds to the cultural determinants of health for Remote, Rural and regional Aboriginal and Torres Strait Islander People and/or Māori.	Considers the unique contexts of Remote, Rural and Regional Aboriginal and Torres Strait Islander People and/or Māori. • Describes cultural determinants of health • Develops knowledge of the Aboriginal and Torres Strait Islander People/Māori community (values, cultural practices, languages, land) in their RRR training or practice context. • Identifies local population health issues and their impact on Aboriginal and Torres Strait Islander People/ Māori. • Discusses how cultural practices and responsibilities may impact on healthcare pathways. • Evaluates disaggregated clinical audit data with an equity lens to identify inequitable access to healthcare or health outcomes. Demonstrates a strengths-based approach to whole-of-person care for Remote, Rural and Regional Aboriginal and Torres Strait Islander People and/or Māori. • Applies cultural competence and cultural safety principles, in caring for patients and their families/whānau. • Demonstrates shared decision-making, balancing protocol-driven care and appropriate cultural care. • Demonstrates culturally safe integration of the patient's family/whānau into shared decision-making. • Incorporates the cultural determinants of health in negotiating management plans with RRR Aboriginal and Torres Strait Islander People/Māori and their families/whānau • Advocates for delivery of healthcare in place, on Country or as close to home as possible. Implements care pathways and quality improvement processes to improve health service acceptability and accessibility for Aboriginal and Torres Strait Islander People and/or Māori • Facilitates access to interpreters in person or virtually, where language barriers exist between the medical team and the patient and their family/whānau.

- Investigates sources of culturally appropriate patient information relevant to specialty.
- Assesses acceptability and accessibility of local services, from a patient, family/whānau and community perspective.
- Identifies health resources available in the healthcare team, Aboriginal and Torres Strait Islander People/Māori liaison team, Aboriginal and Torres Strait Islander People/Māori healthcare services, the local community and family/whānau.
- Applies principles of self-determination, partnership, community ownership, consultation, capacity building, reciprocity and respect to healthcare delivery.
- Recognises the effectiveness of Aboriginal and Torres Strait Islander People/Māori healthcare workers, and the delivery of healthcare by specific Aboriginal and Torres Strait Islander/Māori interprofessional healthcare teams and healthcare organisations, in enhancing health outcomes.

Applies cultural competence and cultural safety principles in working with and supporting Aboriginal and Torres Strait Islander and/or Māori colleagues in training, surgery and the health workforce in general.

Discusses the elements of ideal health systems.

Demonstrates commitment to the effectiveness and sustainability of the healthcare system.

- Uses resources efficiently and effectively to optimise patient outcomes.
- Supports the transparent and equitable allocation of healthcare resources, based on need and evidence of benefit.

Critically evaluates healthcare guidelines, pathways and services for conditions and procedures, to determine if they are fit for purpose for RRR people.

- Evaluates existing health systems to identify barriers and formulate strategies to deliver care to RRR populations.
- Evaluates specialty-specific health outcomes data for RRR people and considers rural/urban inequity.

6.3 Utilises systemic opportunities to advocate for rural health equity.

Evaluates centralised and dispersed models of care.

- Discusses the strengths and limitations of centralised and dispersed models of healthcare.
- Analyses research and clinical quality databases to identify patients, conditions and procedures where the outcomes of centralisation may justify travel for RRR people.
- Analyses the social, cultural and financial implications for RRR people of centralisation of healthcare.

Advocates for and/or designs place-based healthcare services relevant to the context of the target population.

- Demonstrates engagement and partnership with RRR communities and RRR healthcare teams to develop healthcare services and pathways.
- Discusses the importance of rural expertise on decision-making bodies. Demonstrates awareness of and mitigation of bias and management of conflicts of interest.

	• Evaluates and supports evidence-based initiatives to increase rural surgical workforce recruitment, retention and wellbeing.
6.4 Demonstrates commitment to rural health equity in quality improvement and reflective practice	Applies a rural health equity lens to quality assurance and quality improvement activities to identify and address inequity in access and outcomes, and to inform service improvement. Considers context in assessing healthcare quality, employing quality metrics including the whole course of care, and patient and provider experience. Considers contextual factors in reflective practice, including review of self and of others.
6.5 Demonstrates commitment to rural health equity in designing and evaluating research activities.	Demonstrates use of national systems of geographic classification to ensure consistency and comparability in research. Critically appraises research with a rural health equity lens. • Evaluates disaggregated data to identify inequitable access to healthcare or health outcomes for RRR people. • Applies evidence from research to RRR contexts. Designs research and clinical trials inclusive of and relevant to RRR communities. • Identifies barriers to inclusion in research and clinical trials for rural people. • Collaborates with RRR patients and colleagues in design and conduct of research and clinical trial protocols. • Facilitates national and regional systems to recruit RRR people into research and clinical trials and to include RRR researchers in multicentre and collaborative research.

3 Teaching and learning strategies

3.1 Environments

Suggested learning environments include

1. Experience in remote, rural or regional training post and or RUFUS training sites, including elective and emergency surgery, transferring and receiving patients and clinical handover over distance.
2. Experience in telehealth, outreach, on-call and remote decision support for remote, rural and regional patients and surgeons.
3. Participation in virtual meetings, for example, multidisciplinary meetings, quality assurance and quality improvement meetings including audit, tutorials, lectures, webinars and conferences.

3.2 Core learning activities

Completion of RACS Rural Professional Skills eLearning course including content and multimedia case studies and the Rural Context Profile inquiry-based learning activity.

The Rural context profile inquiry-based learning activity involves:

1. Investigation and analysis of a remote, rural or regional training/practice context (or RUFUS context)
2. a personal development and learning plan to maximise training outcomes within the RRR or RUFUS context
3. planning and/or implementing a quality improvement or research project
4. collaboration with supervisors and peers
5. reflective practice.

3.3 Optional learning activities

Further optional activities are included as reflective or practice prompts within the RACS Rural Professional Skills eLearning course. Examples are given below.

Access Doctor Connect and The Geographic Classification for Health webpages to locate patient's RRR context.

Complete a patient journey map and costings. Uses map apps to understand distance, travel time by car and public transport, for RRR patient travelling for care.

Access policies and forms for Patient Transport Assistance Schemes.

Access Remote and Rural reports on health outcomes, particularly those within your specialty area. Access the Australian Atlas of Healthcare variation. Critically evaluate recent research in your field with a rural equity lens. Research systems at regional, state or national level your specialty already has in place to ensure equitable outcomes for RRR people (e.g. trauma, burns, stroke). Plan a rapid review comparing RRR and urban health outcomes in your specialty.

Read the RACS Rural Health Equity Strategic Action Plan, the Australian National Medical Workforce Strategy and The New Zealand Rural Health Strategy.

Read the Neurosurgical Society of Australia Guide to management of acute neurotrauma in remote and rural areas.

Complete the RACS Aboriginal and Torres Strait Islander Health and Cultural Safety eLearning program courses 1 to 4 and/or the

Māori/Indigenous Health Institute (MIHI) courses.

Locate your RRR training post in https://aiatsis.gov.au/explore/map-indigenous-australia. Find your ACCHO https://www.naccho.org.au/acchos/

Read MBA/AHPRA and MCNZ standards for telehealth.

Access the resources in the table below, including policies, journals, media, conferences.

3.4 Resources

Source	Australia	New Zealand
World Health Organisation	WHO health building blocks(25), WHO sustainable development goals(26), WHO guidelines for rural workforce retention(6)	
Geographic Classifications for Health	Modified Monash Model(1)	The Geographic Classification for Health(2)
Government departments, strategies, policies, information	National Medical Workforce Strategy(27) National Rural Health Commissioner(28) Australian Institute of Health and Welfare AIHW(29) Rural health multidisciplinary training program(30) Rural Generalist Program(31) Specialist Training Program STP(32) Flexible approach to training in expanded settings program FATES(33) State based rural workforce agencies: e.g. RWAV(34), WACHS(35)	The Pae Ora (Healthy Futures) Act 2022(36) Health New Zealand (Te Whatu Ora), (37) Māori Health Authority (Te Aka Whai Ora) New Zealand Rural Health Strategy 2023(38)
Interdisciplinary peak organisations	National Rural health alliance NRHA (39) Funding: 50% government, and 50% from 54 members including RACS Annual rural health snapshot, regular newsletter – Bushwire, emagazine – Partyline, Podcast: Build ‘em up The Australian Journal of Rural Health	Hauora Taiwhenua (Rural Health Network)(40)
Primary, Prevocational and Specialist Medical Training	Australian Medical Council(41) Medical Deans of Australia & New Zealand (graduate outcomes data base)(42) Council of Presidents of Medical Colleges(43)	
Universities	Rural Health Multidisciplinary Training Program - Rural health multidisciplinary training hubs, University Departments of Rural Health, Rural clinical schools(30)	University of Otago Rural health section,(44) Whatunga Rangahau Oranga Ahuwhenua Rural Health Research Network
Medical	Rural Doctors Association of Australia(45) (website, newsletter, podcast, Rural Medical	

	Australia conference, Australian Journal of Rural Health) AMA Rural Doctors section(46) NSW Rural Doctors network	
Surgical	RACS Rural Surgery Section(47) RACS Rural health equity strategic action plan, Rural health equity steering committee. Membership, webpage, resources	
	Provincial Surgeons Australia(48) ASOHNS Society of Country ENT surgeons	
General practice	RACGP Rural,(49) ACRRM(50)	NZCGP – Rural and Rural Hospital Medicine(51)
Nursing	CRANA (52)	
Allied health	SARAH (53)	
Journals	Australian and New Zealand Journal of Surgery ANZJS Rural Section(54) Australian Journal of Rural Health AJRH (RDAA) Journal of Remote and Rural Health RRH	
Conferences	GSA Provincial Surgeons Australia Conference (48) Rural Surgery Section sessions at RACS ASC, Monash Rural Health DRIVERS conference (55)(VIC), Southwest Surgical conference WA, National Rural Health Alliance Rural Health Conferences Rural and Remote Health Scientific Symposium(56) co-hosted by NRHA, Australian Rural Health Education Network (ARHEN), the Federation of Rural Australian Medical Educators (FRAME) and the Lowitja Institute. Rural Medicine Australia RMA conference (RDAA) and ACRRM(57)	

3.5 Assessment

	Formative assessment	Summative assessment
Core	Supervisors may utilise the Trainee's Rural context profile inquiry-based learning activity completed as part of the RACS Rural Professional Skills eLearning course.	RACS Rural Professional Skills eLearning course end of module assessments/knowledge checks. Multiple attempts allowed to learn from mistakes, completion of each module contingent on 80% pass rate for five questions. Thirty-five questions in total.

Optional	Presentation and discussion of rural contextual decision-making case, using rural contextual decision-making algorithm (contained in RACS RRR Professional Skills eLearning course, Module 5 Rural contextual decision making), with supervisor Observation and feedback from supervisor on entrustable professional activities (e.g. mini-Clinical examination) 1. Assessing and negotiating whole-of-person management plans for RRR patients 2. Telehealth consultation 3. Collaboration and teamwork: recognising and responding to acutely unwell patient including providing or requesting remote decision support and transfer 4. Communication: safe handover over distance	In future, RACS and the SET committees/AOA Training Committee may choose to incorporate the RACS Rural PSC domains into the RACS PSC and then into the fellowship examination.

3.6 Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
Ahpra	Australian Health Practitioner Regulation Agency
AMC	Australian Medical Council
AOA	Australian Orthopaedic Association
GRiD	Global, Remote/Rural/Regional and Deployable Surgery.
MBA	Medical Board of Australia
MCNZ	Medical Council of New Zealand
RACS	Royal Australasian College of Surgeons
RACS PSC	RACS Professional Skills Curriculum
RACS Rural PSC	RACS Remote, Rural and Regional professional skills curriculum
RRR	Remote, Rural and Regional
RUFUS	Rural focused urban surgeon. Can be used interchangeably with rural facing urban surgeon.
SET	Surgical Education and Training
WHO	World Health Organisation

3.7 Glossary

Asynchronous telehealth	Digitally transmitted health information from patient at time point 1, then clinician assessment, analysis and reply at time point 2. For example, a patient requesting a repeat prescription from a surgeon via an online portal or practice website.
Audit	A systematic review of clinical care against a predetermined set of criteria.(58)

Broad scope specialist	Regularly practices across the full range of their specialty ('core scope'), can be used interchangeably with 'generalist'. In nursing and allied health. 'Top of scope' has a similar meaning.
Centralised models of healthcare	Organisation of health services into fewer specialised units serving a higher volume of patients, generally in urban centres.
Collaborative healthcare	In the context of this curriculum, care in geographically dispersed teams including urban and rural practitioners. Examples include seeking and providing remote decision support, shared care, secondary telehealth, virtual multidisciplinary meetings, virtual quality assurance and quality improvement including audit and continuing professional education.
Community integration	Being connected to and engaged with your community. Participating and belonging. Contributing to and feeling part of a community, including social, cultural, civic, sports and leisure.
Country	'Country is the term often used by Aboriginal peoples to describe the lands, waterways and seas to which they are connected. The term contains complex ideas about law, place, custom, language, spiritual belief, cultural practice, material sustenance, family and identity- IATSIS'(59)
Cultural determinants of health	The protective factors that enhance resilience, strengthen identity and support good health and wellbeing. These include, but are not limited to, connection to Country; family, kinship and community; Indigenous beliefs and knowledge; cultural expression and continuity; Indigenous language; and self-determination and leadership.(60,61) Whakapapa (connection to iwi, hapu and family/whānau and to land/whenua family/whānau) is a cultural determinant of health for Māori. Family, mob/kinship relationships and Country are cultural determinants of health for Aboriginal and Torres Strait Islander Peoples. First Nations people value family/whānau-centred care provided as close to home as possible. The intersection of rurality and Indigeneity results in poorer health outcomes for RRR dwelling Māori and Aboriginal and Torres Strait Islanders compared to non-Indigenous rural people and urban people.
Digital health literacy	The ability to use information and communication technologies to find, evaluate, create, and communicate information, requiring both cognitive and technical skills.(62)
Disaggregated data	Data broken down into categories of interest to identify differences between groups. In the context of this course, disaggregated data means reporting data in line with geographic classifications for health and for Aboriginal and Torres Strait Islander people and Māori to identify differences in access to healthcare or health outcomes.
Dispersed models of healthcare	A majority of elective and emergency care is provided close to home in geographically dispersed health facilities, within a system or network of care enabling transfer of patients to facilities with higher capability levels when needed.
Extended scope of practice	In addition to practicing in their specialty, practices in limited areas of other specialties in response to community need. In general practice, nursing and allied health, 'advanced practice' has the same meaning.
Generalism	'Generalism is a philosophy of care that is distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger healthcare team in order to respond to patient and community needs.

	The philosophy of generalism applies to all physicians and surgeons regardless of their scope of practice. Where one lies on the spectrum influences the application, incorporation and utilization of the philosophy of generalism in one's practice. The professional's responsibility and role within their community also dictates the application of generalism'.(15)
Generalist	Generalists are a specific set of physicians and surgeons with core abilities characterised by a broad-based practice. Generalists diagnose and manage clinical problems that are diverse, undifferentiated, and often complex. Generalists also have an essential role in coordinating patient care. Generalists advocate for patients within the health system.(15)
GRiD - Global, remote/rural/regional and deployable surgery	Deployable surgery includes humanitarian and military surgery. The unique skill set of GRiD surgeons includes 1. rapid assessment and adaptation to context 2. recognising and responding to the needs of the community or situation 3. cultural competence and cultural humility, collaboration and teamwork, and professionalism and ethics. 4. generalist surgical skills: maintaining a broad and extended scope of practice 5. strategies for delivering best possible healthcare in constrained resource and austere environments- contextual decision making 6. developing and maintaining operational clinical readiness – managing complex high acuity care in resource limited environments
Fatigue risk mitigation, fatigue recognition and fatigue response	Fatigue risk mitigation involves organisational culture and systems to proactively reduce the risk of fatigue occurring. Fatigue recognition means recognising when a practitioner is experiencing fatigue. Fatigue responses are actions to prevent the harm to patients and the practitioner when fatigue is recognised.
Geographic classifications for health	National systems of geographic classification specific to healthcare, including The Geographic Classification for Health Aotearoa New Zealand(2) and Modified Monash Model Australia.(1)
Geographically dispersed teams	Team members share a common goal in providing care for one or more patients, while working in geographically separate facilities and collaborating in a virtual environment, and/or with members of the team travelling between facilities at defined times, for example, to provide outreach or a rural surgeon with a dual appointment in an urban hospital. Regional multidisciplinary meetings are the most common example of collaborative care delivered by geographically dispersed teams.
Inreach	Providing healthcare from a central location or providing healthcare for rural people in an urban setting. Examples include caring for RRR patients who travel to urban centres for care and/or providing virtual healthcare/telehealth from an urban setting for rural people in their home or community. Inreach in a health professional context also refers to the movement of healthcare workers from rural or lower capability facilities to urban and/or higher capability facilities to work, train, maintain skills or update skills.
Local community	The people living in a defined geographic region or from a specific group who receive services from a health service organisation.(58)

Multidisciplinary team	A team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient. Multidisciplinary care includes interdisciplinary care.(58)
RRR locum	A surgeon from an urban or larger regional centre travelling to work temporarily in a remote, rural or regional facility, often to replace a local surgeon during a period of leave.
Outreach	Travelling from one location to provide healthcare in another location. In this context, applies to travelling from an urban centre to a RRR community to provide services, or from a larger regional centre to a remote or rural community.
Operational clinical skill set	A proposed list of skills expected of deployed Australian Defence Force general surgeons developed by Bender et al.(16)
Operational clinical readiness pathway	The process of defining and rectifying any skill deficiencies of general surgeons prior to operational deployment; 'an individualised plan for development arising from a process of facilitated reflection on their current skill set (readiness review) and supported by a compendium of recognised learning experiences'.(17)
Patient-end and patient-end assistance	Describes the location of the patient during a telehealth consultation. Patient-end assistance means another person is with the patient to provide support, including non-clinical support (providing access to a device, connectivity and the skills to operate the device), or a clinician participating in secondary telehealth.
Partnership	A situation that develops when patients and consumers are treated with dignity and respect, when information is shared with them, and when participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose.(58)
Place-based approaches	Contextual healthcare design; tailoring the health service or process to the context of the community receiving the healthcare service. Policy, program and service approaches that recognise and respond to the characteristics of the community in which they operate. For place-based approaches to be successful, the community and its needs must be at the centre. This includes co-development, planning, selecting, designing and governing physical and social infrastructure, as well as for the facilities and services themselves.(60,61)
Primary telehealth	Phone or video consultation with a clinician at the clinician-end and the patient at the patient-end of call.
Quality assurance and quality improvement	Collectively, to 'protect the public from harm and to improve the quality of health service provision'. Quality assurance involves mechanisms to 'test whether relevant systems are in place to ensure that expected standards of safety and quality are met'. Quality improvement involves 'the combined efforts of the workforce and others – including consumers, patients and their families, researchers,

	planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development. Quality improvement activities may be undertaken in sequence, intermittently or continually.'(58)
Remote	Depending on context, may refer to virtual communication, collaboration or healthcare between geographically distant people/patient/team members or a geographical region as defined by national geographic classifications for health.
Remote decision support	A collaborative model of healthcare involving geographically distant surgeons providing advice by phone or video call to support a RRR surgeon or health practitioner in delivering healthcare.
Remote, rural and regional	Geographic areas as defined in National Geographic Classifications for Health.(1,2)
Resource-limited environments	In this context, can be taken to mean any healthcare setting without 24-hour onsite or on-call access to all medical and surgical specialties and associated multidisciplinary teams, infrastructure and resources.
Resource variability	Variability in resources between healthcare settings, or over time within a given healthcare setting.
Rural clinical courage	Rural clinical courage(21–23) involves practising outside your usual scope of practice to provide access to essential (including emergency) medical care in the absence of a more suitable practitioner. There are six elements: 1. A strong sense of belonging to and seeking to serve your community. 2. Accepting clinical uncertainty and persistently seeking to prepare for clinical challenges 3. Deliberately developing detailed contextual awareness, knowing what resources are available, how best to use them and how to advocate for more. 4. Humbly seeking to know the limits of your own clinical practice 5. Needing to clear a cognitive hurdle when deciding to act, the courage to act when necessary. Developing and maintaining professional networks to support your practice.
Rural context	Context comprises three inter-related elements: • Place: geography, topography, natural resources, climate, climate change, transport, industry, disasters and disaster preparedness • People: First Nations people, demography, culture, community, health and welfare • Healthcare system: health facility resources and capability level and connections to other facilities in the healthcare network
Rural contextual decision making	The incorporation of rural contextual factors into clinical decision making when caring for rural people or when practicing in a remote, rural or regional context. Considerations in rural contextual decision making include whole-of-person care, patient and family/whānau values and preferences; community need; resource variability or limitation; capacity and capability of surgical team and healthcare facility; community integration and boundaries; fatigue prevention, mitigation and response; transport, retrieval and balancing

	potential benefits and risks of transferring a patient for care in another facility.
Rural culture	Rural culture is a subculture of national culture, with impacts on individual and collective values, attitudes, lifestyles and ways of doing things, including patient's experience of health and accessing healthcare. Rural culture is influenced by factors including local Aboriginal and Torres Strait Islander and/or Māori culture, the natural environment, agriculture and industry, tourism, weather and climate, geographic isolation and population density.
Rural-focused urban surgeon	Rural-focused urban surgeons engage in activities that support rural patients, surgeons and healthcare teams. RUFUS actions include • Inreach: providing care for rural people in an urban setting, including caring for RRR patients who travel to urban centres for care and/or providing virtual healthcare for rural people in their home or community • Outreach and locum practice: travelling to provide services in rural facilities. • Collaborative healthcare: care in geographically dispersed teams including urban and rural practitioners • Professional and personal peer support for rural colleagues and Trainees. • Application of rural and Indigenous equity principles to specialty and subspecialty training, healthcare delivery and health system design, research, management and leadership.
Rural Generalist	A medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care, and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.(63)
Rural generalism	Describes the 'broader generic contextual skills beyond the normal scope of a particular profession, but relevant for all rural professionals'. (64)
Rural Health Multidisciplinary teams	Pertains to primary care in rural settings. The rural health multidisciplinary team • consists of generalist/broad/top of scope and extended/advanced scope General Practitioners, Nurses, Allied Health Practitioners and Indigenous Healthcare Workers. • working in interdisciplinary, multiskilled and multipurpose teams with overlapping scopes of practice. • with support and collaborative care arrangements with non-GP specialists in secondary and tertiary facilities • providing comprehensive care close to home within frameworks to ensure clinical safety, quality, risk management and accountability, clearly defined roles, professional autonomy, and communication processes.(65)
Rural medical culture	Rural medical culture describes the unique values and attitudes demonstrated by RRR doctors, which enable them to successfully meet community need, practising across a broad and/or extended scope of practice, in environments of resource limitation or variability and at a distance from other specialist or subspecialist teams. Rural medical culture intersects with the philosophy of generalism, and includes the concepts of rural self-efficacy, rural practice capability and rural clinical courage.

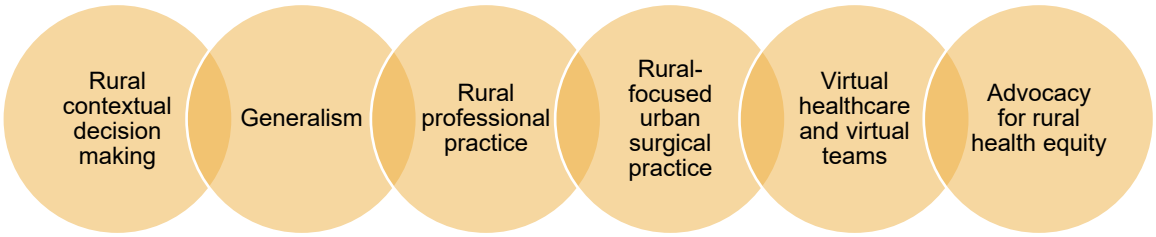
Rural practice self-efficacy	An individual's belief in their capabilities to practice in rural settings.(18,19)
Rural practice capability	The intersection of competence, capacity and performance in a specific rural professional and social context, or the ability to live and work effectively in a rural context. This requires contextual knowledge and the ability to optimise your performance within a given context.(20)
Self determination	The right of all people to 'freely determine their political status and freely pursue their economic, social and cultural development' and to make their own decisions about matters that affect their lives.(60,61)
Scope of practice	Professional activities that a practitioner is educated, competent and authorised to perform, and for which they are accountable.(66) The 'core scope' of clinical practice refers to those aspects of clinical practice that can reasonably be expected to be undertaken by all practitioners holding a particular qualification, having successfully completed the education and training leading to that qualification.(67) Individual scope is time-sensitive and dynamic. Scope of practice for individual practitioners is influenced by the settings in which they practise, the health needs of people, the level of their individual competence and confidence and the policy requirements (authority/governance) of the service provider.(68)
Secondary telehealth	Collaborative model of healthcare involving a clinician at both ends of the phone or video call, either clinician 1 at clinician-end and clinician 2 with patient at patient-end, or clinician 1 at clinician-end and clinician 2 without patient at patient-end. Clinician 2/at the patient-end of the consultation may relay information, negotiate a management plan or be a de facto examiner directed by clinician 1. Patient-end clinicians could be nurses, Indigenous Health Workers or doctors. Examination can include external examination or technology assisted examination, e.g. digital video endoscopes in ENT; digital stethoscopes.
Shared decision making	A consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.(58)
Strengths-based approaches	A strengths-based approach focuses on the unique strengths, capabilities and resources of people, places and communities, and looks for opportunities to capitalise on, complement and support existing strengths. Strengths-based approaches work in opposition to deficit-based discourse and approaches, which focus on areas of problem or concern, and can perpetuate negative stereotyping. Viewing situations realistically and looking for opportunities to complement and support existing strengths (see cultural determinants of health) and capacities as opposed to a deficit-based approach which focuses on the problem or concern.(60,61)
Subspecialist	A specialist practicing within a limited clinical area of their specialty. A practitioner may practice only within their subspecialty (narrow or limited scope specialist) or may engage in subspecialist practice in addition to generalist practice.

Synchronous telehealth	Real-time phone or video consultation with a clinician and patient. Both parties can see or hear each other and exchange information, ask questions and negotiate a management plan in real time.
Virtual healthcare (e-health)	The use of technology to facilitate access to healthcare and health information, including patient self-management, delivering health services (consultations, remote monitoring), health workforce development, health research, management and leadership. The terms e-health, e-medicine and virtual healthcare are often used interchangeably to refer to any technology facilitated communication or healthcare episode, occurring outside of a face-to-face encounter between patient and healthcare worker.
Virtual healthcare teams	Healthcare teams engaging in a virtual environment, especially where team members may be geographically dispersed. Teams may be formal and ongoing (for example, a regional multidisciplinary team) or may be informal, ad hoc and time-limited (for example, when a rural Trainee contacts an urban Trainee or surgeon for advice, referral or transfer of a patient).
Whānau	Family, including extended family and close friends
Whole-of-person care principles	'Consideration of a patient's physical, emotional, social, economic, cultural and spiritual needs and their geographical location, acknowledging that these factors can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources-Australian Medical Council'.(24)

4 Appendix 1: RACS Remote, rural and regional professional skills eLearning course – A guide for supervisors

The purpose of the RACS Remote, Rural and Regional Professional Skills Curriculum (RACS Rural PSC) is to define the knowledge, skills, values and behaviours required to care for rural people within remote, rural and regional (RRR) practice, rural-focused urban surgical practice (RUFUS), virtual healthcare, and collaboration in virtual and/or geographically dispersed healthcare teams.

There are six domains of competence within the RACS Rural PSC.



The RACS Rural PSC is designed to accompany remote, rural or regional training experience, and/or RUFUS training experience. It presents a standardised guide to the development of skills for Trainees and supervisors to optimise surgical training experience in rural, RUFUS, virtual and collaborative care settings.

The RACS Rural PSC is supported by the RACS Remote, rural and regional professional skills eLearning course, available on the RACS website for Trainees, Specialist International Medical Graduates (SIMGs) and Fellows. There is no cost associated with enrolling in and completing the course.

Engagement with the RACS Rural PSC and eLearning course is optional for Trainees, SIMGs and Fellows. In the longer term, there are opportunities for the curriculum domains to be incorporated into future iterations of the RACS Professional Skills Curriculum and the specialty specific Surgical Education and Training and AOA Curricula.

The course can be accessed via this link: https://elearning.surgeons.org/course/view.php?id=683

4.1 Resources for supervisors

The curriculum and eLearning course are significant new resources, designed to reduce the load on individual supervisors and training sites of providing formal learning experiences for, and workplace assessment of, professional skills in rural and RUFUS contexts.

The course comprises seven modules.

1. Rural health equity
2. Health systems for rural health equity
3. Rural context
4. Rural professional practice
5. Rural contextual decision making

6. Rural-focused urban surgical practice
7. Virtual healthcare and virtual teams

The course includes formative and summative assessment activities. There are in-module assessment items for each module with an 80% pass rate to enable progression through the course.

Formative assessment can be undertaken by completion of the Rural context profile inquiry-based learning activity. Using a Rural context profile template, supplied with the course, Trainees will undertake five sequential activities as they progress through the course modules and their training term.

1. Investigation and analysis of their remote, rural or regional training/practice context (or RUFUS context).
2. A personal development and learning plan to maximise training outcomes within the RRR or RUFUS context – discussed and negotiated with supervisor.
3. Planning and/or implementing a quality improvement or research project, including collaboration with their team or a peer.
4. Collaboration with supervisors and peers – presenting the data and analysis at a unit, supervisor or peer meeting, discussion and incorporating feedback.
5. Reflective practice – reflecting on the process.

The Rural context profile template is intentionally detailed. It accurately represents the depth and breadth of contextual knowledge rural and RUFUS surgeons develop to practice effectively. Rural facilities are highly variable, and not all elements may be relevant to every site. The intention is to enable Trainees to develop the skills to rapidly gain situational or contextual awareness in new practice contexts, to enable them to rapidly adapt to become an effective member of the healthcare team and to deliver healthcare effectively.

It is not necessary for a Trainee to ‘start from scratch’, complete the entire profile themselves or work in isolation. Collaboration with local and distant peers is a core skill for rural and RUFUS surgeons and Trainees are encouraged to work with their surgical team, including surgeons and supervisors, and local and distant peers, to complete the profile.

It is likely that the rural context profile for each training site will become a living document for the training site and/or surgical unit, with each Trainee updating and adding to it over time. The rural context profile may be shared between surgical units and used as a handover document for Trainees, prevocational doctors and students joining the team. Trainees should be mindful of the data they include and ensure no sensitive information is captured, as well as implement security measures such as file protection and provide their supervisor with access to support continuity.

4.2 How to use the curriculum and eLearning course

Supervisors are encouraged to incorporate the curriculum, eLearning course and Rural context profile into the formal learning program for their training site, and in the development of personal development and learning plans and reflective practice for individual Trainees. Supervisors may incorporate the rural context profile into the orientation and onboarding of Trainees, as well as other members of the surgical team.

Supervisors are also encouraged to engage with the eLearning course to support their continuing professional development, including in the Cultural Safety, Addressing Health Inequity, Professionalism and Ethical Practice (CAPE) category. The estimated time for completion of the course including the rural context profile is approximately 20 to 25 hours, spread over a six- to twelve-month period.

4.3 Feedback from trainees and supervisors

More than 200 Trainees, Specialist International Medical Graduates and surgeons were involved in developing, evaluating and improving the curriculum and eLearning course before publication. In the first year of release, the development team welcomes further feedback to ensure the curriculum and learning environment are fit for purpose for Trainees and supervisors.

5 Appendix 2: Mapping rural professional skills curriculum domains to existing curricula

5.1 Mapping to RACS professional skills curriculum, Australian medical council graduate outcomes statements for primary medical programs and the prevocational framework and a better culture curriculum

DOMAIN 1 RURAL CONTECTUAL DECISION MAKING	
Maps to RACS PSC	Judgement and clinical decision making 5.3 Makes shared and autonomous decisions using situational awareness and judgement, and considers patients, colleagues, circumstances and resource management. Accountable for making the decision and its impact. Assesses environmental, personnel and patient related factors that may affect treatment outcome. Scholarship and teaching 8.1 As scholars and teachers, surgeons demonstrate a lifelong commitment to surgical practice through reflective learning and the creation, dissemination, application and translation of medical knowledge for optimal patient outcomes.
Maps to AMC Graduate outcome statements	Domain 1 Practitioner Primary: 1.2 Apply whole-person care principles in clinical practice, including considering a patient's physical, mental, developmental, emotional, social, economic, environmental, cultural and spiritual needs and their geographic location. 1.5 Culturally safe practice 1.11 provide accessible information… to enable fully informed choices, 1.12 adapt management proposals to needs of patients and their families. 1.16 Work within the interprofessional team to identify and justify management options, based on evidence, access to resources and services, and on the patient's needs and preferences. Prevocational: 1.2 shared decision making 1.7 patient management: Make evidence-informed management decisions and referrals using principles of shared decision-making with patients, carers and the healthcare team. Domain 2 professional and leader Primary: 2.13 Demonstrate lifelong learning behaviours, including seeking feedback on, reflecting on and evaluating their own professional practice. 2.14 Seek, reflect on and use feedback in critically evaluating their own professional practice to improve the cultural and clinical safety of their practice for colleagues, patients and their families and carers. Prevocational

	2.3 Self Education: Demonstrate lifelong learning behaviours and participate in, and contribute to, teaching, supervision and feedback.

DOMAIN 2 GENERALISM

Maps to RACS PSC	No correlate
Maps to AMC Graduate outcome statements	Domain 2 professional and leader Primary: 2.5 Recognise the complexity and uncertainty inherent in the healthcare of diverse patients and be aware of the limits of their own expertise. 2.6 Engage with the interprofessional team to optimise patient outcomes, particularly to manage complexity and uncertainty. Prevocational: 2.4 Clinical Responsibility: Take increasing responsibility for patient care, while recognising the limits of their expertise and involving other professionals as needed to contribute to patient care. Domain 3 Health Advocate Primary 3.12 Describe global health issues and determinants of health and disease, including their relevance to healthcare delivery in Australia and Aotearoa New Zealand, the broader Western Pacific region and in a globalised world.

DOMAIN 3 RURAL PROFESSIONAL PRACTICE

Maps to RACS PSC	Professionalism 7.4 Demonstrates commitment to patients, the community and the profession through the ethical practice of surgery and demonstration of cultural competence and cultural safety. Maintains personal health and wellbeing to optimise performance
Maps to AMC Graduate outcome statements	Domain 2 professional and leader Primary: 2.7 Demonstrate awareness of professional limitations and actively monitor and address personal wellbeing, fatigue, health and safety to support self-care and patient care. This includes seeking support when needed and following the relevant advice of a trusted health professional. 2.9 Respect the boundaries that define professional and therapeutic relationships in clinical practice. Prevocational: 2.2 Self-management: Identify factors and optimise personal wellbeing and professional practice, including responding to fatigue, and recognising and respecting one's own limitations to mitigate risks associated with professional practice.

DOMAIN 4 RURAL FOCUSED URBAN SURGICAL PRACTICE

Maps to RACS PSC	No correlate

Maps to AMC Graduate outcome statements	Domain 3 Health Advocate Prevocational 3.2 Whole of person care: Apply whole-of-person care principles to clinical practice, including consideration of a patient's physical, emotional, social, economic, cultural and spiritual needs and their geographical location, acknowledging that these factors can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources. (Whole-of-person care includes consideration of all dimensions that can affect a person's overall health. These dimensions include but are not limited to an individual's geographical location, culture, sexual orientation, gender identity and any disabilities, Social, economic, cultural, historical and environmental (including climate change).

DOMAIN 5 VIRTUAL HEALTHCARE AND VIRTUAL TEAMS, INCLUDING GEOGRAPHICALLY DISPERSED TEAMS

Maps to RACS PSC	Collaboration and teamwork 1.1 Works cooperatively with others 1.4 patient safety, continuity of care Communication: 'telehealth' appears as a teaching and learning activity and in reference list
Maps to AMC Graduate outcome statements	Domain 1 Practitioner Primary 1.1 patient safety (clinical handover), 1.16 work within the interprofessional team, 1.24 Demonstrate digital health literacy and capability in supporting patients and their families and carers to use technology for promoting wellbeing and managing health concerns. EPA 4 Team communication – documentation, handover and referrals: facilitate high quality care at transition points and referral, Prevocational: 1.7 shared decision making with patients, carers and the healthcare team, 1.10 Utilising and adapting to dynamic systems: Appropriately use and adapt to dynamic systems and technology to facilitate practice, including for documentation, communication, information management and supporting decision-making. Domain 2 Professional and Leader Primary: 2.11 Describe and show respect for the roles and expertise of healthcare and other professionals. Prevocational: 2.5 Teamwork: Respect the roles and expertise of healthcare professionals and learn and work collaboratively as a member of an inter-professional team.

Domain 3 Health Advocate

Primary

3.8 Describe how incorporating health technologies in clinical practice can both improve patient experiences and outcomes and present risks, particularly for community groups who experience health inequities and for Aboriginal and/or Torres Strait Islander and Māori communities.

DOMAIN 6. 1 ADVOCACY FOR RURAL HEALTH EQUITY – WHOLE-OF-PERSON CARE AND HEALTH SYSTEMS

Maps to RACS PSC

Communication

2.3 recognising and mitigating bias

Health Advocacy

Identifies and responds to the health needs and expectations of patients, families, carers and members of the healthcare team. Responds to the health needs of communities and the health system by supporting rational, evidence-based measures to improve health outcomes in the wider community. Promotes cultural competence and safety to improve health outcomes in the broader community.

4.2

Responds to the social determinants of health Is aware of how social determinants of health and the health system can impact on patients and their health outcomes. Advocates for better healthcare to assist in more equitable health outcomes for patients, especially those living in rural and remote areas, those affected by disadvantage related to disability, education, geography, nutrition and living standards, and with particular reference to Aboriginal and Torres Strait Islander people and Māori.

Discusses how social determinants impact on health and healthcare. Discusses how the health system and design impacts on patients and their health outcomes. Optimises practical interventions to minimise the effects of the social determinants of health and improve outcomes. Discusses ideas how the health system could work differently. Advocates for equitable and culturally safe healthcare. Discusses different models for health system transformation and their implementation.

4.3

Demonstrates a commitment to the sustainability of the healthcare system. Discusses value-based healthcare and the financial and environmental costs of healthcare Uses an evidence-based approach to identify investigations or procedures that are shown to have minimal or marginal benefits for patients. Evaluates treatment plans from the perspective of financial and environmental considerations. Demonstrates commitment to the sustainability and efficiency of the healthcare system.

(no correlate for climate change)

Maps to AMC Graduate outcome statements

Domain 1 Practitioner

Primary:

1.2 Apply whole-person care principles in clinical practice, including considering a patient's physical, mental, developmental, emotional, social,

economic, environmental, cultural and spiritual needs and their geographic location.

1.5 Culturally safe practice

1.11 provide accessible information… to enable fully informed choices,

Domain 3 Health Advocate

Primary:

3.1 Describe differences in healthcare access, healthcare delivery and patient experiences across diverse hospitals and community health settings in metropolitan, rural and remote areas.

3.2 Identify the social, cultural, personal, physical and environmental determinants of health for individuals and communities, including factors related to the ongoing impacts of climate change.

3.10 Describe the principles of sustainable and equitable allocation of finite resources to meet the needs of individuals and communities now and in the future, and the roles and relationships between health agencies, disability agencies and services in resource allocation.

3.9 Describe a systems approach to improving the quality, safety, sustainability and inclusivity of healthcare.

Prevocational:

3.2 Whole of person care: Apply whole-of-person care principles to clinical practice, including consideration of a patient's physical, emotional, social, economic, cultural and spiritual needs and their geographical location, acknowledging that these factors can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources.

(Whole-of-person care includes consideration of all dimensions that can affect a person's overall health. These dimensions include but are not limited to an individual's geographical location, culture, sexual orientation, gender identity and any disabilities, Social, economic, cultural, historical and environmental (including climate change).

Maps to Better Culture Curriculum

7. Trauma-informed care:

L.1.7 Describe the principles of trauma-informed care, recognising the impact of trauma on individuals' physical, emotional, and cognitive states.

L.2.7 Demonstrate trauma-informed interactions with patients and workplace colleagues. Provide immediate support when patients or team members experience trauma and identify where to seek additional help.

L.3.7 Compare exemplars of trauma-informed health interventions at group or population level to own system and collaborate to develop improvement actions.

O2.7 Evaluate the effectiveness of systems for disclosing and managing trauma in staff and patients. Demonstrate planning and processes to manage the enhanced risks of trauma during exceptional events.

O3.7 Develop pathways to support trauma recovery and post-traumatic growth in staff and peers. Show how cultural and contextual considerations are incorporated to recognise the diverse range of trauma responses.

9. Working for equity in systems:

	L.1.9 Describe deficit-based narratives and develop skills in respectfully prompting awareness of them during routine work. L.2.9 Demonstrate integration of cultural safety and equity into responses to non-routine demands such as high emergency demand or environmental event. L.3.9 Identify systemic inequity in healthcare delivery and implement collaborative actions for sustainable improvement at unit, organisation or population level.

DOMAIN 6 ADVOCACY FOR RURAL HEALTH EQUITY – CULTURAL COMPETENCE AND CULTURAL SAFETY

Maps to RACS PSC	Communication 2.3 recognising and mitigating bias Cultural competence and cultural safety 3.1 Demonstrates a willingness to embrace diversity among all patients, families, carers and the healthcare team and respects the values, beliefs and traditions of individual cultural backgrounds which are different to their own. Promotes self-reflection, acknowledges their own biases, prejudices and stereotypes and works to mitigate their effects. Promotes a safe and inclusive healthcare environment and works to eliminate health inequities. Critically evaluates their own ways of working with patients and in healthcare teams, applying an equity lens to determine if they are fit for purpose for RRR people, and whether they contribute to improving rural health equity.
Maps to AMC Graduate outcome statements	Domain 3 Health Advocate 3.3 Describe the ongoing impact of colonisation, intergenerational trauma and racism on the health and wellbeing of Aboriginal and/or Torres Strait Islander and Māori people. 3.4 Describe the systemic and clinician implicit and explicit biases in the health system that impact on healthcare access, experience, quality and safety for Aboriginal and/or Torres Strait Islander and Māori people. This includes understanding current evidence around all forms of racism as a determinant of health and how racism establishes and sustains inequities in health. 3.11 Describe Aboriginal and/or Torres Strait Islander and Māori holistic concepts of wellbeing and Aboriginal and/or Torres Strait Islander and Māori health models, including programs and Aboriginal and/or Torres Strait Islander and Māori specific interprofessional healthcare teams that can enhance patient health outcomes. 3.6 Apply health advocacy skills by partnering with patients and their families and carers, and/or communities to define and highlight healthcare issues, particularly health inequities and sustainability. Prevocational 3.5 Understanding impacts of colonisation and racism: Demonstrate knowledge of the ongoing impact of colonisation, intergenerational trauma and racism on the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

	3.3 Cultural Safety for all communities: Demonstrate culturally safe practice with ongoing critical reflection of the impact of a health practitioner's knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism and discrimination. 3.6 Integrated healthcare: Partner with the patient in their healthcare journey, recognising the importance of interaction with and connection to the broader healthcare system. Where relevant, this should include culturally appropriate communication with caregivers and extended family members while also including and working collaboratively with other health professionals (including Aboriginal Health Workers, practitioners and Liaison Officers).
Maps to A Better Culture	9. Working for equity in systems: L.1.9 Describe deficit-based narratives and develop skills in respectfully prompting awareness of them during routine work. L.2.9 Demonstrate integration of cultural safety and equity into responses to non-routine demands such as high emergency demand or environmental event. L.3.9 Identify systemic inequity in healthcare delivery and implement collaborative actions for sustainable improvement at unit, organisation or population level

DOMAIN 6 ADVOCACY FOR RURAL HEALTH EQUITY – QUALITY ASSURANCE, QUALITY IMPROVEMENT AND REFLECTIVE PRACTICE

Maps to RACS PSC	Advocacy plus Professionalism 7.1 Demonstrates commitment to patients, the community and the profession through the ethical practice of surgery and demonstration of cultural competence and cultural safety. Demonstrates awareness and insight. Reflects upon one's surgical practice and has insight into changes that may occur, and its implications for patients, colleagues, Trainees and the community. Makes appropriate changes to practice as areas of improvement are identified. Discusses own professional practice to improve outcomes for patients, colleagues and the community. Participates in audit processes and procedures. Participates in open disclosure and error recovery events. Reflects on own professional practice and discusses plans to improve outcomes. Analyses surgical practice through audit procedures. Makes changes to practice based on identified areas for improvement. Implements strategies to constantly improve professional practice. Teaches strategies to lead an audit Facilitates others to learn strategies to identify areas for improvement by leading open disclosure and error recovery discussions.
Maps to AMC Graduate outcome statements	Domain 4 Scientist and Scholar Primary 4.7 Comply with relevant quality and safety frameworks, legislation and clinical guidelines, including health professionals' responsibilities for quality assurance and quality improvement. Prevocational

	4.3 Quality Assurance: Participate in quality assurance and quality improvement activities such as peer review of performance, clinical audit, risk management, incident reporting and reflective practice.

DOMAIN 6 ADVOCACY FOR RURAL HEALTH EQUITY – RESEARCH	
Maps to RACS PSC	Advocacy plus Scholarship and teaching 8.3 As scholars and teachers, surgeons demonstrate a lifelong commitment to surgical practice through reflective learning and the creation, dissemination, application and translation of medical knowledge for optimal patient outcomes.
Maps to AMC Graduate outcome statements	Domain 4 Scientist and Scholar Primary: 4.5 Access, critically appraise and apply evidence from medical and scientific literature. 4.6 Apply scientific methods to formulate relevant research questions and identify applicable study designs. Prevocational: 4.2 evidence informed practice: Access, critically appraise and apply evidence from the medical and scientific literature to clinical and professional practice.
Maps to Better Culture Curriculum	**10. Evidence-based practice (about impact of culture on outcomes, how to develop Better Culture Curriculum in workplace)**

5.2 Dashboard map RACS internal curricula and specialty specific set and AOA curricula

Domain	Theme	RHESAP	JDOCS	SCPF	PSC	CTS SET	GEN SET	NEU SET	ORT SET	OTO SET	PAE SET	PRS SET	URO SET	VAS SET
Domain 1	Rural context, resources	■			■	■	■			■	■			
	rural contextual decision making	■	■	■	■	■	■	■		■	■		■	■
	low resource environments	■	■	■	■	■	■	■		■	■		■	■
Domain 2	generalism, broad and extended scope, GRiD (SOP)	■		■	■	■	■	■	■		■		■	■
Domain 3	fatigue, safe working hours (burnout)	■	■	■	■	■	■		■	■				
Domain 4	RUFUS	■									■			
	inreach	■						■			■			
	collaboration with RRR colleagues	■	■	■	■	■	■	■	■	■	■			■
	outreach, delegation over distance	■		■					■		■			
Domain 5	transfer/retrieval/handover over distance	■	■	■	■	■	■	■	■		■		■	■
	telehealth	■			■	■		■	■	■	■			
	virtual meetings	■					■							
Domain 6	advocacy: equity, inequity, disparity, access	■		■	■	■	■	■	■	■	■	■	■	■
	advocacy: RRR patient content context	■	■	■	■	■		■		■	■	■	■	
	remote, rural, regional, geographic, distance	■		■	■	■	■	■		■	■	■		
	health systems response to inequity	■	■	■	■	■	■	■	■	■	■	■	■	■

Abbreviations:

RHESAP	RACS Rural Health Equity Strategic Action Plan
JDOCS	RACS JDocs Framework and ePortfolio
SCPF	RACS Surgical competence and performance framework
PSC	RACS SET Professional Skills Curriculum 2024

CTS SET	Curriculum Cardiothoracic Surgery Education and Training Program RACS, uses PSC and separately mentions patient context
GEN SET	Curriculum General Surgery Education and Training Program RACS Australian Board in General Surgery, ANZ Committee in General Surgery (undated)
NEU SET	Curriculum Surgical Education and Training Program in Neurosurgery 2024 Neurosurgical Society of Australasia
ORT SET	Australian Orthopaedic Association Curriculum for Education & Training in Orthopaedic Surgery 2020, NZOA Curriculum for Education and Training in Orthopaedic Surgery 2020
OTO SET	SET Curriculum –Modules & Topics Otolaryngology Head and Neck Surgery Australia and New Zealand 2022
PAE SET	RACS Paediatric Surgery Curriculum V4 for consultation 2024
PRS SET	Plastic and Reconstructive Surgery Curriculum 2019 Australia and New Zealand, Australian Society of Plastic Surgeons
URO SET	Urological Society of Australia and New Zealand Surgical Education and Training Urology Curriculum 2021
VAS SET	Australian and New Zealand Society for Vascular Surgery, Vascular Surgery Curriculum 2022

5.3 External mapping to Australian Medical Council, MCNZ and AMA standards and other rural-specific medical training curricula

Domain	Theme	AHPRA	MCNZ	AMC Pri	AMC Pre	AMC Spec	AMC MSC	MSCTN	FARGP	ACRRM	UQ3	RNZCGP
Domain 1	Rural context, resources		■	■				■	■	■	■	■
	rural contextual decision making		■					■	■	■	■	■
	low resource environments		■					■	■	■	■	■
Domain 2	generalism, broad and extended scope, GRiD (SOP)				■	■		■	■	■		■
Domain 3	fatigue, safe working hours (burnout)	■	■	■		■	■	■	■			
Domain 4	RUFUS				■							
	inreach							■	■			
	collaboration with RRR colleagues	■	■			■		■		■		■
	outreach, delegation over distance								■			
Domain 5	transfer/retrieval/handover over distance	■	■		■		■	■	■	■	■	■
	telehealth	■	■	■			■			■	■	■
	virtual meetings						■	■	■	■	■	■
Domain 6	advocacy: equity, inequity, disparity, access	■	■	■		■		■	■	■		■
	advocacy: RRR patient content context	■	■	■	■			■	■	■		■
	remote, rural, regional, geographic, distance	■	■	■	■	■		■	■	■	■	■
	health systems response to inequity		■	■				■	■	■		■

Abbreviations:

AHPRA	The Medical Board of Australia (MBA), Good medical practice: a code of conduct for doctors in Australia 2021
MCNZ	NZMC Medical Council of New Zealand Current Standards 2024
AMC Pri	Australian Medical Council Standards for Assessment and Accreditation of Primary Medical Programs 2023
AMC Pre	Australian Medical Council National Framework for Prevocational PGY1 and PGY2 Medical Training 2024
AMC Spec	Australian Medical Council Standards for Assessment and Accreditation of Specialist Medical Programs 2023

AMC MSC 2024	Australian Medical Council Consultation Draft Model Standards for specialist medical college accreditation of training settings September 2024
MSCTN	Multispecialty community training network, University of Ontario Canada
FARGP	Royal Australasian College of General Practice RACGP Fellowship Advanced Rural General Practice FARGP
ACRRM	Australian College of Remote and Rural Medicine ACRRM core and advanced rural generalist training, remote medicine course
UQ3	University of Queensland Medical School, Rural and Remote Medicine course (3rd year)
RNZCGP	Royal New Zealand College of General Practitioners RNZCGP Rural Hospital Medicine

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