# Accreditation Report: The Rural Generalist Medicine Program of the Australian College of Rural and Remote Medicine

Specialist Education Accreditation Committee

June 2026

Australian Medical Council Limited

August 2026
Digital

ABN 97 131 796 980
ISBN 978-1-923118-54-6



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## Acknowledgement of Country

The Australian Medical Council acknowledges the Aboriginal and/or Torres Strait Islander peoples as the original Australians, and Māori as tangata whenua (Indigenous peoples) of Aotearoa New Zealand.

We acknowledge and pay our respects to the Traditional Custodians of all the lands on which we live and work, and their ongoing connection to the land, water and sky. We acknowledge government policies and practices impact on the health and wellbeing of Indigenous peoples and commit to working together to support healing and positive health outcomes.

Through its accreditation and assessment processes for the medical profession, the AMC is committed to improving equity and outcomes for the Aboriginal and/or Torres Strait Islander peoples of Australia, and the Māori peoples of Aotearoa New Zealand.

# 1. Introduction

### 1.1 The process for accreditation of a proposed specialist medical program

The Australian Medical Council (AMC document)*, Procedures for Assessment and Accreditation of Specialist Medical Programs by the Australian Medical Council 2024* (the Procedures), describes AMC requirements for accrediting specialist programs and their education providers. For new programs, the AMC will assess if the program likely complies with accreditation standards and if the provider can implement it.

The AMC's Specialist Education Accreditation Committee reviews the submission and may decide on one of the following options for accreditation:

i. Accreditation for a period up to one year after the full program has been implemented, subject to conditions being addressed within a specific period and depending on satisfactory annual monitoring submissions. The conditions may include a requirement for follow-up assessments to review progress in implementing the program. In the year the accreditation ends, the education provider will submit an accreditation extension submission. Subject to a satisfactory accreditation report, the AMC may grant a further period of accreditation, up to the maximum possible period, before a new accreditation assessment.

ii. Accreditation will be refused where the education provider has not satisfied the AMC that it can implement and deliver the program of study at a level consistent with accreditation standards. The AMC will give the provider written notice of the decision and its reasons, as well as the procedures available for reconsideration and internal review of the decision within the AMC.

The AMC and the Medical Council of New Zealand work collaboratively to streamline the assessment of education providers that provide specialist medical training in Australia and Aotearoa New Zealand, and both have endorsed the accreditation standards. The two Councils have agreed to a range of measures to align the accreditation processes, resulting in joint accreditation assessments, joint progress and comprehensive reporting, and aligned accreditation periods. The AMC will continue to lead the accreditation process.

### 1.2 The recognition of rural generalist medicine as a new specialty

Under the *Health Practitioner Regulation National Law Act 2009* (the National Law), the Medical Board of Australia (the Board) may recommend that the Ministerial Council approve new or amended specialties and fields of specialty practice. As the accreditation authority for medicine, the AMC provides advice to the Board on proposals for recognition. In 2020, the AMC received a request from the Board to provide advice on a joint proposal from the Australian College of Rural and Remote Medicine (ACRRM; 'the College') and the Royal Australian College of General Practitioners (RACGP) for

the approval of rural generalist medicine as a new field within the specialty of general practice. This initiated a two-stage process in which the applicants had to demonstrate that:

- recognition is likely to contribute to one or more of the objectives of the National Law. That is to: enhance protection of the public, facilitate workforce mobility, facilitate access to health services and enable the continuous development of a flexible, responsive and sustainable health workforce and innovation in service delivery
- regulation will offer an overall net benefit and alternative, non-regulatory options will not offer the same benefit.

In 2021, following the initial (Stage 1) assessment, the AMC provided advice to the Board that there may be a case for the recognition of rural generalist medicine based on the above criteria, and the proposal proceeded to a detailed (Stage 2) assessment. ACRRM and RACGP submitted further information to support this assessment in 2022.

In 2023, to support the Stage 2 assessment, the Board initiated public consultation on the joint proposal from ACRRM and RACGP. The majority of stakeholders supported the proposal; the AMC also conducted additional meetings with stakeholders, including health consumer groups and Aboriginal and Torres Strait Islander health organisations.

In December 2024, the AMC provided advice that there is a case for rural generalist medicine to be recognised. Subsequently, the Board recommended that the Ministerial Council approve rural generalist medicine as a new field within the specialty of general practice.

In September 2025, the Ministerial Council approved the specialty of rural generalist medicine. The full list of specialties, fields of specialist practice, and related specialist titles is published on the Medical Board of Australia's website. The AMC can now assess and accredit education and training programs in rural generalist medicine, and organisations with education and training in the field may apply for accreditation. In 2025, ACRRM and RACGP separately applied for accreditation of their respective rural generalist medicine programs, initiating this assessment.

Definition of rural generalist medicine

The following definition for rural generalist (RG) was agreed to by the ACRRM and the RACGP in collaboration with the National Rural Health Commissioner during a meeting at Collingrove Homestead in South Australia in February 2018 (the 'Collingrove Agreement'):

> A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care, and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.

The RG scope of practice is described in the Colleges' application as:

> comprised of a core skill set which enables practitioners to provide general practice care plus emergency care in a clinical context of relative professional isolation, and in addition, at least one additional area of advanced skills related to the needs of their communities.

## 1.3 Decision on accreditation

Under the National Law, the AMC can accredit a program of study if it is reasonably satisfied that:

(a) the program of study, and the education provider that provides the program of study, meet the accreditation standard; or

(b) the program of study, and the education provider that provides the program of study, substantially meet the accreditation standard and the imposition of conditions will ensure the program meets the standard within a reasonable time.

Having made a decision, the AMC reports its accreditation decision to the MBA to enable the Board to make a decision on the approval of the program of study for registration purposes.

The 30 June 2026 meeting of the AMC's Specialist Education Accreditation Committee resolved that:

i. The Australian College of Rural and Remote Medicine's specialist training program in the specialty of general practice in the specialty field of rural generalist medicine substantially meets the approved accreditations standards.

ii. The Australian College of Rural and Remote Medicine's specialist training program, leading to Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) in the specialty of general practice in the specialty field of rural generalist medicine be granted accreditation **for two years to 31 March 2028**, aligning with the College's existing accreditation period for the specialty medical program of general practice, subject to satisfying AMC monitoring requirements, including monitoring submissions and addressing accreditation conditions.

| Condition | | To be met by |
|---|---|---|
| **Standard 1** | | |
| 1 | Demonstrate collaboration in the development, management, implementation and continuous improvement of the rural generalist medicine program with RACGP through the Joint Consultative Committee for Rural Generalist Medicine. (Standard 1.4) **NEW** | 2028 |
| 2 | Demonstrate collaboration with other specialist medical colleges in the development, management, implementation and continuous improvement of the Advanced Specialised Training programs in the rural generalist medicine program. (Standard 1.4) **NEW** | 2028 |
| 3 | Develop mechanisms for the collaboration with RACGP and the other specialist medical colleges in the development, management, implementation and continuous improvement of the rural generalist medicine program to occur on a regular and ongoing basis. (Standard 1.4 and 6.3.3) **NEW** | 2028 |
| 4 | Demonstrate a formal approach to strengthening partnerships with relevant local communities, organisations and individuals in the Indigenous health sector. (Standard 1.6.4) | 2023 |
| **Standard 2** | | |
| 5 | Consistent with the Collingrove Agreement, demonstrate alignment with the graduate outcomes of the FRACGP-RG program. (Standard 2.3 and 3.2.1) **NEW** | 2027 |
| **Standard 3** | | |
| 6 | Diversify Aboriginal and/or Torres Strait Islander input into the development and implementation of the curriculum and provide substantive evidence of this. (Standard 3.2.9) **NEW** | 2028 |
| 7 | Evaluate the effectiveness of the Rural Generalist Curriculum with respect to its application at CGT and AST levels to meet program and graduate outcomes. (Standard 3.2.1) | 2024 |
| **Standard 4** | | |
| Nil. | | |

| Condition | | To be met by |
|---|---|---|
| **Standard 5** | | |
| 8 | Develop a blueprint to guide assessment and progress through each stage of the specialist medical program mapped to program outcomes and curriculum. (Standard 5.2.2) **NEW** | 2027 |
| **Standard 6** | | |
| Nil. | | |
| **Standard 7** | | |
| 9 | Strengthen monitoring and evaluation processes to be proactive and effective in:<br>i. Identifying existing power imbalance between supervisor and trainee and ensuring wellbeing supports are communicated well to trainees.<br>ii. Measuring effectiveness of the resolution of training problems and disputes. (Standard 7.4, 7.5, 6.1 and 6.2) | 2024 |
| **Standard 8** | | |
| 10 | In the training post accreditation standards, include a requirement that sites and posts demonstrate a commitment to Aboriginal and Torres Strait Islander health with appropriate cultural safety and protocols with an acknowledgement of local context. (Standard 8.2.2) | 2023 |
| **Standard 9** | | |
| Nil. | | |

**Note:** Greyed-out conditions relate to the 2021 reaccreditation assessment and were outside the scope of the 2026 rural generalist medicine assessment. Accordingly, they have not been closed as part of this review. These conditions remain outstanding and have not yet been satisfied by the College.

# 2. Australian College of Rural and Remote Medicine

## 2.1 Accreditation history

The College's training programs were first accredited by the AMC in 2007.

An overview of the College's accreditation and monitoring history is provided below:

| Assessment type | Outcome |
|---|---|
| 2007: Full assessment | Accreditation granted until 31 December 2010. |
| 2010: Full assessment | Accreditation granted until 31 December 2014. |
| 2014: Follow-up assessment | Accreditation extended to 31 March 2018. |
| 2017: Accreditation extension submission | Accreditation extended until 31 March 2022. |
| 2021: Reaccreditation assessment | Accreditation granted until 31 March 2028, with 23 conditions set on accreditation. |

A copy of the College's 2021 accreditation report can be found here.

In 2025, on the basis of the College's monitoring submission, the College was found to have substantially met the standards.

## 2.2 New specialist medical program submission

In 2025, the AMC received an expression of interest from the College to assess and accredit its rural generalist medicine program of study. The assessment and accreditation of the College's rural generalist medicine program will expand the range of study options available through the College in approved fields under the specialty of general practice.

The AMC undertook a focused review of the College's rural generalist medicine program, covering standards relevant to curriculum and assessment, and related standards in other areas. Governance structures, assessment feedback details, monitoring, evaluation, communication with trainees, engagement with external stakeholders and assessment of specialist international medical graduates were not included in the scope of assessment; however, they will be subject to monitoring requirements. This limited scope was approved by the AMC's Specialist Education Accreditation Committee under Section 1.2 (i) of the Procedures. Appendix 1 provides a full list of standards included in this assessment.

Although rural generalist medicine was not yet a recognised field of specialty practice at the time of the College's reaccreditation assessment in 2021, the rural generalist medicine program and relevant areas were considered as part of the assessment. The AMC understands that the College's existing program in general practice will now operate solely as a rural generalist medicine program.

In 2028, the College and its accredited programs will undergo an accreditation extension assessment, with the revised standards for specialist medical programs planned for implementation in 2026. Subject to the accreditation of the College's rural generalist medicine training program, the accreditation extension assessment will be an opportunity for a contemporary review of all the College's accredited specialist training programs, including consideration of sector-wide reform priorities reflected in the Australian Health Practitioner Regulation Agency (Ahpra) National Scheme Strategy 2031, which commits to advancing cultural safety and the elimination of racism in the Australian healthcare system.

Recognising the joint application for specialty recognition submitted by both ACRRM and RACGP, the AMC conducted both assessments concurrently, using the same assessment team, to ensure consistency and minimise potential bias.

**Assessment procedure**

The AMC assesses specialist medical education and training programs using a standard set of procedures.

Given the focused scope of the review, the AMC undertook a smaller-scale assessment process, using a risk-based approach.

Below is a summary of the steps followed in this assessment:

1. The AMC asked the College to lodge an accreditation submission against specified AMC accreditation standards deemed relevant to the rural generalist medicine program.
2. The AMC appointed an assessment team ('the team' in this report) to complete the assessment, after inviting the College to comment on the proposed membership. A list of members of the team is provided as Appendix 2.
3. The team met in February 2026 to consider the College's accreditation submission.
4. The AMC invited various stakeholders to provide feedback on both colleges; this included written submissions and, where requested, meetings. A list of stakeholders the team met with or received written submissions from is provided as Appendix 3.
5. The team conducted a day of virtual meetings in March 2026 with program stakeholders, including trainees, supervisors, educators, staff, College office bearers and committees (see Appendix 4).

**Appreciation**

The team is grateful to the fellows, trainees and staff who prepared the accreditation submission and managed preparations for the assessment.

# 3. AMC Findings

## 3.1 Summary of findings against the standards

The findings against the accreditation standards are summarised in the table below. Explicit feedback is available on each standard under Section 3.2.

| Standard | Finding in 2025 monitoring submission | Finding in 2026 (rural generalist medicine assessment) |
|---|---|---|
| 1. Context of education and training | Substantially Met | Substantially Met |
| 2. Outcomes of specialist training and education | Met | Substantially Met |
| 3. The specialist medical training and education framework | Substantially Met | Substantially Met |
| 4. Teaching and learning | Met | Met |
| 5. Assessment of learning | Met | Substantially Met |
| 6. Monitoring and evaluation | Met | Met |
| 7. Trainees | Substantially Met | Substantially Met |
| 8. Implementing the program —delivery of education and accreditation of training sites | Substantially Met | Substantially Met |
| 9. Assessment of specialist international medical graduates | Met | ***Not assessed*** |

## 3.2 Detailed findings against the standards

### Standard 1: The context of education and training

Areas covered by this standard: governance of the college; program management; reconsideration, review and appeals processes; educational expertise and exchange; educational resources; interaction with the health sector; continuous renewal. **(Standards 1.1.1, 1.1.2, 1.1.6, 1.2.1, 1.3, 1.4 and 1.6)**

| **Summary of accreditation status** | 2025: Substantially Met | 2026: Substantially Met |
|---|---|---|

The College's 2021 reaccreditation assessment found that Standard 1 was substantially met, and five conditions were implemented at the time.

The College's 2025 monitoring submission found that Standard 1 was substantially met, with one outstanding condition relating to effective partnerships with local communities, organisations and individuals in the Indigenous health sector (Standard 1.6.4). This condition has not yet been satisfied as a result of this accreditation.

**Team findings**

ACRRM has been dedicated to rural and remote medicine since its establishment in 1996. The College's training program has been accredited for general practice training since 2007 and is accredited until 2028. With the approval of rural generalist medicine as a new field within the specialty of general practice, ACRRM has sought approval for its existing program to also be accredited as an RG specialist education program. As such, ACRRM has presented its existing training program largely unchanged for accreditation as an RG specialist education program.

Governance (Standard 1.1); program management (1.2); reconsideration, review and appeals processes (1.3); educational expertise and exchange (1.4); and interaction with the health sector (1.6) are presented largely unchanged, albeit with a shift in emphasis towards RG practice.

1.1 Governance

ACRRM has corporate governance structures that appropriately separate policy, membership and education/training under a single, skills-based Board. The College's constitution is currently under review, with completion anticipated for October 2026. This is a regular review to ensure contemporary governance, and it has allowed the College to update the constitution to support both general practice and rural generalist medicine fields of practice. It is not expected that the review will produce any significant changes to the objects in the constitution.

ACRRM is governed by a skills-based Board consisting of six to ten directors, elected and appointed in accordance with the constitution. Director skills are determined through a Board skills matrix, and a gender target applies. Beneath the Board are established committees and councils that assist the Board in efficiently and effectively performing its functions. Each has its own terms of reference, which are reviewed regularly.

The operational structure reflects the governance structure and, given that the RG specialist medical program is the College's core business, almost all operational structures and resources play a role in some aspect of the delivery, support or continuous improvement of the program and its outcomes.

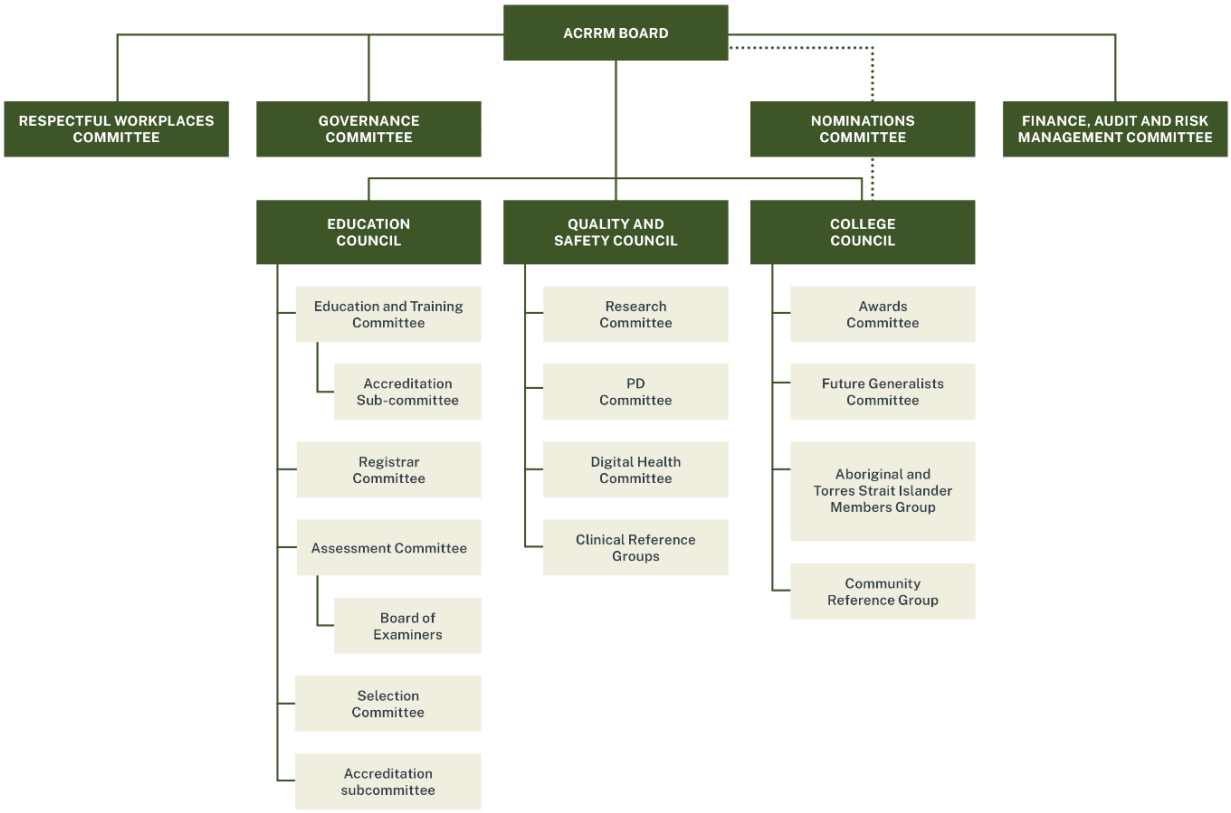


**Figure 1: ACRRM governance structure**

The team considers that the College's governance structure gives appropriate priority to its educational role relative to other activities and is defined in relation to its corporate governance with sufficient autonomy and appropriate resourcing to meet the current education functions. The education program is well established and supported by a large, experienced team of staff and educators, providing confidence in the ongoing delivery, oversight and integrity of the program. There is significant corporate knowledge invested within the relatively small College Executive Leadership Team, posing a risk should the leadership change. Consideration should be given to contingencies and succession planning.

ACRRM has well-developed and validated procedures for identifying, managing and recording conflicts of interest across its training and education functions, governance and decision making. These remain unchanged with the transition to RG training.

1.2 Program management

The College has clear governance and appropriate structures to support program management of its specialist training program. This includes various committees that report to the Board via the Education Council. There are clear terms of reference, and these governance entities function effectively.

ACRRM has a devolved training structure, with regional training networks supported by regional offices in 13 different locations. More than 60% of the College's full-time equivalent (FTE) staff are regionally based and work in these regional offices. This allows the College to address regional stakeholder and community support needs while ensuring consistent support and progression across the RG training program. The structure gives trainees local access to educators and College staff who, in turn, are well connected to the broader College. There are clear lines of local and national oversight and reporting for all staff and program participants.

These structures have not been changed in response to the RG training change.

1.3 Reconsideration, review and appeals processes

The College's Reconsideration, Review and Appeals policy and processes are present and appropriate. They are publicly available. ACRRM collects data from these processes, which are analysed for underlying themes and then used to create system improvements.

1.4 Educational expertise and exchange

ACRRM has considerable educational expertise through College staff, supervisors, training sites, Board and Council. Substantial support is also provided through a series of expert working groups and advisory committees. These members are recruited for their specific expertise and linkages to academic and clinical groups of excellence. These committees include, but are not limited to, an Education and Training Committee and an Assessment Committee. Where necessary, ACRRM also engages external consultants to support the development and delivery of the training program.

ACRRM has worked closely with RACGP over the past seven years, supporting several projects of mutual interest, including the transition to College-led training, the joint application for recognition of rural generalist medicine as a specialised field and establishing the Joint Colleges Training Services (JCTS) company.

As a result of the joint application for recognition of rural generalist medicine, ACRRM and RACGP are in the final stages of establishing a Joint Consultative Committee for Rural Generalist Medicine. This is an advisory committee and is anticipated to report directly to the ACRRM and RACGP Boards. While the committee is yet to meet, it is forecast that this forum will facilitate collaboration on RG program matters, including curriculum, standards, training, certification and regulation of RGs and doctors interested in becoming RGs. One early project that has been flagged is blueprinting of both College's curricula.

The team applauds ACRRM for the ongoing collaboration with RACGP. The Joint Consultative Committee will be an important mechanism through which ACRRM and RACGP can ensure ongoing consistency between the RG qualifications granted by both Colleges. This is critical to ensure that the qualification maintains currency irrespective of which College has awarded it so that the community is safeguarded and employers can be sure of the standard capability of the RGs they are employing.

ACRRM and RACGP have also founded the JCTS as a vehicle to provide ongoing cultural expertise and education for RGs and general practitioners (GPs) as part of the ACRRM and RACGP specialist programs. This has been done in response to feedback from Aboriginal and/or Torres Strait Islander cultural mentors and Elders who expressed a wish for a single company to work with when providing cultural expertise. ACRRM collaborates with JCTS to ensure its curriculum, assessment and resources are culturally informed and supported. JCTS and ACRRM staff work together to deliver regional training workshops and individual education support.

ACRRM and RACGP are also commended for the creation of JCTS and this novel approach to providing cultural expertise and education. As has been highlighted through the accreditation, this should enable ACRRM to provide high-quality education for RGs with a local focus. It also provides a useful avenue for gathering feedback on the cultural safety of training and assessment activities.

ACRRM collaborates with a wide range of other educational institutions and specialist medical colleges, both in Australia and internationally. There are ongoing partnerships and educational support relationships nationally with several specialist medical colleges on matters of mutual interest. ACRRM is also a longstanding member of the Council of Presidents of Medical Colleges (CPMC). The College also makes up a part of several formal relationships for the delivery of Advanced Specialised Training (AST) programs. These include with:

- the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) and RACGP for the Consultative Committee for the Diploma of Obstetrics and Gynaecology.
- the Australian and New Zealand College of Anaesthetists (ANZCA) and RACGP to collaborate on the rural generalist anaesthesia program.

The ASTs provide a space for ACRRM to collaborate with other specialist medical colleges that have an interest in the subject areas of the ASTs. There is substantial variation in collaboration between the ASTs, ranging from formalised partnerships/tripartite committees to no formal collaboration. For example, the Australian College for Emergency Medicine is not directly involved in the emergency medicine curriculum or assessment. These arrangements appear to translate to the formality with which the ASTs are governed and assessed. The team considers the absence of formal collaboration to be a significant risk. The team recommends pursuing formalised collaboration with relevant specialist medical colleges. While the team acknowledges the difficulties inherent in collaboration, it is important for patient safety and quality assurance that where subject matter overlaps there is strategic and consistent collaboration in these areas.

1.6 Interaction with the health sector

The College has longstanding and strong relationships with jurisdictions and health services, RG coordinating units and rural clinical schools. The ACRRM's Stakeholder Engagement Framework governs the College's interactions with the health sector. Some stakeholder feedback identified communication challenges and competing priorities, particularly in relation to jurisdictional workforce needs. The team encourages continued constructive engagement to resolve these matters.

ACRRM continues to develop mechanisms for community engagement and has been active in improving this aspect of College business. It has established a Community Reference Group, which provides a regular forum for consultation.

The College has an existing condition that requires strengthening partnerships with the Indigenous health sector. Feedback from Aboriginal and/or Torres Strait Islander stakeholders was variable, particularly from representatives of the Aboriginal community controlled health sector, where relationships were at times perceived as reactive and lacking reciprocity, and communication was unclear and inconsistent. While the team heard of some positive engagement with some state-based organisations, a more coordinated and systematic approach to external stakeholder engagement is required.

Although JCTS represents an important resource for the College, it should not replace higher-level, formal engagement with Aboriginal and/or Torres Strait Islander stakeholders. The team encourages the College to engage with a broader and more diverse range of Indigenous health sector stakeholders to ensure that its programs appropriately reflect and respond to the diversity of Aboriginal and/or Torres Strait Islander peoples across Australia. This is particularly important for rural generalist medicine, where Aboriginal and/or Torres Strait Islander health care is central to service delivery in many rural and remote communities. Formalised arrangements, such as memoranda of understanding or other agreements, are strongly recommended to support accountability and sustainability.

**Commendations, conditions and recommendations**

*Commendations*

A The establishment of the Joint Colleges Training Services (JCTS), a novel and effective approach to incorporating cultural expertise and education that enhances the delivery of high-quality, locally responsive training.

*Conditions to satisfy accreditation standards*

**New conditions set as a result of the 2026 rural generalist medicine accreditation assessment**

1 Demonstrate collaboration in the development, management, implementation and continuous improvement of the rural generalist medicine program with RACGP through the Joint Consultative Committee for Rural Generalist Medicine. (Standard 1.4)

2 Demonstrate collaboration with other specialist medical colleges in the development, management, implementation and continuous improvement of the Advanced Specialised Training programs in the rural generalist medicine program. (Standard 1.4)

3 Develop mechanisms for the collaboration with RACGP and the other specialist medical colleges in the development, management, implementation and continuous improvement of the rural generalist medicine program to occur on a regular and ongoing basis. (Standard 1.4 and 6.3.3)

**Outstanding conditions from the 2021 reaccreditation assessment**

4 Demonstrate a formal approach to strengthening partnerships with relevant local communities, organisations and individuals in the Indigenous health sector. (Standard 1.6.4)

*Recommendations for improvement*

AA Consider formalised arrangements, such as memoranda of understanding or other agreements, with relevant Aboriginal and/or Torres Strait Islander organisations. (Standard 1.6.4)

## Standard 2: The outcomes of specialist training and education

Areas covered by this standard: educational purpose of the educational provider; and program and graduate outcomes. **(Standards 2.1, 2.2 and 2.3)**

| **Summary of accreditation status** | 2025: Met | 2026: Substantially Met |
|---|---|---|

The College's 2021 reaccreditation assessment found that Standard 2 was substantially met, and four conditions were implemented at the time.

The College's 2025 monitoring submission found that Standard 2 was met, with no outstanding conditions.

**Team findings**

2.1 Educational purpose

ACRRM's educational purpose for rural generalist medicine as a new specialty is embedded in its constitution and reinforced through its strategic plan, which defines its intent as 'to define, promote and deliver quality standards of medical practice for rural, remote and First Nations communities through a skilled and dedicated Rural Generalist workforce.' The constitution is currently undergoing review to ensure it remains contemporary and reflects any required changes, including the formal recognition of rural generalist medicine as a specialty.

The ACRRM training program is designed to ensure appropriate training to support the delivery of care to people in rural and remote areas. The AST component of the program is influenced by identifying service gaps in communities where RG trainees live and work, further embedding their educational purpose across the curriculum.

The ACRRM Strategic Plan 2024–2028 articulates its vision and intent. ACRRM aims to build a culturally responsive workforce through its compulsory assessed domains of rural and remote practice in First Nations peoples' health care and a culturally immersive training experience. The team encourages ACRRM to evaluate the implementation of a culturally safe and responsive learning environment to provide evidence of the College's strategic intention working in practice.

The educational purpose of the College and its RG training program is set and periodically reviewed through extensive internal consultation with members, committee members, staff and external stakeholders, including general practice and rural practice peak bodies, First Nations stakeholders, and the Australian and state and territory governments. ACRRM consulted internally and externally to inform the development of its strategic plan in 2024 and has established an ongoing Community Reference Group that contributes to reviews such as the current ongoing curriculum review. The team noted the current curriculum review has included consultation with 275 community groups and stakeholders, which is applauded.

The team noted that consistent collaboration with other specialist medical colleges and organisations was variable. The transition to formal recognition of rural generalist medicine as a specialty provides an opportunity for ACRRM to move to more formal collaboration with stakeholders, particularly specialist medical colleges with expertise in AST modules and Aboriginal and/or Torres Strait Islander organisations to inform their educational purpose.

2.2 Program outcomes

ACRRM's only specialist medical program outcome focus is rural generalist medicine, and the program demonstrates how it relates its training and education functions to the healthcare needs of the communities it services. The program outcomes are clearly articulated in the curriculum's definition of the role of an RG medical practitioner. The role's responsibilities include providing and adapting expert primary, secondary, emergency and specialised medical care to community needs; providing safe, effective medical care while working in geographic and professional isolation; working in

partnership with Aboriginal and/or Torres Strait Islander peoples and other culturally diverse groups; applying a population approach to community needs; and providing access to quality services in contexts isolated from a full complement of specialist staff and resources. This requires medical practitioners in situ, assessed and credentialed, ready to assume the high levels of clinical responsibility that this environment demands.

The AST modules provide a range of specific advanced skills that are tailored to the community needs. Some stakeholders noted opportunities to further align training pathways with community needs and workforce planning considerations in addition to practitioner interest. The team encourages alignment and equivalence of advanced skills across RACGP and ACRRM programs and has identified this as a priority area for consideration by the Joint Consultative Committee.

2.3 Graduate outcomes

The Collingrove Agreement, agreed to by both RACGP and ACRRM in 2018, defines the RG as:

> 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.

The graduate outcomes of the rural generalist medicine program are described as competencies listed in the RG curriculum and the Fellowship training handbook, which are staged as 'beginning', 'progressing' and 'achieved' as trainees progress through the program. These are publicly available.

The team received stakeholder feedback indicating that the ACRRM program is perceived as having insufficient focus on comprehensive general practice care. Some RGs reported developing greater confidence in their advanced skill than in their role as generalist practitioners, which may contribute to a tendency toward predominantly hospital-based roles following Fellowship. While acknowledging the recent increase in core primary care requirements to 12 months, the team considers this an area warranting further exploration through engagement with jurisdictions and employers, to better align the program with health workforce priorities and to ensure adequate preparation in health promotion, disease prevention and chronic disease management.

The team were encouraged by the planned collaboration between ACRRM and RACGP through the Joint Consultative Committee to improve alignment of their rural generalist medicine programs. The team noted the importance going forward that the graduate outcomes of the specialty of rural generalist medicine are aligned, and the rural generalist medicine graduates of ACRRM and RACGP have equivalent knowledge, skills and scope of practice, agnostic of which training program they have completed. While the two training programs have evolved through different pathways, alignment of graduate outcomes is important to provide confidence that an RG from either College is equivalent. One example of a significant difference between the two programs was noted in general surgery advanced skills. ACRRM requires 24 months to complete this skill, whereas RACGP only requires 12 months. Such discrepancies pose a risk to the equivalence of graduate outcomes between the programs.

**Commendations, conditions and recommendations**

*Commendations*

Nil.

*Conditions to satisfy accreditation standards*

**New conditions set as a result of the 2026 rural generalist medicine accreditation assessment**

| | |
|---|---|
| 5 | Consistent with the Collingrove Agreement, demonstrate alignment with the graduate outcomes of the FRACGP-RG program. (Standard 2.3 and 3.2.1) |

**Outstanding conditions from the 2021 reaccreditation assessment**

Nil.

*Recommendations for improvement*

Nil.

## Standard 3: The specialist medical training and education framework

Areas covered by this standard: curriculum framework; curriculum content; continuum of training, education and practice; and curriculum structure. **(Standards 3.1, 3.2, 3.3 and 3.4)**

| **Summary of accreditation status** | 2025: Substantially Met | 2026: Substantially Met |
|---|---|---|

The College's 2021 reaccreditation assessment found that Standard 3 was substantially met, and two conditions were implemented at the time.

The College's 2025 monitoring submission found that Standard 3 was substantially met, with one outstanding condition relating to evaluating the effectiveness of the rural generalist curriculum (Standard 3.2.1). This condition has not yet been satisfied as a result of this accreditation.

**Team findings**

3.1 Curriculum framework

ACRRM's curriculum is completed over a minimum of four years, comprising a minimum of three years in Core Generalist Training (CGT) and a minimum of one year of AST. The curriculum is underpinned by ten educational principles organised around a framework of eight domains of rural and remote practice outlined by ACRRM as to:

- provide expert medical care in all rural contexts
- provide primary care
- provide secondary medical care
- respond to medical emergencies
- apply a population health approach
- work with Aboriginal and/or Torres Strait Islander and other culturally diverse communities to improve health and wellbeing
- practise medicine within an ethical, intellectual and professional framework
- provide safe medical care while working in geographic and professional isolation.

The curriculum is publicly available. The competencies that align with the stated outcomes of the RG Fellowship program are organised by domains.

Trainees undertake at least one of the 12 AST curricula offered by ACRRM:

- Aboriginal and Torres Strait Islander health
- academic practice
- adult internal medicine
- anaesthetics
- emergency medicine
- mental health
- obstetrics and gynaecology
- palliative care
- paediatrics
- population health
- remote medicine

- rural generalist surgery.

The range of specialties offered reflects the areas of medical care that would most benefit rural and remote populations. Specialties vary as to whether a specialist medical college has been involved in the curriculum development. The team noted the success of the tripartite collaborative arrangement with ANZCA and RACGP in developing the anaesthetics AST curriculum. There is also a collaborative arrangement with RANZCOG, where trainees enrol in the Associate Training Program (Advanced Procedural) to complete their obstetrics and gynaecology AST. This has advantages with improving external stakeholder perceptions and promoting public confidence in the training program. Many ACRRM fellows work in rural hospitals as well as in general practice. Some stakeholders expressed concern that a focus on one area of specialist training may detract from the concept of a generalist foundation to the new RG specialty. The College is encouraged to prioritise collaboration with other relevant specialist medical colleges in curriculum and assessment requirements for the ASTs to ensure appropriate capability, aligned scope of rural generalist practice and patient safety.

The team noted that there have been no changes to the curriculum as a result of recognition of the specialty of rural generalist medicine. The team is aware that a review of the written curriculum was conducted in 2025 and that several opportunities for improvement and strengths were identified. The AMC looks forward to hearing progress on the development of the new curriculum framework, which is currently in the consultation phase.

3.2 The content of the curriculum

The curriculum content aligns with the stated graduate outcomes and builds on trainees' prior teaching and learning in their primary medical degree. Communication, clinical diagnostic, management and procedural skills are developed largely in a workplace learning environment.

The curriculum clearly articulates expectations for developing leadership skills and professionalism. It was not clear how trainees formally learn about this key area of rural generalist medicine in practice or how they could reliably demonstrate attainment of these skills, and this is an area of the curriculum that could be strengthened in future.

Scientific foundations of rural generalist medicine are embedded in the three-year CGT, especially in Learning Area 36—Scholar—which outlines knowledge, skills and attributes required for critical appraisal and engagement with scientific literature.

Trainees are exposed to health system issues and their management throughout their training and are provided with opportunities to teach and supervise medical students, interns and other health professionals. They are encouraged to publish their scholarly work. Formal research opportunities are available through five 0.5 FTE academic posts available each year.

There has been significant work done to promote a comprehensive understanding of Aboriginal and/or Torres Strait Islander health, history and cultures. The College has worked with the JCTS to ensure a strengths-based approach to cultural safety training. The College is aware of the risk of imposing a cultural burden on First Nations trainees and staff in promoting a strong cultural safety agenda. The team strongly encourages the College to prioritise increasing the number of Aboriginal and/or Torres Strait Islander staff to share this load. This will be increasingly important when the new standards for specialist medical programs are implemented.

3.3 Continuum of training, education and practice

There is a purposeful curriculum design with horizontal and vertical integration. The core generalist indicators provided for each competency are especially helpful in informing trainees and supervisors about the practicalities of gauging progression through the program.

Clear mechanisms are in place to recognise prior learning and award credit appropriately.

3.4 Structure of the curriculum

The program is clearly structured, and the recent increase to a requirement of at least 12 months in a general practice is welcomed. Trainees appreciate the flexibility of the program in terms of timing and the availability of part-time training opportunities. While there was no detailed staged blueprint for each stage of the program available, the team noted that trainees appeared to be clear about what was required of them to achieve Fellowship.

**Commendations, conditions and recommendations**

*Commendations*

B The successful tripartite collaboration with ACRRM, RACGP and ANZCA in developing the Anaesthetics Advanced Specialised Training curriculum.

*Conditions to satisfy accreditation standards*

**New conditions set as a result of the 2026 rural generalist medicine accreditation assessment**

6 Diversify Aboriginal and/or Torres Strait Islander input into the development and implementation of the curriculum and provide substantive evidence of this. (Standard 3.2.9)

**Outstanding conditions from the 2021 reaccreditation assessment**

7 Evaluate the effectiveness of the Rural Generalist Curriculum with respect to its application at CGT and AST levels to meet program and graduate outcomes. (Standard 3.2.1)

*Recommendations for improvement*

Nil.

## Standard 4: Teaching and learning

Areas covered by this standard: teaching and learning approach; teaching and learning methods. **(Standards 4.1 and 4.2)**

| **Summary of accreditation status** | 2025: Met | 2026: Met |
|---|---|---|

The College's 2021 reaccreditation assessment found that Standard 4 was substantially met, and one condition was implemented at the time.

The College's 2025 monitoring submission found that Standard 4 was met, with no outstanding conditions.

**Team findings**

4.1 Teaching and learning approach

The ACRRM RG training program adopts a structured, competency-based teaching and learning approach, grounded in an apprenticeship model that integrates supervised workplace-based learning with structured education delivered flexibly across diverse training environments. Trainees undertake training in a range of general practice and hospital settings, including in rural, remote and First Nations communities, enabling learning to occur in authentic clinical and community contexts. There are opportunities for the College to improve support for trainees working and training in remote Aboriginal and/or Torres Strait Islander communities and develop stronger relationships with Aboriginal community controlled health organisations, as discussed in Standard 1, could help facilitate this.

The teaching and learning approach is characterised by its blended and multimodal design, incorporating structured teaching alongside experiential learning in the workplace. This includes semester-based learning (Semesters A–D), national workshops delivered virtually and face to face, webinars, cultural education, emergency training (including advanced life support [ALS]2) and regionally tailored education sessions. These structured components are complemented by self-directed learning, peer learning, clinical supervision and workplace-based experiential learning.

A key strength of the program is its regionalised training model, supported by the ACRRM Regional Training Network and regional coordination units. This network provides structured guidance and localised support for trainees, supervisors, practice managers and training posts, ensuring that teaching and learning are responsive to the needs of rural and remote communities. The Regional Training Network is supported by a multidisciplinary team that includes regional directors of training, training network coordinators, training program advisors, medical educators, cultural educators and mentors, as well as trainees and supervisor liaison officers. This integrated structure was identified as a significant strength, enabling consistent program delivery while maintaining strong localised support across training regions.

A further strength of the program is the effective socialisation of trainees in rural clinical and community contexts, which enhances contextualised learning and supports the development of professional identity as RGs. Trainees reported that training is strongly embedded in the realities of rural practice, with effective integration into local clinical teams and communities.

The approach is further strengthened by its balance of flexibility and rigour, with trainees describing the program as adaptable to individual learning needs while maintaining clear structure, expectations and standards of progression. Strong supervisory and educational support was consistently identified as a key enabler of learning, contributing to a well-supported training experience.

The program aligns with the ACRRM RG Fellowship curriculum, ensuring that teaching and learning are mapped to defined competencies and educational outcomes. This supports consistent development of knowledge, skills and professional behaviours across varied training environments.

This teaching and learning practice is well embedded in clinical practice, with structured supervision, feedback and opportunities for reflection supporting progressive development across the training continuum.

4.2 Teaching and learning methods

The program employs a broad range of structured teaching and learning methods that are embedded within clinical practice and delivered across workplace-based and formal educational settings.

The program is delivered synchronously and asynchronously, through face-to-face regional and national education sessions, targeted online learning modules, webinars, self-paced learning activities and simulation-based training. These approaches enable flexible engagement aligned to the trainee's stage of training, clinical context and learning needs.

Supervised direct patient care remains the central teaching method, with trainees progressively undertaking increasing clinical responsibility under supervision. Teaching is delivered through structured clinical coaching, bedside teaching, feedback and reflective learning within real-time clinical encounters.

A key strength of the program is the use of multi-supervisor teams, particularly in rural and remote settings. This model enhances access to expertise, improves continuity of supervision and strengthens educational support in geographically dispersed training environments. Remote supervision arrangements were also identified as an effective and appropriate mechanism to support trainees in areas with local workforce constraints, a positive feature of the program's flexibility and scalability.

The program demonstrates strong use of interprofessional and multidisciplinary teaching approaches, including learning alongside fellows, supervisors, nurses, medical educators and allied health professionals. This supports authentic team-based learning reflective of RG practice.

Workplace-based assessment is integrated as a core teaching and learning mechanism, providing structured formative feedback and supporting progressive development of competence. Supervisor reports and ongoing feedback processes further contribute to monitoring performance and guiding learning progression.

The team notes that with the growth of the specialty, there will be increasing demand for certain training experiences within regional hospitals. While the program has implemented flexible placement and supervision models to manage training capacity, continued attention will be required to ensure equitable access to high-demand procedural training experiences. For example, high demand for anaesthetic training placements in regional hospital settings for RG trainees as well as other specialty trainees may create bottlenecks that require ongoing workforce planning and placement coordination to ensure a fair distribution of learning opportunities. The program may benefit from further formalisation of its approach to monitoring and managing potential training capacity pressures across rural and remote settings, in collaboration with relevant stakeholders. While current systems such as placement coordination, supervision structures and regional oversight are effective in supporting equitable access to training experiences, a more explicit and documented approach to tracking emerging demand and distribution of learning opportunities may further strengthen transparency, consistency and long-term sustainability of training delivery.

**Commendations, conditions and recommendations**

*Commendations*

C The effective embedding of trainees within rural and remote communities, fostering authentic contextual learning and the development of a strong rural generalist professional identity.

*Conditions to satisfy accreditation standards*

**New conditions set as a result of the 2026 rural generalist medicine accreditation assessment**

Nil.

**Outstanding conditions from the 2021 reaccreditation assessment**

Nil.

*Recommendations for improvement*

Nil.

## Standard 5: Assessment of learning

Areas covered by this standard: assessment approach; assessment methods; performance feedback; assessment quality. **(Standards 5.1, 5.2, 5.3.3 and 5.3.4)**

| **Summary of accreditation status** | 2025: Met | 2026: Substantially Met |
|---|---|---|

The College's 2021 reaccreditation assessment found that Standard 5 was substantially met, and two conditions were implemented at the time.

The College's 2025 monitoring submission found that Standard 5 was met, with no outstanding conditions.

**Team findings**

5.1 Assessment approach

ACRRM implements a largely programmatic assessment framework across the duration of the Fellowship program (approximately four years), with a summative assessment conducted in the final year. Assessment activities are longitudinal and cumulative, enabling progressive judgements about trainees' preparedness for independent RG practice. Trainees appreciated that assessment is conducted primarily in local training locations (e.g. the final summative Structured Assessment using Multiple Patient Scenarios [StAMPS] can be completed online), ensuring they can continuously practice in rural and remote communities.

Assessment content is developed by clinically active RGs, supporting relevance, contextual validity and alignment with the outcomes of rural and remote medical practice. The program employs multiple assessment modalities spanning all levels of Miller's pyramid, including direct observation, clinical reasoning, knowledge testing and professional behaviours. As assessment in medical education becomes more complex, it may be helpful for the College to consider engaging or developing more specific educational and assessment expertise to ensure reliability, validity and fairness in assessment across the program.

Policies for special consideration are in place, and academic, pastoral and financial supports are available for trainees.

5.2 Assessment methods

A variety of programmatic and summative assessment methods are used across the ACRRM training program. These include:

- multiple-choice questions (MCQs) that test applied knowledge across all eight domains
- StAMPS, an ACRRM-designed summative assessment based on a combination of objective structured clinical examination (OSCE) and viva voce examination, which is conducted online. Candidates move through a series of four rurally contextualised scenarios marked by four different examiners. StAMPS aims to assess clinical skills rather than knowledge.
- case-based discussion (CBD) summative assessments with approximately one assessment every eight to ten weeks for 12-month ASTs, with scaled requirements for ASTs with longer terms, such as surgery
- mini-clinical evaluation exercise (mini-CEX) assessments, which are workplace observations across different contexts, patients and assessors
- multi-source feedback (MSF), which contributes to a multi-perspective assessment of professionalism and interpersonal competencies
- procedural logbooks, which support longitudinal demonstration of procedural competence, and supervisor reports contribute to holistic judgements of readiness for specialist practice.

The application of a consistent workplace-based assessment toolset across all 12 AST disciplines represents a design strength that enables appropriate contextual variation.

Cultural safety is assessed in a range of ways across the program, including contextually within clinical placements through MSF and as part of the StAMPS examination. While these approaches provide multiple points of assessment, there remains an opportunity for the College to more explicitly and systematically embed cultural safety across the curriculum and assessment framework.

Some First Nations trainees reported mixed experiences regarding the cultural content and framing of assessments. Some trainees felt disadvantaged by assessment content or approach, while others reported that assessment rubrics accommodated culturally informed clinical reasoning and practice. This variability suggests that cultural validity may be influenced by individual assessor interpretation rather than consistently embedded guidance.

The College has responded reactively to concerns when raised and has commenced an active cultural review of assessment content. Further probing during the review confirmed that this engagement is genuine and ongoing. However, the reliance on trainees' self-reporting to identify issues, combined with reliance on a single Aboriginal and/or Torres Strait Islander staff member for curriculum and assessment strategy and guidance, creates fragility and limits systematic assurance.

The College describes an assessment blueprint that maps assessment activities across the eight domains of rural and remote practice. The team could not locate a blueprint guiding assessment across the training stages; however, trainees appeared clear about what was required to achieve Fellowship. The team recommends that the College develop a staged blueprint/guide to assessment to assist trainees and supervisors to better assess progression through the program.

The College uses documented, valid methods of standard setting to determine passing scores across its summative assessment modalities. Standard setting for the MCQ examination is based on the modified Angoff method. StAMPS uses scenario-specific marking guides and behaviourally anchored rating scales (BARS), supporting transparency, consistency and defensible decision making. CBDs use defined global rating criteria, with a clear threshold for overall pass determination. MSF is benchmarked nationally and is based on defined completion criteria, supported by reflection and educational follow-up.

5.3 Performance feedback

The programmatic assessment design integrates both formative and summative components. Mini-CEX assessments are primarily formative, while MCQs, BCDs, StAMPS, MSF, procedural logbooks and supervisor reports contribute to summative assessment. Multiple data points inform progression decisions, enabling continuous, developmental feedback rather than episodic feedback.

ACRRM demonstrates multiple structured mechanisms for early identification of trainees who are not meeting the required outcomes. These include limits on assessment attempts under the Assessment Eligibility policy, escalation through a critical incident framework, and routine monitoring via the trainee progression framework. Where concerns are identified, proportionate and timely responses are implemented, including referral to Structured Focused Assessment Support Registrar Review Panels, and targeted academic and pastoral interventions. Trainees reported that training program advisors and medical educators are valued supports who provide individualised assessment guidance.

Processes for identifying and managing patient safety concerns arising from assessment are clear and well structured. Concerns are captured through assessment marking rubrics, ratified by the Board of Examiners, and escalated through notification to regional directors. Employers and regulators are informed where appropriate. These processes are sound and aligned with patient safety obligations.

**Commendations, conditions and recommendations**

*Commendations*

D The consistent application of a common workplace-based assessment toolset across all 12 AST disciplines is a clear strength, enabling appropriate discipline-specific contextualisation.

*Conditions to satisfy accreditation standards*

**New conditions set as a result of the 2026 rural generalist medicine accreditation assessment**

8 Develop a blueprint to guide assessment and progress through each stage of the specialist medical program mapped to program outcomes and curriculum. (Standard 5.2.2)

**Outstanding conditions from the 2021 reaccreditation assessment**

Nil.

*Recommendations for improvement*

Nil.

## Standard 6: Monitoring and evaluation

Areas covered by this standard: program monitoring; evaluation; feedback, reporting and action **(Standard 6.3.3)**

| **Summary of accreditation status** | 2025: Met | 2026: Met |
|---|---|---|

The College's 2021 reaccreditation assessment found that Standard 6 was substantially met, and four conditions were implemented at the time.

The College's 2025 monitoring submission found that Standard 6 was met, with no outstanding conditions with the development of the College's evaluation framework.

**Team findings**

6.3 Feedback, reporting and action

ACRRM maintains a range of policies and procedures that support the management of risks and incidents, including business continuity, critical incidents, fraud and corruption, privacy, information and data security, and complaints. To support organisation-wide oversight and coordination, the College is in the final stages of procuring an Enterprise Operations and Risk Management Platform, with full implementation planned by the end of 2026. Risk identification is informed by stakeholder feedback, including surveys of trainees and supervisors, as well as relevant national survey data. The College's evaluation framework contributes to risk identification through systematic evaluation and reporting to the executive, and a review of the framework was undertaken in 2025, with further revisions planned in 2026 to align with updated operational priorities and data capabilities. The team was satisfied that this risk management approach is effective; however, further work is required to ensure that collaborations with other specialist medical colleges are formally documented so that associated risks are appropriately identified and managed, as discussed in Standard 1.

**Commendations, conditions and recommendations**

*Commendations*

Nil.

*Conditions to satisfy accreditation standards*

**New conditions set as a result of the 2026 rural generalist medicine accreditation assessment**

Nil.

**Outstanding conditions from the 2021 reaccreditation assessment**

Nil.

*Recommendations for improvement*

Nil.

## Standard 7: Issues relating to trainees

Areas covered by this standard: admission policy and selection. **(Standard 7.1)**

| **Summary of accreditation status** | 2025: Substantially Met | 2026: Substantially Met |
|---|---|---|

The College's 2021 reaccreditation assessment found that Standard 7 was substantially met, and two conditions were implemented at the time.

The College's 2025 monitoring submission found that Standard 7 was substantially met, with one outstanding condition relating to the need to strengthen monitoring and evaluation processes to ensure they are proactive and effective in identifying existing power imbalances between supervisors and trainees, and in measuring the effectiveness of responses to training problems and disputes (Standards 7.4, 7.5, 6.1 and 6.2). As the scope of this accreditation assessment was limited, only Standard 7.1 was reviewed. Accordingly, this condition has not been satisfied through this accreditation process.

**Team findings**

7.1 Admission policy and selection

The College employs a comprehensive, well-established trainee selection process for both the Australian General Practice Training (AGPT) program and the Independent Pathway (IP), delivered through a single, aligned framework. Selection policies and principles, together with the mandatory requirements of the training program, are publicly available and clearly articulated.

The selection criteria and processes are designed to identify doctors with the capacity to train as RG practitioners in accordance with ACRRM Fellowship standards. Candidates are assessed against criteria that include:

- demonstrated commitment to a career as a specialist GP in rural or remote Australia
- demonstrated capacity and motivation to acquire the abilities, skills and knowledge described in the ACRRM domains of practice
- demonstrated connection with rural communities
- demonstrated commitment to meeting the needs of rural and remote communities through an extended scope of practice
- personal characteristics associated with a successful career in rural or remote practice.

These criteria are aligned with the skills, competencies and aptitudes outlined in the College's Fellowship curriculum and support a merit-based approach to selection.

The selection process comprises an online application and suitability assessment, which assesses eligibility using BARS. Eligible candidates are invited to participate in online multiple mini interviews (MMIs). Interview panels comprise an ACRRM fellow, a community representative, and a clinician who is also a College representative.

During meetings with the College, it was advised that an Aboriginal and/or Torres Strait Islander interviewer is available to participate on selection panels for all candidates. This represents a positive measure towards supporting a culturally safe interview process. To ensure consistent and transparent application, this practice should be formally documented within the College's selection policy.

Following the MMIs, referee checks are conducted, and candidates are ranked based on a combined score derived from the suitability assessment and interview performance.

The College advised that, at present, all eligible candidates are offered training places. However, selection into the AGPT program has been consistently oversubscribed in recent years. While the

College has been able to secure additional Commonwealth funding to accommodate all eligible applicants, reliance on supplementary funding remains an ongoing risk.

The College is currently undertaking a review of its trainee selection process with the aim of improving applicant data collection and strengthening the recruitment of Aboriginal and/or Torres Strait Islander trainees. Proposed areas of focus include selecting for attributes such as cultural safety and demonstrated intent to practise rurally.

At present, there is no formal policy or mechanism to prioritise the selection of eligible Aboriginal and/or Torres Strait Islander applicants in circumstances where demand exceeds available places. With the recent recognition of the specialty, applicant numbers are likely to continue to increase, which may reduce the certainty of selection for otherwise eligible candidates and increase the risk that eligible Aboriginal and/or Torres Strait Islander applicants are not offered a position. While planned reforms to the selection process may mitigate this risk, the College may wish to consider introducing explicit policy safeguards.

Notwithstanding this risk, the College demonstrates a proactive approach to recruiting Aboriginal and/or Torres Strait Islander trainees. When a First Nations medical student expresses interest in ACRRM training, a First Nations advisor initiates contact and connects the student with a member of the Aboriginal and Torres Strait Islander Members Group to support the development of a mentoring relationship. The College also maintains a visible presence at the Australian Indigenous Doctors' Association (AIDA) conference and promotes training pathways through the Indigenous General Practice Trainee Network (IGPTN).

The number of Aboriginal and/or Torres Strait Islander trainees has increased in recent years to 52. Formalising targeted recruitment and selection strategies could further consolidate and build on this progress.

**Commendations, conditions and recommendations**

*Commendations*

E The prioritisation of rural intent within the College's selection framework and the commitment to continuously improving selection policies support the development and retention of a sustainable rural and remote workforce.

*Conditions to satisfy accreditation standards*

**New conditions set as a result of the 2026 rural generalist medicine accreditation assessment**

Nil.

**Outstanding conditions from previous accreditation activities**

9 Strengthen monitoring and evaluation processes to be proactive and effective in:

i. Identifying existing power imbalance between supervisor and trainee and ensuring wellbeing supports are communicated well to trainees.

ii. Measuring effectiveness of the resolution of training problems and disputes. (Standard 7.4, 7.5, 6.1 and 6.2)

*Recommendations for improvement*

BB Consider introducing mechanisms to ensure eligible Aboriginal and/or Torres Strait Islander applicants are selected when the number of eligible applicants exceeds available training places. (Standard 7.1)

## Standard 8: Implementing the program – delivery of education and accreditation of training sites

Areas covered by this standard: supervisory and educational roles and training sites and posts **(Standards 8.1.1, 8.2.1 and 8.2.2)**

| **Summary of accreditation status** | 2025: Substantially Met | 2026: Substantially Met |
|---|---|---|

The College's 2021 reaccreditation assessment found that Standard 8 was substantially met, and three conditions were implemented at the time.

The College's 2025 monitoring submission found that Standard 8 was substantially met, with one outstanding condition relating to training sites demonstrating a commitment to Aboriginal and/or Torres Strait Islander health with appropriate cultural safety and protocols with an acknowledgement of local context (Standard 8.2.2). This condition has not yet been satisfied as a result of this accreditation.

**Team findings**

Discussion of supervisory and educational roles and training sites and posts are presented largely unchanged.

8.1 Supervisory and educational roles

Supervisory and educational roles have not been altered in response to the recognition of rural generalist medicine as a new specialty. The specific standards and responsibilities for supervisors are outlined in the College's standards for supervisors and training posts and apply to both CGT and all ASTs. These appear to be appropriate for their purpose.

All accredited posts must have a principal supervisor who is accountable for the clinical supervision and training progression of the trainee at the site. They are supported by additional supervisors when the primary supervisor is unavailable. Supervisors' performance is monitored, and a reaccreditation review is conducted regularly. ACRRM provides ongoing support to supervisors, including access to several online modules.

Remote supervision models are available and appropriate, and governed by appropriate guidelines. ACRRM has recognised that remote trainees need consistency and proactivity in supervision, and the guidelines reflect this. Additional wellbeing resources are also made available for remote trainees. Some trainees raised concerns about the level of support remote supervision provides, particularly in extremely remote Aboriginal and/or Torres Strait Islander communities. The College is encouraged to consult with trainees working in these areas to determine what additional supports would be beneficial.

8.2 Training sites and posts

Training sites, accreditation processes and criteria are described in ACRRM's Supervisors and Training Posts Standards. These have not been changed in response to the recognition of rural generalist medicine as a new specialty. They are fit for purpose and facilitate training in a diverse range of settings.

Regular and ongoing supervisor reporting and trainee feedback provide the College with oversight of the quality of training sites and are used to direct remediation support for underperforming sites.

ACRRM has noted the National Health Practitioner Ombudsman work relating to specialist medical college site accreditation, which is anticipated to change the existing accreditation practices.

**Commendations, conditions and recommendations**

*Commendations*

Nil.

*Conditions to satisfy accreditation standards*

**New conditions set as a result of the 2026 rural generalist medicine accreditation assessment**

Nil.

**Outstanding conditions from the 2021 reaccreditation assessment**

10 In the training post accreditation standards, include a requirement that sites and posts demonstrate a commitment to Aboriginal and Torres Strait Islander health with appropriate cultural safety and protocols with an acknowledgement of local context. (Standard 8.2.2)

*Recommendations for improvement*

Nil.

## Standard 9: Assessment of specialist international medical graduates

Areas covered by this standard: assessment framework; assessment methods; assessment decision; communication with specialist international medical graduate applicants.

Not assessed.

## Appendix 1: AMC standards included in this assessment

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|---|---|
| **Standard 1: Context of education and training** | |
| **1.1 Governance** | |
| 1.1.1 | The education provider's corporate governance structures are appropriate for the delivery of specialist medical programs, and assessment of specialist international medical graduates. |
| 1.1.2 | The education provider has structures and procedures for oversight of training and education functions which are understood by those delivering these functions. The governance structures should encompass the provider's relationships with internal units and external training providers where relevant. |
| 1.1.6 | The education provider has developed and follows procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision making. |
| **1.2 Program management** | |
| 1.2.1 | The education provider has structures with the responsibility, authority and capacity to direct the following key functions:<br>• planning, implementing and evaluating the specialist medical program(s) and curriculum, and setting relevant policy and procedures<br>• setting, implementing and evaluating policy and procedures relating to the assessment of specialist international medical graduates<br>• certifying successful completion of the training and education programs. |
| **1.3 Reconsideration, review and appeals processes** | |
| 1.3.1 | The education provider has reconsideration, review and appeals processes that provide for impartial review of decisions related to training and education functions. It makes information about these processes publicly available |
| 1.3.2 | The education provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem. |
| **1.4 Educational expertise and exchange** | |
| 1.4.1 | The education provider uses educational expertise in the development, management and continuous improvement of its training and education functions. |
| 1.4.2 | The education provider collaborates with other educational institutions and compares its curriculum, specialist medical program and assessment with that of other relevant programs. |
| **1.6 Interaction with the health sector** | |
| 1.6.1 | The education provider seeks to maintain effective relationships with health-related sectors of society and government, and relevant organisations and communities to promote the training and education of medical specialists. |
| 1.6.2 | The education provider works with training sites to enable clinicians to contribute to high-quality teaching and supervision, and to foster professional development. |
| 1.6.3 | The education provider works with training sites and jurisdictions on matters of mutual interest. |
| 1.6.4 | The education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education. |
| **Standard 2: The outcomes of specialist training and education** | |
| **2.1 Educational purpose** | |
| 2.1.1 | The education provider has defined its educational purpose which includes setting and promoting high standards of training, education, assessment, professional and medical practice, within the context of its community responsibilities. |

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| 2.1.2 | The education provider's purpose addresses Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand and their health. |
| 2.1.3 | In defining its educational purpose, the education provider has consulted internal and external stakeholders. |
| **2.2 Program outcomes** | |
| 2.2.1 | The education provider develops and maintains a set of program outcomes for each of its specialist medical programs, including any subspecialty programs that take account of community needs, and medical and health practice. The provider relates its training and education functions to the health care needs of the communities it serves. |
| 2.2.2 | The program outcomes are based on the role of the specialty and/or field of specialty practice and the role of the specialist in the delivery of health care. |
| **2.3 Graduate outcomes** | |
| 2.3.1 | The education provider has defined graduate outcomes for each of its specialist medical programs including any subspecialty programs. These outcomes are based on the field of specialty practice and the specialists' role in the delivery of health care and describe the attributes and competencies required by the specialist in this role. The education provider makes information on graduate outcomes publicly available. |
| **Standard 3: The specialist medical training and education framework** | |
| **3.1 Curriculum framework** | |
| 3.1.1 | For each of its specialist medical programs, the education provider has a framework for the curriculum organised according to the defined program and graduate outcomes. The framework is publicly available. |
| **3.2 Content of the curriculum** | |
| 3.2.1 | The curriculum content aligns with all of the specialist medical program and graduate outcomes. |
| 3.2.2 | The curriculum includes the scientific foundations of the specialty to develop skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge. |
| 3.2.3 | The curriculum builds on communication, clinical, diagnostic, management and procedural skills to enable safe patient care. |
| 3.2.4 | The curriculum prepares specialists to protect and advance the health and wellbeing of individuals through patient-centred and goal-orientated care. This practice advances the wellbeing of communities and populations, and demonstrates recognition of the shared role of the patient/carer in clinical decision making. |
| 3.2.5 | The curriculum prepares specialists for their ongoing roles as professionals and leaders. |
| 3.2.6 | The curriculum prepares specialists to contribute to the effectiveness and efficiency of the health care system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of health settings within the Australian and/or New Zealand health systems. |
| 3.2.7 | The curriculum prepares specialists for the role of teacher and supervisor of students, junior medical staff, trainees, and other health professionals. |
| 3.2.8 | The curriculum includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, so that all trainees are research literate. The program encourages trainees to participate in research. Appropriate candidates can enter research training during specialist medical training and receive appropriate credit towards completion of specialist training. |

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| 3.2.9 | The curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia and Māori health, history and cultures in New Zealand as relevant to the specialty(s). |
| 3.2.10 | The curriculum develops an understanding of the relationship between culture and health. Specialists are expected to be aware of their own cultural values and beliefs, and to be able to interact with people in a manner appropriate to that person's culture. |
| **3.3 Continuum of training, education and practice** | |
| 3.3.1 | There is evidence of purposeful curriculum design which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice. |
| 3.3.2 | The specialist medical program allows for recognition of prior learning and appropriate credit towards completion of the program. |
| **3.4 Structure of the curriculum** | |
| 3.4.1 | The curriculum articulates what is expected of trainees at each stage of the specialist medical program. |
| 3.4.2 | The duration of the specialist medical program relates to the optimal time required to achieve the program and graduate outcomes. The duration is able to be altered in a flexible manner according to the trainee's ability to achieve those outcomes. |
| 3.4.3 | The specialist medical program allows for part-time, interrupted and other flexible forms of training. |
| 3.4.4 | The specialist medical program provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes. |
| **Standard 4: Teaching and learning** | |
| **4.1 Teaching and learning approach** | |
| 4.1.1 | The specialist medical program employs a range of teaching and learning approaches, mapped to the curriculum content to meet the program and graduate outcomes. |
| **4.2 Teaching and learning methods** | |
| 4.2.1 | The training is practice-based, involving the trainees' personal participation in appropriate aspects of health service, including supervised direct patient care, where relevant. |
| 4.2.2 | The specialist medical program includes appropriate adjuncts to learning in a clinical setting |
| 4.2.3 | The specialist medical program encourages trainee learning through a range of teaching and learning methods including, but not limited to: self-directed learning; peer-to-peer learning; role modelling; and working with interdisciplinary and interprofessional teams. |
| 4.2.4 | The training and education process facilitates trainees' development of an increasing degree of independent responsibility as skills, knowledge and experience grow. |
| **Standard 5: Assessment of learning** | |
| **5.1 Assessment approach** | |
| 5.1.1 | The education provider has a program of assessment aligned to the outcomes and curriculum of the specialist medical program which enables progressive judgements to be made about trainees' preparedness for specialist practice. |
| 5.1.2 | The education provider clearly documents its assessment and completion requirements. All documents explaining these requirements are accessible to all staff, supervisors and trainees. |
| 5.1.3 | The education provider has policies relating to special consideration in assessment. |
| **5.2 Assessment methods** | |

| | |
|---|---|
| 5.2.1 | The assessment program contains a range of methods that are fit for purpose and include assessment of trainee performance in the workplace. |
| 5.2.2 | The education provider has a blueprint to guide assessment through each stage of the specialist medical program. |
| 5.2.3 | The education provider uses valid methods of standard setting for determining passing scores. |
| **5.3 Performance feedback** | |
| 5.3.3 | The education provider has processes for early identification of trainees who are not meeting the outcomes of the specialist medical program and implements appropriate measures in response. |
| 5.3.4 | The education provider has procedures to inform employers and, where appropriate, the regulators, where patient safety concerns arise in assessment. |
| **Standard 6: Monitoring and evaluation** | |
| **6.3 Feedback, reporting and action** | |
| 6.3.3 | The education provider manages concerns about, or risks to, the quality of any aspect of its training and education programs effectively and in a timely manner. |
| **Standard 7: Trainees** | |
| **7.1 Admission policy and selection** | |
| 7.1.1 | The education provider has clear, documented selection policies and principles that can be implemented and sustained in practice. The policies and principles support merit-based selection, can be consistently applied and prevent discrimination and bias. |
| 7.1.2 | The processes for selection into the specialist medical program:<br>• use the published criteria and weightings (if relevant) based on the education provider's selection principles<br>• are evaluated with respect to validity, reliability and feasibility<br>• are transparent, rigorous and fair<br>• are capable of standing up to external scrutiny<br>• include a process for formal review of decisions in relation to selection which is outlined to candidates prior to the selection process. |
| 7.1.3 | The education provider supports increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees. |
| 7.1.4 | The education provider publishes the mandatory requirements of the training program, such as periods of rural training, and/or for rotation through a range of training sites so that trainees are aware of these requirements prior to selection. The criteria and process for seeking exemption from such requirements are made clear. |
| 7.1.5 | The education provider monitors the consistent application of selection policies across training sites and/or regions |
| **Standard 8: Implementing the program—delivery of education and accreditation of training sites** | |
| **8.1 Supervisory and educational roles** | |
| 8.1.1 | The education provider ensures that there is an effective system of clinical supervision to support trainees to achieve the program and graduate outcomes. |
| **8.2 Training sites and posts** | |
| 8.2.1 | The education provider has a clear process and criteria to assess, accredit and monitor facilities and posts as training sites. The education provider:<br>• applies its published accreditation criteria when assessing, accrediting and monitoring training sites |

- makes publicly available the accreditation criteria and the accreditation procedures
- is transparent and consistent in applying the accreditation process.

8.2.2 The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and:

- promote the health, welfare and interests of trainees
- ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner
- support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand
- ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment.

**Standard 9: Assessment of specialist international medical graduates**

*The College was not required to provide information under this standard in this accreditation submission.*

## Appendix 2: Membership of the 2026 AMC team

| Name | Role |
|---|---|
| **Professor Kirsty Foster OAM (Chair)**<br>BSc, MBChB, FRCGP, DRCOG, MEd, PhD | Emerita Professor, Faculty of Medicine, University of Queensland |
| **Dr Will Milford (Deputy Chair)**<br>MBBS(Hons), FRANZCOG | Obstetrician and Gynaecologist |
| **Dr Sally Bristow**<br>RN, BN, RM, Grad Dip Mid, MN, PhD | Associate Director, Australian Nursing and Midwifery Accreditation Authority |
| **Associate Professor Kerin Fielding**<br>MBBS, FRACS(Orth), FAOA, GAICD, Hon FRCS, FRCS(ed) Ad Hominem | Chair, Council of Presidents of Medical Colleges |
| **Professor Dianne Stephens**<br>MBBS, FANZCA, FCICM, FCHSM, CHE, MPH | Dean, CDU Menzie School of Medicine, Charles Darwin University |
| **Professor Maree Toombs**<br>PhD, BEd | Deputy Dean Indigenous and Professor, School of Population Health, University of New South Wales |
| **Juliana Simon** | Head, Accreditation Assessments, Australian Medical Council |
| **Melissa Johnson** | Cultural Strategic Facilitator, Indigenous Policy and Programs, Australian Medical Council |
| **Ciara O'Sullivan** | Policy and Programs Officer, Accreditation Assessments, Australian Medical Council |
| **Clare Stuparich** | Program Coordinator, Accreditation Assessments, Australian Medical Council |

## Appendix 3: List of written and interview submissions on the rural generalist medicine program of the Australian College of Rural and Remote Medicine

Aboriginal Health and Medical Research Council of NSW

Aboriginal Medical Services Alliance Northern Territory

Australasian College for Emergency Medicine

Australian and New Zealand College of Anaesthetists

Australian Government Department of Health, Disability and Ageing

Australian Medical Association

College of Intensive Care Medicine of Australia and New Zealand

General Practice Registrars Australia

Indigenous General Practice Trainee Network

Joint Colleges Training Services

National Aboriginal Community Controlled Health Organisation

National Rural Health Alliance

National Rural Health Commissioner

New South Wales Department of Health

Queensland Aboriginal and Islander Health Council

Queensland Department of Health

Queensland Rural Generalist Pathway

Royal Australasian College of Physicians

Royal Australasian College of Surgeons

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Royal Australian College of General Practitioners

Royal College of Pathologists of Australasia

Rural Doctors Association of Australia

Rural Doctors Network

Rural Generalist Pathway Western Australia

Rural Workforce Agency Victoria

South Australian Department of Health

Victorian Department of Health

Victorian Aboriginal Community Controlled Health Organisation

Western Australian Country Health Service

## Appendix 4: Summary of the 2026 AMC team's accreditation program

Professor Kirsty Foster OAM (Chair), Dr Will Milford (Deputy Chair), Dr Sally Bristow, Associate Professor Kerin Fielding, Professor Dianne Stephens, Professor Maree Toombs, Juliana Simon (AMC Staff), Melissa Johnson (AMC Staff), Ciara O'Sullivan (AMC Staff), Clare Stuparich (AMC Staff)

| Meetings | Attendees |
|---|---|
| ***Thursday 19 March 2026*** | |
| Briefing with CEO | President<br>CEO<br>COO<br>General Manager Policy and Impact<br>Manager Policy and Advocacy |
| Standards 1, 2 & 7.1: Governance, Outcomes of specialist training and education, and Trainees—Admission policy and selection | President<br>ACRRM Board Members<br>CEO<br>COO<br>General Managers<br>Manager Policy and Advocacy |
| Trainees | Trainee representatives |
| Advanced Specialised Training | CEO<br>Censor in Chief<br>General Manager<br>Director of Training<br>Regional Directors of Training |
| Meeting with Supervisors of Training | Supervisor Liaison Officers |
| Meeting with New Fellows | New Fellow representatives |
| Standards 3 and 4: Curriculum and Teaching and learning | Education Committee<br>Education Council |
| Standard 7.1: Trainee Selection | Selection Committee<br>CEO |
| Standard 5: Assessment of learning | Examiner<br>Assessment Committee<br>Board of Examiners |
| Consumer Representatives | Consumer representatives |
| ***Wednesday 25 March 2026*** | |
| Aboriginal and/or Torres Strait Islander Fellows | Aboriginal and/or Torres Strait Islander Fellow representatives |
| ***Tuesday 14 April 2026*** | |

| Meetings | Attendees |
|---|---|
| Aboriginal and/or Torres Strait Islander Trainees | Aboriginal and/or Torres Strait Islander Trainee representatives |
| ***Wednesday 15 April 2026*** | |
| Standards 1, 2, 3, 7 and 8: Aboriginal and/or Torres Strait Islander health | Aboriginal and/or Torres Strait Islander Rural Generalist Fellows<br>College Council Member (Aboriginal and Torres Strait Islander Representative)<br>Policy and Advocacy Manager<br>Aboriginal and/or Torres Strait Islander Clinical Supervisors<br>General Manager, Education Services<br>General Manager, Member Engagement |

## Appendix 5: Glossary of Acronyms, Abbreviations and Terms

| Term | Definition |
|---|---|
| ACRRM, the College | Australian College of Rural and Remote Medicine |
| AGPT | Australian General Practice Training |
| Ahpra | Australian Health Practitioner Regulation Agency |
| AIDA | Australian Indigenous Doctors' Association |
| AMC | Australian Medical Council |
| ANZCA | Australian and New Zealand College of Anaesthetists |
| AST | Advanced Specialised Training |
| BARS | Behaviourally anchored rating scales |
| CBD | Case-based discussion |
| CGT | Core Generalist Training |
| CPMC | Council of Presidents of Medical Colleges |
| FACCRM | Fellowship of the Australian College of Rural and Remote Medicine |
| FTE | Full-time equivalent |
| GPs | General practitioners |
| IGPTN | Indigenous General Practice Trainee Network |
| IP | Independent Pathway |
| JCTS | Joint Colleges Training Services |
| MBA, the Board | Medical Board of Australia |
| MCQs | Multiple-choice questions |
| Miller's pyramid | A framework to assess clinical competence in medical education |
| Mini-CEX | Mini-clinical evaluation exercise |
| MMIs | Multiple mini interviews |
| Modified Angoff method | An expert-judgment approach used to determine defensible passing scores for exams without relying on arbitrary percentages |
| MSF | Multi-source feedback |
| National Law | Health Practitioner Regulation National Law |
| OSCE | Objective structured clinical examination |
| RACGP | Royal Australian College of General Practitioners |
| RANZCOG | Royal Australian and New Zealand College of Obstetrics and Gynaecology |
| RG | Rural generalist |
| StAMPS | Structured Assessment using Multiple Patient Scenarios |
| The Procedures | Procedures for Assessment and Accreditation of Specialist Medical Programs by the Australian Medical Council 2024 |

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