

Securing a stable medical workforce for rural communities:

A discussion paper



Health

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Background

1. Rural Local Health Districts (LHDs) face increased difficulty in attracting and recruiting a permanent specialist, general practice and non-specialist workforce to regional facilities. Recruitment and retention constraints have also been evident in engaging General Practitioners (GPs) and hospital non-specialists to district hospitals to provide services in Emergency Departments and to provide procedural services, particularly in anaesthetics, surgery and obstetrics and gynaecology.
2. It is noted that in spite of the range of financial and training incentives offered by both the Commonwealth and State governments to encourage medical graduates to pursue a career in rural general practice, an increase of only 28 GPs per annum was achieved in the size of the Australian-trained component of the rural GP workforce.¹
3. NSW has a number of initiatives aimed at training a rural workforce. However, it is acknowledged that these are not structured as a package, and it is largely left to the trainee to navigate through these initiatives.
4. There is consensus that a training program which provides rural exposure, and is coordinated and structured to match training with employment opportunities will contribute to securing a sustainable and skilled medical workforce for rural communities.
5. Whilst the NSW GP Procedural Training program has been implemented since 2003, it has been noted that there is insufficient coordination to match GPs with procedural skills to positions within LHDs. The recruitment of GP procedural trainees is not directly linked with the service needs of rural facilities. This has resulted in some procedural trainees facing difficulty securing ongoing employment within a LHD to provide procedural services as well as continuing shortages in GP Proceduralists within a number of rural facilities.
6. Some rural LHDs have expressed an interest in the Queensland Rural Generalist Training model as an opportunity to provide a sustainable and suitably skilled rural general practice workforce
7. The merits of the Rural Generalist model (as implemented in Queensland) have also been considered at a national level. In 2010, the Commonwealth Department of Health and Ageing commissioned a review on the Queensland Rural Generalist program which was undertaken by NOVA Consulting. The NOVA Report notes that the Queensland program is specific to the Queensland industrial and health service environment. Given that the first graduates from the Queensland program are expected in 2011, it is unclear how many Rural Generalist trainees will go on to practice long term as rural community GPs with advanced procedural skills.

1. Webber, D.K. (11 February 2011). *Parliamentary Inquiry into Overseas Trained Doctors: The 10-Year Moratorium*. Melbourne VIC 3004: Rural Health Workforce Australia. <http://www.aph.gov.au/house/committee/haa/overseasdoctors/subs/sub107.1.pdf>

NSW initiatives targeted towards recruitment of rural medical practitioners

8. The **Rural Preferential Recruitment (RPR) program** was established from the 2007 clinical year. The RPR scheme, coordinated by the Clinical Education and Training Institute (CETI), was implemented to allow doctors to spend the majority of their first two years training in a rural location. It is a merit-based recruitment process in which graduates with an interest in rural training can apply directly to a rural hospital for prevocational training. In 2011, 56 interns were recruited to the 81 RPR positions available across 11 rural hospitals.
9. The **NSW General Practitioner Procedural Training Program** was established in 2003. It provides opportunities for GPs to gain experience in procedural general practice that will equip them to practice in rural areas. Through this Program, up to 30 procedural training posts have been established in rural NSW in the following five specialities: anaesthetics; obstetrics; emergency medicine; surgery; and mental health. Since the Program's inception, there have been 260 full-time, part-time and flexible positions filled across these five specialities in rural hospitals across NSW
10. In NSW GPs provide services to a number of smaller rural hospitals as Visiting Medical Officers under the **Rural Doctors Settlement Package**. This provides more incentivised fee-for-service arrangements for VMOs working in these rural facilities.
11. The **NSW Rural Resident Medical Officer Cadetship Program** is funded by NSW Health and administered by the NSW Rural Doctors Network. The aim of the program is to increase the number of junior medical officers working in regional base hospitals and to increase the overall recruitment of medical practitioners working in rural and remote communities. The RDN offers 12 cadetships per year, 2 of which are allocated for Indigenous medical students. Cadets receive \$15,000 per year for the final two years of their medical studies. Following graduation, cadets participate in the RPR scheme and complete 2 years of service as a JMO at a non-coastal NSW regional base hospital.
12. The **Prevocational General Practice Placement Program (PGPPP)** is a Commonwealth funded program intended to provide general practice placements for prevocational doctors. There are 43 accredited GP practices for PGPPP positions across the 15 prevocational training networks, two of which are at intern level; the others are PGY2 positions. Many are in rural and regional locations.
13. A number of Base and District hospitals are also accredited for **vocational training**. Following the Special Commission of Inquiry into acute care in public hospitals, NSW funded 22 additional vocational training places. Sixteen of these positions are based in rural areas.
14. The **Hospitalist Training program** is designed to establish a new training pathway for Career Medical Officers (CMO) in public hospitals and will complement the VMO/staff specialist workforce. Hospitalists could be used as a supervisor for GP trainees in some regional/rural hospitals. The Hospitalist could also be used to boost out of hours cover for some rural facilities thus taking the pressure of GP VMOs.

The GP Training Program

15. The Australian General Practice Training program (AGPT) program involves a three-year full-time commitment, or four years for rural and remote medicine registrars. The AGPT program is overseen and funded by General Practice Education and Training Limited (GPET), a wholly owned government company established in 2001 by the Commonwealth Government. Training is delivered through regional training providers (RTPs) across Australia. The Commonwealth Government places a quota on the number of AGPT positions available, therefore entry into the program is competitive. GPET advises that approximately 1,000 training positions will be available for commencement in the 2012 training year within the AGPT program.
16. The AGPT program is designed to prepare trainees to be eligible for Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) and/or Fellowship of the Royal Australian College of General Practitioners (FRACGP). Both fellowships are recognised General Practice qualifications.
17. Some RTPs also offer training for the award of Fellowship in Advanced Rural General Practice (FARGP) which is offered by the National Rural Faculty of the RACGP. This award aims to equip doctors to practise independently, safely and competently across a range of rural and remote settings in Australia. Registrars must complete the additional requirements designated by the RACGP to be eligible for the conferment of this award. Fellowship of RACGP *plus* Fellowship Australian Rural General Practice (FRACGP/FARGP) is considered comparable to the FACRRM.

Proposed Training Models for Consideration

18. Two training models are proposed to address the issue of a stable medical workforce to rural hospitals. Both models can be implemented simultaneously as they have different target groups.
19. The NSW models have been developed on the premise that community general practice is the main provider of primary health care in NSW. It is therefore important for general practice trainees to continue to undertake a significant part of their training in a community general practice environment.
20. Both models are based on the assumption that GP trainees can undertake part of their training within a hospital setting. However, the current NSW hospital service model does not meet the accreditation requirements of ACRRM or the RACGP to enable GP trainees to complete all of their GP training in a hospital setting. Continuity of care is considered a necessary part of GP training and primary care under both College programs and NSW hospitals do not meet this training requirement.
21. The proposed *NSW Rural Medical Practitioner Training program* would be undertaken within a NSW industrial and service environment. Trainees and graduates of the program would be employed and engaged under existing Awards and determinations. The program would support trainees to obtain a Fellowship with either ACRRM or the RACGP and to obtain at least one procedural skill.
22. The proposed *NSW Rural Medical Practitioner Training Program* offers two Training Pathways:
 23. **Training Pathway 1** is a procedural GP training program which will result in an FRACGP/FARGP or FACRRM qualification. However, the training pathway also provides an opportunity for the GP registrar who has completed the procedural component of their training to be credentialed for independent practice within a hospital. This pathway enables GP trainees to maintain their interest and skills in the procedural speciality whilst undertaking the community GP component of their training.
 24. Training Pathway 1 will access some of the positions available in the existing GP Procedural Training Program. However, it is not proposed that this pathway replaces the GP Procedural Training Program. The GP Procedural Training program will continue to offer training positions to GPs Fellows and GP trainees wishing to gain a procedural skill. The *NSW Rural Medical Practitioner Training program* will target GP trainees who wish to pursue a career as a procedural GP in a rural area.
 25. **Training Pathway 2** provides for dual hospital/community General Practice training terms during the four year training program. GP registrars would undertake some of their training in a rural hospital facility and some in a community general practice. This allows rural hospitals to access the GP registrar workforce and allows Regional Training Providers (RTPs) to expand overall GP training places by offering a mix of training opportunities. Trainees within this program would qualify as a FRACGP. However, should they choose to, they can undertake further training to meet the requirements of FACRRM or FRACGP/FARGP.
 26. A flow chart illustrating the two training models is attached at the end of this paper (page 15).

There are a series of questions that are contained within this discussion paper. We would appreciate your responses to these questions as well as your overall comments on the proposed training pathways.

Training Pathway 1: Rural Procedural General Practice Training

27. The aim of this model is twofold:

- a) To link existing NSW initiatives targeted to establishing a stable and skilled rural GP workforce in a structured package with specific branding. This brand could be termed – the NSW Rural Medical Practitioner Training (Procedural) model or alternatively another name which reflects the intent of the program.
- b) To provide a model of engagement which allows GP trainees who have achieved competency in a procedural skill to be credentialed and privileged to undertake those procedures in an appropriate rural facility.

Training program

28. The training program would be structured as follows:

Year of training	Intern (PGY 1)	PGY2	PGY3	PGY 4	PGY 5
Training pathway	Intern training at a rural facility – recruitment via the Rural Preferential Recruitment (RPR) Scheme	Entry into GP training program	Procedural training at rural facility	Community General Practice training	
	PGPPP intern post (where available)	PGPPP term		Credentialed to provide procedural services at a rural facility	

Entry into the scheme

- 29. Under this model, medical graduates would be invited to apply for intern training opportunities under both the Rural Preferential Recruitment (RPR) Scheme or through the main allocation round.
- 30. During their Intern (PGY 1) year, the intern would apply for a GP training position as part of the GP Education and Training (GPET) program.
- 31. Upon selection to the GPET program, the trainee would apply to the NSW Rural Medical Practitioner Training. Selection to this program would be merit based. Factors taken into consideration as part of the selection process would include commitment to rural general practice, interest in procedural training and interest in rural hospital medicine.
- 32. Delaying entry to the program to the end of PGY1/ start of PGY 2 ensures that only trainees who have been selected into the GPET program are recruited into this program. This model builds on the RPR scheme, and does not create confusion by asking medical graduates to apply to two separate rural recruitment programs for interns. It also recognises that these trainees will be undertaking General Practice training and thus need to gain entry into the AGPT program. There may be opportunities to combine the selection process to this model with the GPET GP training selection.
- 33. It is recognised that some junior doctors have already identified during their university training what career pathway they wish to pursue after graduating from university. However, a number are still unsure and often will make their decision during their intern year, and are often influenced by their clinical and location experiences. By delaying entry until PGY2, it allows for the program to be marketed to both medical students and to interns. This will support them to make an informed decision regarding their training and career pathway.

Discussion Points

1. Do you support trainees commencing the Rural Medical Practitioner Training Program in their PGY 2 year? If not, why not? In your opinion, when should they commence?
2. Do you support trainees in the program being guaranteed specific rotations in their PGY 2 year?

For training facilities

3. Would your training facility be able to provide guaranteed PGY 2 rotations in nominated specialities for trainees undertaking the Rural Medical Practitioner Training program? If yes, please detail the range of rotations that may be available. If not, please provide reasons for your decision.

34. Junior doctors selected into the program would be given an initial two year employment contract. They would undertake a five term rotation in their PGY2 year with guaranteed rotations in anaesthetics/ICU, obstetrics and gynaecology and paediatrics. They would undertake advanced procedural training in their PGY3 year.
35. Trainees would have a training plan developed for them outlining their training pathway at the time of entry. This would be negotiated by the Statewide Director of Training and signed by the trainee, hospital and the RTP. Agreement on which procedural training is to be undertaken by the trainee would be determined based on the trainee's interests and preferences as well as the identified workforce and service needs. The intent will be to match the trainee's career aspirations with the rural community with the workforce need.
36. During their PGY 4 and PGY 5 years, the trainee would undertake their GP training in accredited community general practices or other accredited settings. They would also be engaged by the rural hospital to provide procedural services. The Director of Training would negotiate this with the RTP and the practice to ensure that the trainee has time to undertake this work.
37. Trainees would be remunerated as per the current Public Hospital Medical Officers Award when undertaking hospital based training. In Years 4 and 5 they would be employed by the community GP Practice and be engaged to provide procedural services at smaller rural public facilities (either as a GP VMO or a CMO).

Benefits

38. Training Pathway 1 provides a GP trainee who is in their PGY 4 and PGY 5 year the opportunity to undertake independent practice in the procedure they have been trained in. The GP trainee would be credentialed and privileged to provide the procedural service at an appropriate rural facility. It enables the trainee to maintain their skills and interest in the procedure they have been training in from the outset.
39. In undertaking the procedural independent practice, the trainee would be employed as a GP VMO or CMO and receive the benefits under the relevant Industrial Award.
40. The GP Trainee would continue to participate in community general practice training to meet the requirements of Fellowship. Formal arrangements will be made with the community general practice to ensure time off to undertake the procedural activity. This will be negotiated at the institutional level.
41. Trainees would also be provided with procedural GP mentors who will guide them in their training pathway.
42. Training Pathway 1 provides rural hospitals with a pool of candidates to fill their service and workforce requirements. It is envisaged that trainees within this pathway will be undertaking lists in small rural facilities which have a service load which is suitable for a GP proceduralist and does not require a fulltime commitment.

Discussion Points

4. Do you support the proposal that GP trainees in their PGY 4 and 5 year, who have completed their procedural training, undertake independent practice in the procedure they have been trained in at an appropriate rural facility? Please provide reasons.
5. Would such an arrangement benefit service delivery in your community/facility? Why/Why not?

43. Rural facilities advise that during periods when their GP Procedural VMO is on leave, the locum community GP may not be skilled or willing to provide procedural cover at the public facility. There is opportunity to explore the creation of a Locum GP Proceduralist pool which includes trainees within this training pathway who could be used to provide relief/leave cover to rural hospitals.
44. The Director of Training would liaise with the General Practice, RTP and LHD to seek agreement from all parties to enable the trainee to undertake procedural lists. The trainee would be required to meet the credentialing requirements of the rural facility.
45. Following the completion of GP Training and achievement of Fellowship, the trainee could continue the provision of procedural services at the LHD if they chose to or apply for another position based on their career plans.
49. Establish a set number of posts and look at how these are distributed across LHDs. Whilst PGY 2 positions are already established and funded in LHDs, additional positions may need to be created to accommodate this training program. The availability of specific terms such as anaesthetics, obstetrics and gynaecology and paediatrics in participating hospitals would also need to be considered. If these are not available within participating LHDs, rotations would need to be negotiated with other facilities, including metropolitan hospitals.
50. LHDs would also be required to identify facilities where there were employment opportunities in procedural services for GP trainees (in their PGY 4/5 years and beyond).
51. The program would be marketed to medical students and interns as a structured and supported training pathway.
52. Trainees would be selected for the program – a state wide merit selection process is proposed with input from Rural LHDs. The selection process could be undertaken jointly with the selection of trainees to the GPET program.

Implementation

46. This training pathway matches trainee career aspirations with service and workforce needs. To enable the training program to accurately match trainee selection with availability of training positions and employment opportunities, LHDs would be required to advise of current and medium term workforce needs. Given the lead training time, LHDs would need to identify their workforce requirements 2-4 years out. As part of this process, LHDs would need to take into consideration issues such as staff turnover, retirement plans and changes to service models to enable them to identify their future workforce requirements which could be addressed through a procedural GP workforce.
47. Implementation would involve the establishment of a Statewide Director of Training position and Training Oversight Committee composed of key stakeholders including LHD representatives, GPET, RACGP, ACRRM, rural GP trainee and RTP representatives.
48. LHDs would need to identify the participating hospitals where the procedural training would be undertaken. Currently GP Procedural training posts are in regional/ rural hospitals. Procedural training opportunities and exposure in a metropolitan hospital could be considered and negotiated where necessary or appropriate.
53. As trainees progress through the program, their credentialing requirements and procedural VMO/CMO appointments would be facilitated. This would require a revision of position descriptions and selection criteria to enable GP trainees with procedural qualifications to be considered. The Statewide Coordinator would need to broker agreements with the relevant RTP or community GP practice for dedicated time for the trainee within their community GP terms to provide services at the rural public facility.
54. Training Pathway 1 is not intended to replace the GP Procedural Training program. The GP Procedural Training program will continue to offer training positions to GPs Fellows and GP trainees wishing to gain a procedural skill. The NSW Rural Medical Practitioner Training program will target GP trainees who wish to pursue a career as a procedural GP in a rural area.

Discussion Points

- 6. Would you support Rural Medical Practitioner trainees undertaking rotations to metropolitan facilities if suitable training positions were not available in rural or regional facilities?**
- 7. What procedural training should be available to trainees in the Rural Medical Practitioner Training Program?**

Training Pathway 2: GP training program with mix of rural hospital and community GP terms

55. Under this model a GP training pathway would be structured to provide a mix of rural hospital terms and community GP terms which can be undertaken simultaneously. The GP trainee would work a combination of hours in a community general practice and in a rural public facility (both in hours as well as on call).
56. The key differences between this model and Model 1 are:
- a) This program is not targeted exclusively towards those GP trainees who wish to pursue procedural training.
 - b) The selection of posts under this model will be in negotiation between the Regional Training Provider and local hospital.
 - c) Under this model, the trainee will be employed at the rural facility as a Junior Medical Officer (JMO). Therefore unlike Model 1, the trainee will require some supervision. The level of supervision will be based on the training requirements and experience of the trainee. Hence the hospital will be required to provide supervision – this supervision could be provided by a CMO or VMOs.

Training pathway

57. The training program would be structured in the following manner:

Year of training	Intern (PGY 1)	PGY2	PGY3	PGY 4	PGY 5
Training pathway	Intern training at a rural facility – recruitment via the Rural Preferential Recruitment (RPR) Scheme	Entry into GP training program	Combination of Community General Practice training and rural hospital training		
	PGPPP intern post (where available)	PGPPP term			

58. Under this model the central coordinating body would negotiate with RTPs to expand GP training positions in NSW through a mix of rural hospital and community GP training opportunities.
59. These training terms would be undertaken part time at a community GP practice and part time at a rural public facility.
60. This program would target those trainees who have career aspirations towards a joint hospital/community general practice appointment. This training program allows trainees to continue their exposure to hospital based medicine.
61. This training pathway would be most suitable for rural facilities that have a high emergency load.
62. The GP trainees, when undertaking a hospital rotation, would be employed as a postgraduate medical trainee under the Public Hospital Medical Officers Award. They would undertake training within the rural facility and participate in on call rosters as part of their employment agreement.

Discussion Point

- 8. Do you support a combined community and hospital training term?
Please provide reasons.**

Entry into the scheme

63. Medical graduates would be invited to apply for intern training opportunities under both the Rural Preferential Recruitment (RPR) Scheme or through the main allocation round. During their Intern (PGY 1) year, the intern would apply for a GP training position as part of the GP Education and Training (GPET) program.
64. The recruitment process to this model would be the same as a GPET program. The main difference between a trainee in this pathway and the traditional GPET pathway is that the trainee would undertake some of their GP training within the rural public facility.
65. Exposure to community GP terms would still be required under this model.

Benefits

66. Training Pathway 2 is a structured training program which will be coordinated by the RTP. The trainee will be provided with a training plan which would outline the community and hospital terms and the skills they are expected to attain whilst on these terms.
67. Training Pathway 2 does not require the trainee to commit to procedural training. However, should they wish to pursue procedural training in the course of their training program, this can be facilitated by the RTP in negotiation with the Statewide Director of Training.
68. This pathway provides a mix of hospital and community general practice terms which will enable the trainee to have exposure to secondary care as well as primary care. This also offers career opportunities as a GP VMO or Career Medical Officer for those trainees who may wish to continue in the field of rural hospital medicine post Fellowship.
69. On achievement of Fellowship, the trainee is well equipped and skilled in the provision of hospital based medicine. Where trainees embark on a career as a community GP, they are able to use the hospital training in the provision of GP VMO services.

70. The relationships the trainee develops during their hospital training can facilitate employment opportunities post Fellowship.
71. As these trainees have an interest and exposure to hospital medicine, they may be more likely to take on GP VMO services.
72. The training terms within the hospital as accredited by the relevant training college (RACGP/ACRRM) as part of the overall AGPT. The hospital terms do not add to the overall training time commitment to achieve either the FRACGP or FACCRM.
73. This training program will offer dedicated training opportunities within rural facilities. Given the increased competition for hospital training as a result of increased numbers of medical graduates, this program provides trainees with an assurance of guaranteed hospital based terms.
74. Should a trainee within this Pathway wish to pursue procedural training opportunities, there is scope for these trainees to receive the benefits of Training Pathway 1 including the opportunity to engage in independent practice upon completion of their procedural training.
75. This Training Pathway provides trainees with alternative career opportunities should they wish to consider an alternative career pathway to community general practice.

Implementation

76. LHDs would be required to identify and establish suitable training terms which could be filled by a GP trainee. As part of this undertaking, LHDs would need to ensure adequate supervision for the GP trainee. This may require funding for supervision and presents an opportunity to explore innovative training and supervision models which link the rural facility with community general practices, regional and metropolitan facilities.
77. There would need to be accreditation of GP training terms which provide a combination of community GP and rural public facility training within the same term. Hospital based training terms would need to meet the accreditation and training requirements of the RACGP and ACRRM.

78. Negotiation and formal agreement with rural facilities and community GP practices would need to occur to share the GP trainee(s) during their time in the local community. This would include agreements around on-call arrangements and rostering.
79. The program would be marketed to medical graduates, interns and trainees as a structured program.
80. As part of the process to link this training program with future employment opportunities, LHDs would be required to advise of current and future vacancies which could be filled by these trainees upon achievement of Fellowship. LHDs would need to develop strategic workforce plans which take into account service needs, and staff turnover.

Limitations

- 81. Training Pathway 1 and 2 are training models designed to maximise existing rural training pathways through increased coordination. Whilst they provide access to GP trainees to provide procedural services and/or undertake part of their training within a rural hospital, they will not provide rural hospitals with a fulltime GP registrar to fulfil service needs.
- 82. A Hospital based training model may not necessarily address workforce issues within smaller rural hospitals as smaller hospitals may not be able to provide the necessary supervision for GP trainees.

Possible barriers which will need to be managed

Barrier	Mitigation Strategy
CMO resistance to supervising interns at rural hospital	Target facilities in the first instance which have a stable CMO workforce.
Ability to obtain agreement between rural facility and GP Practice regarding trainee roster arrangements and on call obligations	RTP to be the lead negotiator for the agreement – ensure that this model results in the expansion of training places and not take away existing training opportunities
Accreditation of joint training terms	Commence discussions with RACGP/ACRRM at the outset
May not address workforce issues for smaller rural facilities who may not have adequate medical staff to provide supervision	Work with RACGP/ACRRM, regional hospitals to establish a combination of supervision arrangements between Regional hospital, GP practice, GP VMO and CMO as applicable

Post Fellowship

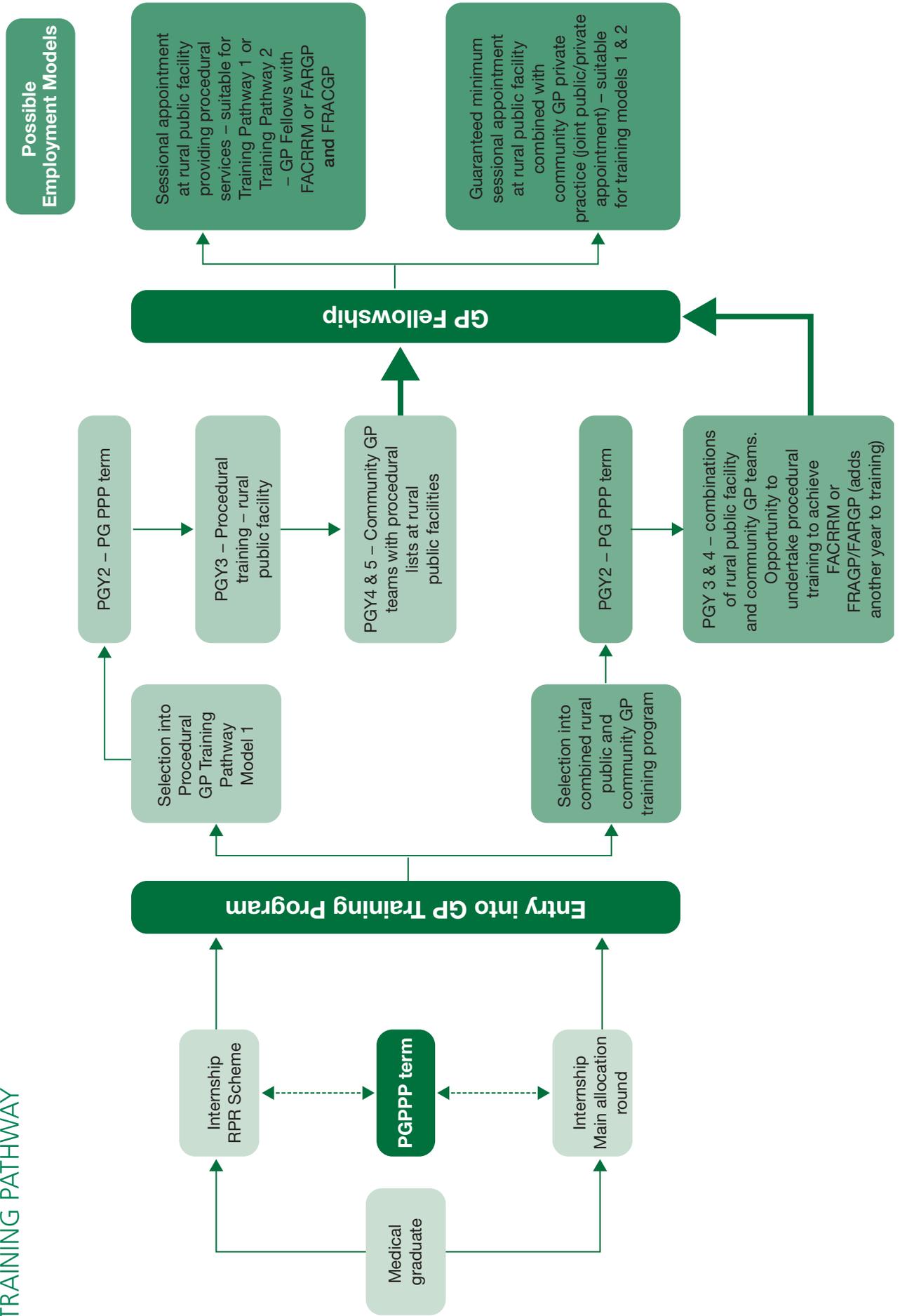
83. To avoid trainees being under-utilised or not being recruited to where there is a rural service need, the existing recruitment strategies and training models will need to be reviewed. If an appropriate recruitment strategy is not provided, trainees completing the program may still not end up working as a GP in a rural area or providing procedural services in a rural area.
84. Anecdotal advice suggests a generational shift amongst GP Registrars/New Fellows who prefer a salaried position over establishing a private community practice with its related business and overhead costs. Many are choosing to take up a salaried position in a General Practice rather purchasing an existing practice or establishing their own general practice.
85. In NSW, GPs are engaged as GP VMOS in rural and regional hospitals. There is scope for GPs to be offered a minimum sessional appointment as a GP VMO or be appointed as Career Medical Officers under the CMO Award. The CMO Award is the industrial classification for doctors not in training who are not covered by the eligibility provisions of the Staff Specialists Award.
86. In a number of rural locations the same medical workforce provides both primary care in the community and hospital-based services under an arrangement with the state. The type of care provided is not uniquely defined by setting and there is a degree of overlap across the two settings. As the source of funds and policy frameworks can be different in these different settings it is important to clarify and understand the 'rules' applying to each.

Please forward your comments to:

**Rural Medical Practitioner Feedback
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or via email to WDI@doh.health.nsw.gov.au

Ensuring a Stable Medical Workforce for Rural Hospitals: TRAINING PATHWAY



List of Acronyms

LHDs	Local Health Districts
GP	General Practitioner
RPR	Rural Preferential Recruitment Scheme
GPPTP	NSW General Practitioner Procedural Training Program
RDN	NSW Rural Doctors Network
PGPPP	Prevocational General Practice Placement Program
CMO	Career Medical Officer
VMO	Visiting Medical Officer
AGPT	Australian General Practice Training program
GPET	General Practice Education and Training Limited
RTP	Regional Training Provider
RACGP	Royal Australian College of General Practitioners
FRACGP	Fellowship of the Royal Australian College of General Practitioners
FARGP	Fellowship in Advanced Rural General Practice
ACRRM	Australian College of Rural and Remote Medicine
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
PGY	Postgraduate Year
JMO	Junior Medical Officer

