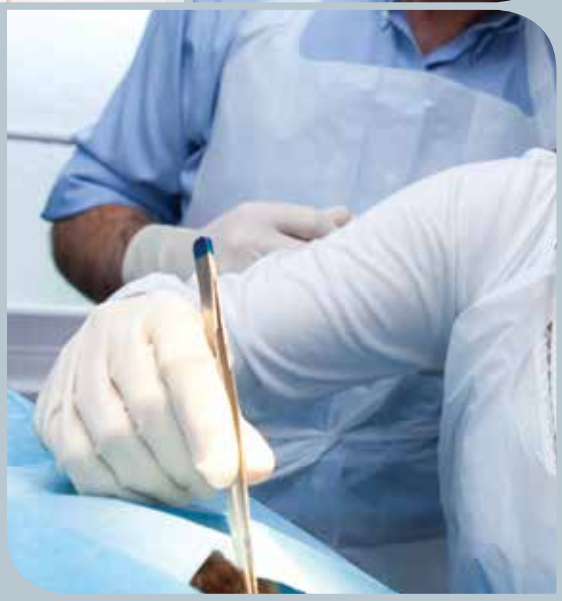
# Guide for Supervisors

## Primary Rural and Remote Training



FELLOWSHIP

Australian College of
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## Copyright



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# Table of Contents

# 1. Introduction

The supervisor is the cornerstone of the apprenticeship model of education and training as registrars progress towards Fellowship of the Australian College of Rural and Remote Medicine (ACRRM). This role in maintaining ACRRM's standards ensures that safe, confident and independent doctors will emerge as Fellows of ACRRM.

This resource has been developed for doctors providing (or intending to provide) supervision of registrars undertaking Primary Rural and Remote training on the Australian General Practice Training program (ACRRM Vocational Preparation Pathway).

It provides:

- information on eligibility criteria to become a supervisor, outlines the supervisor roles and responsibilities;
- provides an overview of the ACRRM Primary Curriculum, training and assessment;
- describes how to get your practice ready to provide training for registrars; and
- provides guidance on how to teach effectively.

# 2. Supervisors

## 2.1 Supervisor qualifications and experience

ACRRM has set the following qualifications and experience as a minimum to provide supervision for ACRRM registrars. Supervisors must meet all of the following:

1. Current full and unrestricted registration with the medical board of Australia;
2. Fellowship of ACRRM or has experience and qualifications which are assessed by ACRRM to be equivalent (see appendix 1);
3. Not less than five years full-time equivalent experience in rural and remote medicine or other rural specialist practice (including training time);
4. The ability to act as an appropriate role model, exhibiting a high standard of clinical competence, communication skills and professional values in relation to patient care; and
5. Demonstrated commitment to ongoing professional development.

## 2.2 Supervisor roles and responsibilities

A supervisor's role is primarily to provide oversight, guidance and feedback to a registrar on matters of personal, professional and educational development. This includes the requirement to anticipate a doctor's strengths and weaknesses in particular clinical situations, in order to maximise patient safety.

Supervision must be provided for registrars while working. This may be either on site, or by telephone, radio, or other electronic means. The amount of time a supervisor is required to be accessible and available to the registrar on site needs to be adjusted according to the stage of training and the ability of the registrar. As a guide ACRRM would expect would expect a supervisor to be onsite:

- 80% in the first 6 months;
- 50% in the second 6 months; and
- 25% thereafter.

A first year registrar will obviously need more supervision than a more senior registrar. However, you might get a seemingly experienced registrar about whose competence you feel uneasy. Intense supervision in the first week or two should give a feel for the level of supervision required/appropriate. A balance needs to be found between safety for the patient, security for the registrar and progressive development towards autonomous decision-making.

Supervisors are required to provide structured educational activities for registrars in their first year of Primary Rural and Remote Training. Three hours per week for registrars in the first six months and one and half hours per week in the second six months. In subsequent months educational activities are provided according the needs of the registrar. Supervisors need to adjust own clinical workload to be compatible with these teaching commitments.

It is also worth noting, however, that as a registrar becomes more knowledgeable and experienced, and therefore more aware of what they don't know that they may seek more time with a supervisor.

To provide the required level of supervision and education may call for more than one supervisor. Deputy supervisors are also required to be accredited by ACRRM. Deputy Supervisors may be onsite or in another post.

In addition to providing activities outlined above supervisors are also required to:

- maintain knowledge of the ACRRM vocational training and assessment program and ACRRM Primary Curriculum;
- assist the registrar to develop a learning plan and identify learning goals;
- provide appraisal and formative assessment of the registrar in accordance with their stage of learning;
- participate in appropriate supervisor training and assessor training activities.

(The Standards for Supervisors and Teaching Posts in Primary Rural and Remote Training provide further information.)

## 2.3 Process to become a supervisor

Regional Training Providers (RTPs) are accredited by ACRRM (and funded by the Australian government) to deliver ACRRM Vocational Preparation Pathway regionally. Generalist practitioners wishing to provide supervision for ACRRM registrars on this pathway need to contact the local Regional Training Provider (see www.agpt.com.au).

Applying to become a supervisor for ACRRM vocational training is usually incorporated in the process of becoming an accredited teaching post. Occasionally where the registrar is more experienced and the teaching post has no onsite supervisor, supervisors may be accredited to provide supervision remotely.

A teaching post refers to the environment in which the ACRRM registrar trains and works under supervision. ACRRM does not define a particular practice business model or type of medical facility in which training can occur. A teaching post may be a single facility such as a private practice, rural hospital, Aboriginal Medical Service or Rural Flying Doctors or a composite post where more than one primary location has joined together to form a post. Teaching posts are chosen by the Regional Training Provider and recommended to ACRRM. ACRRM accredits posts that demonstrate that they meet the ACRRM Standard for Supervisors and Teaching posts in Primary Rural and Remote Training.

Teaching posts enter into a service agreement with the local Regional Training Provider to provide training for registrars. This agreement outlines the supervisor requirements' and training subsidises as well as support, resources, orientation and training for the role.

## 2.4 Supervisor support and orientation

### 2.4.1 Regional Training Providers

Regional Training Providers provide orientation to the supervisor role and are the main source of ongoing support and training.

Australian General Practice and Training (AGPT) website contains references to a number of useful resources' and a curriculum for supervisors.
http://www.agpt.com.au/Supervisors/SupervisorResources/

Two national organisations provide representation for GP Supervisors, the independent National GP Supervisor Association (NGPSA) and the GPET funded GP Supervisor Liaison Officers Network (GPSLO Network).

### 2.4.2 National General Practice Supervisor Association (NGPSA)

The National GP Supervisors Association was formed in 1998 in response to the proposed changes to the GP training program and the need to review the remuneration and employment conditions of GP Supervisors.

The aim of the NGPSA is to represent the interests of GP Supervisors in the provision of vocational training and education, provide a legal entity for negotiating with Government and other interested parties (i.e. renegotiation of the National Minimum Terms and Conditions) as well as ensuring national standards of quality training through sharing of experience and expertise.

### 2.4.3 GP Supervisor Liaison Officers (GPSLO) Network

The GPSLO Network provides support for regional GPSLOs. The Network was formed in March 2003 following a national meeting of GPSLOs in Melbourne. The GPSLO Network receives funding from GPET for secretarial support, a list server for GP Supervisors, teleconferences and meetings. The GPSLO Network acts as a forum for GP Supervisor Liaison Officer issues and has regular national meetings.

### 2.4.4 Australian College of Rural and Remote Medicine

***Staff***
ACRRM's Vocational Training and Assessment team members are available to provide advice and guidance on supervision, training and assessment requirements for ACRRM registrars.

ACRRM can be contacted during office hours on: (07) 3105 8200 or toll free 1800 223 226 or email us at training@acrrm.org.au.

***Newsletter***
ACRRM provides supervisors with regular information and updates through FACRRM Fundamentals an electronic newsletter published bimonthly. Supervisors are linked to this network once accredited.

***Workshops***
Supervisor workshops are held annually in conjunction with the Rural Medicine Australia the annual conference for ACRRM and Rural Doctors Association of Australia.

***RRMEO***
Rural and Remote Medicine Education Online (RRMEO) is ACRRM's medical education and online learning platform that combines online resources and education activities with telemedicine services.

Through RRMEO, ACRRM members (and other RRMEO subscribers) participate in a wide range of learning activities and discussion groups, sharing experiences and knowledge with mentors and peers nearby or thousands of kilometres away.

RRMEO allows each doctor to:

- locate educational events, online education, teaching posts and clinical attachments via the RRMEO Educational Inventory;
- engage in online modules and online groups; and to
- record their lifelong learning.

RRMEO offers a supervisor support module which is highly relevant for Vocational Preparation Pathway supervisors. This module was produced for doctors providing support to Overseas Trained Doctors but also provides generic teaching and supervision skills. The Overseas Trained Doctors Supervisors Support Module comprises of four discrete parts, which can be undertaken independently in your own time.

RRMEO can be accessed via https://www.rrmeo.com/

***Professional Development Program***
Supervisors may claim Professional Development points for providing supervision and gaining accreditation as a Teaching Post. See the ACRRM PDP Handbook for details. http://www.acrrm.org.au/maintenance-vocational-recognition-for-gps

# 3. Teaching Posts

Preparation to become a teaching post requires planning and the involvement and support of the whole team. Adequate preparation assists in ensuring that teaching is a positive experience for all involved, registrar, supervisor/s and staff.

The Standards for Supervisors and Teaching Posts in Primary Rural and Remote Training sets the standards for posts.

## 3.1 Clinical Learning experiences

Registrars need to be provided with a range of learning experiences to prepare them for rural and remote practice. Over the period of Primary Rural and Remote Training a registrar is required to work in a post or posts that provide the following broad range of experiences.

- Managing undifferentiated acute and chronic health problems in an unreferred patient population;
- Providing care to all age groups;
- Providing continuing care for individuals with chronic conditions;
- Participating in after hours care;
- Providing extended continuity of care such as home visits, nursing home visits and hospital visits and other visits outside the practice premises;
- Undertaking preventative activities such as screening, immunisation and health education;
- Responding to emergencies, including stabilisation and definitive management as appropriate;
- Providing hospital-based secondary care;
- Participating in aspects of practice management including business aspects, quality and safety, time and resource management;
- Delivering antenatal and postnatal obstetric care;
- Undertaking procedures in ACRRM Procedural Logbook;
- Undertaking a range of population health interventions at the practice and community level; and
- Providing culturally secure healthcare to Aboriginal and Torres Strait Islander persons.

Supervisors should consider how exposure to these experiences can be provided in their post. If the post is able to provide a registrar with the majority of the experiences listed above ACRRM allows a registrar to spend their entire 24 months Primary Rural and Remote Training (PRRT) time in the post. If the scope is more limited the registrar may be required to spend part of PRRT time in another post/s with a different or additional scope of practice.

Please note that your local Regional Training Provider policies will also affect how long a registrar may stay in a post.

## 3.2 Resources

Teaching posts need sufficient space and resources for a registrar. At minimum registrars require access to:

- telephone, fax, the internet and email;
- range of relevant clinical resources;
- appropriate computer equipment, software and hardware;
- a suitably equipped, dedicated patient consultation room;
- essential medical equipment as defined in the standards;
- clear and adequate systems for clinical records and registers;
- adequate access to diagnostic and medical services;
- contact details for avenues for support;
- range of relevant educational resources; and
- equipment for participation in educational activities for example the internet.

Appendix 2 provides information on educational resources that may be useful for supervisors and registrars.

## 3.3 Teaching plan

A teaching plan documents what the post has to offer a registrar and how orientation, supervision and teaching requirements will be managed. Having a written plan will assist to ensure that teaching is provided consistently.

Accredited teaching posts are required to have a teaching plan which covers at a minimum:

- an outline of how the post organises orientation, teaching, learning and supervision;
- a description of the clinical, educational and social strengths and other opportunities to offer registrars;
- a description of the post, the practice population and teaching resources;
- an outline of how supervisors will assess the performance of the registrar and manage feedback;
- a description of how the post provides opportunities to be involved in quality assurance, audit and peer review; and
- a description of how the post provides opportunities for off site visits relevant to rural and remote medicine.

The above information is also required as part of the application process for post accreditation so will be easily converted into a teaching plan. A template and an example of a teaching plan is provided in appendices 3 and 4.

## 3.4 Reducing risk

Supervisors should advise their medical defence organisation of their intent to provide supervision and check with them that they have adequate and appropriate insurance cover.

When employing a registrar:

- Check with the Register of Practitioners Australian Health Practitioner Regulation Agency (AHPRA)
- Australia, to ensure that the registrar has current medical registration with no restrictions.

- Check that the registrar has appropriate medical indemnity including run off cover for the term of the appointment. Obtaining a copy of the policy details and a receipt is advisable.
- Have a written employment contract with the registrar covering terms of the appointment.

## 3.5 Orientation to the post

Providing effective orientation will be important to how the registrar experiences the post. Orientation is also crucial to ensuring that the registrar is safe and provides safe care.

Planning and documenting an orientation process in advance will ensure that all important components are covered.

Orientation should include:

- information on the practice/post, such as the major clinical focus of the post and post profile;
- introductions to staff, including roles and special interest areas;
- a description of duties;
- weekly roster;
- expectations regarding hospital and /or nursing home rounds and other clinical commitments (if relevant);
- cover arrangements;
- appointment system;
- ordering and following up of tests;
- medical records;
- recalls systems;
- information on referral services;
- equipment and where it is stored;
- an explanation of formal and informal protocols; and
- a timetable of educational activities both formal and informal relevant to registrars.

# 4. ACRRM Vocational Training Program

## 4.1 Training program summary

To support the registrar it is important that the supervisors and other staff have an understanding of the training and assessment processes the registrars are undertaking.

The Australian College of Rural and Remote Medicine was established by rural practitioners for rural practitioners. It is particularly focussed on standards that apply for appropriate and safe practice in rural and remote contexts. Improving access to quality care that meets the needs of rural and remote communities is paramount in the College's vision and approach to its work.

ACRRM is one of two medical colleges in Australia approved to determine and uphold the standards that define and govern competent independent medical practice in the specialty of general practice. ACRRM has developed a comprehensive vocational training and assessment program that is accredited by the Australian Medical Council and that on successful completion leads to the award of Fellowship of ACRRM (FACRRM).

The ACRRM vocational training program requires completion of:

- A minimum of four years of vocational training in accredited posts with accredited supervisors. This includes:
  - 12 months Core Clinical Training (CCT) in an ACRRM-accredited metropolitan, regional or rural hospital recognised for intern training.
  - 24 months Primary Rural and Remote Training (PRRT) in rural and remote ACRRM-accredited private practices, Aboriginal Medical Services, rural hospitals or community based facilities.
  - 12 months Advanced Specialised Training (AST) in ACRRM-accredited posts in one of the ten approved disciplines.
- A minimum of two emergency courses;
- Four RRMEO modules;
- Procedural Skills Logbook and
- A range of formative and summative assessment modalities.

Whilst the ACRRM training program is a four-year full-time program, registrars can apply for Recognition of Prior Learning (RPL) which has the potential of shortening their training time depending on the relevance of their previous experience.

There are three training pathways which enable a registrar to complete the necessary training and assessment required to obtain Fellowship of ACRRM:

1. Vocational Preparation Pathway (VPP) which is suited to recent graduates with limited general practice experience; the pathway is funded by the Australian Government. General Practice Education and Training Limited (GPET) manage the Australian General Practice Training (AGPT) program on behalf of the Australian Government; training is delivered by a network of Regional Training Providers (RTPs).
2. Remote Vocational Training Scheme (RVTS); provides vocational training for isolated rural practitioners who are not able to leave their communities to undertake training. It is provided mainly by distance education. The pathway is funded by the Australian Government.

3. Independent Pathway (IP) which is suited to experienced doctors; training is provided mainly by distance education, there is no government funding for this pathway, registrars pay the full cost of training, the pathway is provided by ACRRM.

While training is provided through a number of training providers all registrars are required to become registrar members of ACRRM, this entitles the registrar assess to all member benefits and the support of the Vocational Training team.

More information on the ACRRM vocational training program can be found at http://www.acrrm.org.au/vocational-training

## 4.2 The ACRRM Primary Curriculum

ACRRM's Primary Curriculum (http://www.acrrm.org.au/curriculum) is designed to be a practical resource, which outlines the curriculum content and the processes necessary to meet the teaching, learning and assessment requirements for those undertaking training towards Fellowship of ACRRM.

The ACRRM Primary Curriculum represents a comprehensive statement of the knowledge, skills and attitudes required for doctors to work anywhere in Australia. It provides a clear view of what, where and how the doctor needs to learn to undertake safe and independent practice across the full range of diverse rural, remote and urban settings in Australia.

The Primary Curriculum contains seven domains and 22 discipline specific curriculum statements that make up the discipline of rural and remote medical practice. Each curriculum statement defines specific learning objectives and overall educational outcomes expressing what rural doctors need to be able to do in that discipline. The subject matter covered in each of the curriculum statements is based on clinical presentations and problem solving where possible. What is required of the registrar is stated in terms of actions that can be demonstrated rather than a list of subject headings.

The registrar is required to have acquired the knowledge and skills in the Primary Curriculum by the time they have completed Core Clinical and Primary Rural and Remote Training. During the 12 month Advanced Specialised Training term registrars are required to develop skills and knowledge beyond the Primary Curriculum in one of the following 10 disciplines; Anaesthetics, Paediatrics, Surgery, Emergency, Adult Internal Medicine, Remote Medicine, Population Health, Obstetrics and Gynaecology, Aboriginal and Torres Straight Islander Health, and Mental Health.

## 4.3 Learning plan

ACRRM registrars are required to have a documented learning plan; this should be written early in training with their Medical Educator and updated as training progresses. Learning objectives ideally should be selected and referenced against the Curriculum to assist the registrar to track progress.

Supervisors are encouraged to discuss with the registrar how this post can assist in meeting their training requirements and learning objectives. There should also be a discussion and agreement about time off to attend educational activities.

Registrars are encouraged to use the RRMEO "Learning Planner" to manage and document their learning objectives and outcomes including learning goals, logbook requirements, and emergency medicine course completion. To use this resource effectively, it should be revisited regularly to reassess the learning plan and its goals.

Supervisors should encourage registrars to use RRMEO modules to fill gaps in learning.

ACRRM records teaching posts, assessment outcomes and other training requirements in the RRMEO registrar learning planner, providing a record of training progress.

## 4.4 ACRRM Assessment

ACRRM has five summative assessments that must be passed to achieve FACRRM. They are:

- Multiple Source Feedback (MSF);
- Mini Clinical Evaluation Exercise (MiniCEX);
- Multiple Choice Questions (MCQs);
- Structured Assessment Using Multiple Patient Scenarios (StAMPS); and
- Procedural Skills Logbook.

### 4.4.1 Multi Source Feedback

Multi-Source Feedback (MSF), also known as 360$^{o}$ feedback, is a method of gathering information about the registrar's interpersonal and communication skills, and their clinical skills by way of ratings of these aspects of their performance by people who are familiar with their work.

The MSF assessment is conducted for ACRRM under licence by Client Focused Evaluations Program (CFEP). MSF consists of three components; a colleague assessment tool (12 feedbacks required), a patient assessment tool (25 questionnaires required), and an online self-assessment. MSF participants receive a detailed 32-page report that includes qualitative and quantitative results, as well as comparison with international normative values. This level of detail greatly assists in structured feedback to the registrar and informing remediation when required.

Registrars are strongly encouraged to undertake a formative MSF. Formative MSF is available to arrange and undertake at a time of the registrar's choosing in accordance with the rules and regulations of a training provider, or by contacting CFEP direct on 07 3855 2093 or email cfep@bigpond.net.au.

Registrars can enrol in the summative MSF after completing 24 months of FACRRM training. The MSF is available for enrolment on an ongoing basis. Once enrolled, the registrar will have four months in which to complete the MSF process.

For further information regarding the MSF process, please visit http://www.cfepsurveys.com.au.

### 4.4.2 Mini Clinical Evaluation Exercise

The mini Clinical Evaluation Exercise (miniCEX) is a practice-based assessment where an examiner observes the registrar in their regular practice environment with their patients.

MiniCEX assesses competency in communication skills, history taking, physical examination, clinical judgment / clinical management, rural and remote context / organisation / efficiency, and overall clinical competence.

Registrars are strongly encouraged to complete regular formative miniCEX throughout training. The miniCEX is a valid and reliable method of simultaneously observing and assessing the clinical skills of registrars, and then being able to use this information to provide immediate and structured feedback on their performance. A formative miniCEX can be conducted within the context of a medical educator visit or at the instigation of the

registrar with any medical practitioner of their choosing, as long as the assessor is a fully training general practitioner, hospital based senior registrar or consultant.

An online modular program is available on RRMEO to assist the registrar and their assessor in the formative miniCEX process see https://www.rrmeo.com/ Formative miniCEX forms are available in appendix 6 or can be downloaded from the ACRRM website at http://www.acrrm.org.au/assessment.

Summative miniCEX involves an ACRRM appointed examiner observing nine patient consultations during which the registrar must meet mandatory requirements for history taking and physical examinations. The examiner will simultaneously observe and rate the registrar against six criteria.

Registrars are able to enrol in the summative miniCEX after completing 24 months of FACRRM training. They may not, however, undertake the miniCEX during the Advanced Specialised Training (AST) year. The summative miniCEX is available for a block period each semester. Registrars are able to enrol in this assessment by the enrolment closing date for the relevant block period.

### 4.4.3 Multiple Choice Question Examination

The Multiple Choice Question (MCQ) exam, consisting of 125 questions, is delivered through a secure website over a three hour period. All questions require a single best response from multiple options. There is no negative marking and examinations are marked by computer. Available on two dates during any one year (one date per semester), registrars are able to undertake this examination at the ACRRM examination centre in Brisbane or at a venue equipped with adequate IT facilities in their local environment.

To enrol in the MCQ examination, the registrar must have completed 12 months of training. We do, however, strongly recommend that they have completed at least 12 months of primary, rural and remote training prior to undertaking the MCQ, as the standard required is that of a fully qualified rural doctor working without supervision. Registrars are able to enrol in the MCQ by the enrolment closing date for each semester's examination.

Ten practice MCQ examination questions are available on the ACRRM website by visiting http://www.acrrm.org.au/assessment. Once enrolled, the registrar will also be offered the opportunity of participating in a 50 question practice MCQ examination.

### 4.4.4 Structured Assessment using Multiple Patient Scenarios

The Structured Assessment using Multi Patient Scenarios (StAMPS) is a new OSCE / VIVA type examination which is delivered via videoconference and consists of eight scenarios, each of 10 minutes duration. Registrars remain in one place at their videoconference facility and the examiners (all in one location) rotate between the registrars.

StAMPS is designed especially to provide ACRRM rural and remotely located registrars with a reliable, affordable, flexible, acceptable and contextually relevant assessment method.

StAMPS assesses ACRRM learning outcomes such as communication and interpersonal skills / diagnostic reasoning skills / flexibility in response to new information / management of complex problems in the rural and remote context / developing an appropriate management plan that incorporates relevant contextual factors / overall clinical competence.

Registrars are able to enrol in the summative StAMPS after completing 24 months of FACRRM training. The StAMPS is available on two to three dates per year and registrars are able to enrol by the enrolment closing date for each semester's examination.

Practice StAMPS scenarios are available on the ACRRM website by visiting http://www.acrrm.org.au/stamps-practice-scenarios-2010-0.

### 4.4.5 Procedural Skills Logbook

The Procedural Skills Logbook is drawn from the Primary Curriculum. It details the key psychomotor procedural skills and the level of competency required for independent rural and remote practice. The Logbook is located on the RRMEO Electronic Learning Planner and is also available in hard copy.

Across the specified items there are four different levels of minimum competency that are required to be satisfied to qualify for certification. In decreasing level of complexity they are:

A. Performed to the standard of an independent practitioner on a real patient and not just in a simulated environment.
B. Performed to a pass standard in a certified course in a simulated environment.
C. Performed under supervision to the standard of a practitioner working under supervision.
D. Assisted with the supervisor performing the task.

Supervisors are encouraged to review the logbook with the registrar early in the post to identify those procedural competencies still required. Procedures are to be certified by the supervisor or other medical practitioner when the procedure is performed in a safe, competent, professional and ethical manner. The certifier is required to complete the relevant documentation at the time the performance is witnessed.

The completed Procedural Skills Logbook must be presented to ACRRM as a completion of training requirement.

### 4.4.6 Assessment Blueprint

The assessable Learning Outcomes are defined in the ACRRM Primary Curriculum and the Assessment Blueprint details which of the assessment modalities examines each of the learning outcomes. See http://www.acrrm.org.au/curriculum/

While the assessments are undertaken progressively the standard set for all assessments is that of a safe, confident and independent general practitioner able to work across a full and diverse range of healthcare settings in Australia, including rural and remote settings.

### 4.4.7 Assisting the registrar to prepare for assessment

The best preparation is to provide the registrar with exposure to the broad scope of practice described in the curriculum and reinforcing and enhancing this by using the teaching activities outlined later in this resource.

Encouraging and assisting the registrar with formative assessment is also valuable for learning and assessment preparation.

It is in the registrar's interest to use the ACRRM structured formative assessment tools, as this will greatly assist in familiarity with the modalities and hence with examination preparation. The person providing feedback can be anyone the registrar chooses and is not limited to the formal supervisor.

# 5. Teaching/Learning Guidance

## 5.1 The learner

Learners have different ways of learning. These may be related to a range of factors including individual, age related, developmental, cultural and generational factors. There are many different models describing learning styles or preferred ways of processing information. A few models are outlined below and the implications they have for teaching and learning described.

### 5.1.1 Principles of adult learning

Adult learners generally:

- find learning rewarding;
- use all of their senses to learn;
- learn more effectively when they can relate new information to their existing knowledge;
- need opportunities to practise their new skills and apply their new knowledge;
- remember best the first and last things in a learning session;
- need feedback on their progress;
- need to be actively involved in the learning process; and
- need time to make sense of and value new information.

### 5.1.2 Individual learning styles

Everyone has a mix of learning styles/intellectual abilities. Some people may find that they have a dominant style of learning; others may find that they use different styles in different circumstances. Styles may also change overtime.

One model called Multiple Intelligences was developed by Howard Gardner: The model describes pathways to learning:

- *Visual/Spatial Intelligence*: These learners tend to think in pictures and need to create vivid mental images to retain information. They enjoy looking at maps, charts, pictures, videos, and movies.
- *Verbal/Linguistic Intelligence:* These learners have highly developed auditory skills and are generally elegant speakers. They think in words rather than pictures. They prefer using words, both in speech and writing.
- *Logical/Mathematical Intelligence:* These learners think conceptually in logical and numerical patterns making connections between pieces of information. Always curious about the world around them, these learners ask lots of questions and like to do experiments.
- *Bodily/Kinesthetic Intelligence:* These learners express themselves through movement. They have a good sense of balance and eye-hand co-ordination. Through interacting with the space around them, they are able to remember and process information. They prefer using their body, hands and sense of touch.
- *Musical/Rhythmic Intelligence:* These musically inclined learners think in sounds, rhythms and patterns. Many of these learners are extremely sensitive to environmental sounds (e.g. crickets, bells, dripping taps). They prefer using sound and music.
- *Interpersonal Intelligence:* These learners try to see things from other people's point of view in order to understand how they think and feel. They are great organizers. Generally they try to maintain peace in group settings and encourage co-operation. They use both

verbal and non-verbal language to open communication channels with others. They prefer to learn in groups or with other people.

- *Intrapersonal Intelligence:* These learners try to understand their inner feelings, relationships with others, and strengths and weaknesses. They prefer to work alone and use self-study.

### 5.1.3 Generational influences

It is most likely that registrars will come from a different generation to yourself this may also have an affect on how they learn.

| | **Baby boomers**<br>**1946-1962** | **Generation X**<br>**1963-1981** | **Generation Y**<br>**1982-2000** |
|---|---|---|---|
| **Description** | Work hard out of loyalty, expect long term job, pay dues, self sacrifice is a virtue, respect authority | Work hard if balance allowed, less likely to put jobs before friends, family, or other interests, less fixed on titles and status, less likely to delay gratification, expect many jobs, question authority. | Net generation, emotionally uninhibited, several careers over life, limitless choice, option a fundamental right. |
| **Influences** | Evidential<br><br>experts | Pragmatic<br><br>practitioners | Experiential peers |
| **Teaching focus** | Technical data, evidence | Practical case studies | Emotional, participative |
| **Learning format** | Formal structured | Relaxed interactive | Spontaneous multisensory |
| **Learning environment** | Classroom style, quiet | Round table, relaxed | Café, music, multimodal |
| **Iconic technology** | TV, audio, cassette | VCR, walkman, PC | Internet, email, SMS |
| **Leaders** | Command, control | Co-ordination, co-operation | Consensus, collaborative |

### 5.1.4 Novice to expert scale

The Dreyfus model “Novice to Expert” scale provides a way to understand the progress in the development of skills or competencies and assists in determining the level of supervision required.

| | **Knowledge** | **Standard of work** | **Autonomy** | **Coping with complexity** | **Perception of context** |
|---|---|---|---|---|---|
| **Novice** | Minimal, or 'textbook' knowledge without connecting it to practice | Unlikely to be satisfactory unless closely supervised | Needs close supervision or instruction | Little or no conception of dealing with complexity | Tends to see actions in isolation |
| **Beginner** | Working knowledge of key aspects of practice | Straightforward tasks likely to be completed to an acceptable standard | Able to achieve some steps using own judgment, but supervision needed for overall task | Appreciates complex situations but only able to achieve partial resolution | Sees actions as a series of steps |
| **Competent** | Good working and background knowledge of area of practice | Fit for purpose, though may lack refinement | Able to achieve most tasks using own judgment | Copes with complex situations through deliberate analysis and planning | Sees actions at least partly in terms of longer-term goals |
| **Proficient** | Depth of understanding of discipline and area of practice | Fully acceptable standard achieved routinely | Able to take full responsibility for own work (and that of others where applicable | Deals with complex situations holistically, decision-making more confident | Sees overall 'picture' and how individual actions fit within it |
| **Expert** | Authoritative knowledge of discipline and deep tacit understanding across area of practice | Excellence achieved with relative ease | Able to take responsibility for going beyond existing standards and creating own interpretation | Holistic grasp of complex situations, moves between intuitive and analytical approaches with ease | Sees overall 'picture' and alternative approaches; vision of what may be possible |

## 5.2 Teaching activities

Rural practice is an ideal learning environment; there are many clinical and professional opportunities for learning. Having a structured teaching plan will assist to ensure that teaching is integrated, efficient and relevant and that teaching requirements are met.

Registrars who are in the first year of Primary Rural and Remote Training are required to be provided with structured educational activities (three hours per week in the first six months and one and half hours per week in the second six months). In subsequent months educational activities should be tailored according to registrar needs.

When planning learning activities consider the following:

- Learning in isolation or out of context is always hard. If the registrar can see a relationship between what they are expected to learn and what they are expected to do, it becomes much easier. Therefore education should be linked to daily activities for example, debriefing after a consultation.
- It is also easier if what they are expected to learn to is linked with what they already know.
- The environment and their clinical duties or daily activities should be engineered to optimise learning.
- A range of learning activities should be provided to account for different learning and teaching styles.

The following are some suggestions for practice-based teaching activities:

- direct observation of consultations;
- case studies;
- topic tutorials;
- journal reviews;
- role play;
- procedural simulations;
- shadowing a colleague;
- demonstrations;
- clinical audits;
- medical record review;
- reviewing video taped consults;
- analysing prescriptions;
- teaching others e.g. students;
- formative assessment for example mini CEX;
- visits with allied health professionals; and
- online education modules.

Practice based teaching activities will be the most appropriate method to learn many of the Primary Curriculum learning outcomes, others will be best learnt through workshops, courses and self directive learning.

Appendix 5 Teaching Blueprint lists the Primary Curriculum Learning Outcomes and suggests how they may be best taught or learnt.

## 5.3 Teaching Skills

### 5.3.1 Feedback

Feedback is an essential teaching skill. Feedback should encourage self-reflection, raise self-awareness and help students plan for future learning and practice. Feedback may be formal or informal. Formal feedback is planned as part of appraisal and assessment and occurs episodically. It may cover specific areas or outcomes as set down by the Regional Training Provider or the College (see undertaking a mini CEX). Informal feedback should be given on a daily basis in relation to specific events for example managing a case or doing a procedure.

When providing feedback:

- Be timely:
  - Give feedback soon after an event and as regularly as possible (preferably daily or weekly). Waiting till the end of a rotation is too late. Don't give feedback at times when you or the registrar is tired or emotionally charged.
- Be specific:
  - Give specific feedback with examples, rather than a global "overall, you are doing fine".
- Be constructive:
  - Help provide solutions for areas of weakness.
  - Give positive critique, which looks at "what can be improved" rather than "what is wrong", encourages the registrar to look for solutions.
- Depersonalise the message:
  - Speak in the third person rather than the first.
- Involve attentive listening.
- Focus on the positive:
  - Avoid jokes, hyperbole or personal remarks (concentrate on the act or behaviour, not the person).
  - Try not to dampen positive feedback by qualifying it with a negative statement ("I was very happy with your presentation, Jayne, however . . ."; "Overall, David, we are pleased with your performance, but. . .").
- Use the feedback sandwich:
  - Give positive feedback before and after constructive feedback.
- Be in an appropriate setting:
  - Positive feedback is effective when highlighted in the presence of peers or patients.
  - Constructive criticism should be given in private — an office or some neutral territory where you are undisturbed is ideal. Phones should be off the hook, mobiles and pagers turned off.
- Allow time for discussion or explanation:
  - Registrars should be given the chance to comment on the fairness of the feedback and to provide explanations.
  - There may well be circumstances you are not aware of.
- Agree on a specific action:
  - Offer help if appropriate.
- Verify that the message has been heard:
  - For example say "What is your understanding of what we have just agreed"?

### 5.3.2 Good questions

Good questioning skills are important for effective teaching. Think about your questioning style, not only what you ask but also how long you wait for a reply.

- Use higher order questions: how, why, tell me about, tell me how. They are good to develop thinking and reasoning skills.
- Restrict the use of lower order questions such as what, when, to when you need to obtain detail.
- Wait and allow for response (up to five seconds) don't speak too soon.
- Follow a poor answer with another question which returns to the issue.
- Resist the temptation to answer learners' questions—use counter questions instead.
- Use statements—for example, “registrars sometimes find this difficult to understand” instead of “Do you understand?” which may be intimidating.
- Sequence questions to draw out contributions or to promote thinking at higher cognitive levels and to develop new understanding, for example: given your conclusions about the management of this case how would this influence future management in similar situations.

### 5.3.3 Effective explanations

Providing effective explanations is another important skill:

- Check understanding before you start, as you proceed, and at the end—non-verbal cues may tell you all you need to know about someone's grasp of the topic.
- Give information in “bite size” chunks.
- Put things in a broader context when appropriate.
- Summarise periodically (“so far, we've covered . . .”) and at the end; asking learners to summarise is a powerful way of checking their understanding.
- Reiterate the take home messages.
- Ask registrars to give you feedback on what has been learnt.

### 5.3.4 Developing clinical reasoning skills

The One Minute Preceptor model is a five step process which provides a framework for teaching. Try using it after a registrar has presented a case study. The structure encourages registrars to think critically about the case and gives insight into clinical reasoning skills. It also reminds supervisors to provide feedback on performance.

- Get a commitment: A question such as “What do you think is happening here?” or “What would be your treatment plan?” helps the learner commit to a diagnosis or treatment option, rather than simply going along with the supervisors plans.
- Avoid prompting or suggesting a diagnosis or treatment plan at this point
- Probe for supporting evidence: Explore the registrars thought processes. Was this a lucky guess or a well thought out evaluation?
- Questions such as “Were there any other alternatives you considered?” or “What made you rule out condition X?” are helpful.
- Questions that rely on rote memory, such as “What is the differential diagnosis for retrosternal chest pain?” don’t aid clinical reasoning.
- Teach general rules: Try to find a teaching point that can be applied to other situations.
- Reinforce what was done right: Positive feedback will encourage desirable behaviours.
- Correct mistakes: Point out any errors.

# Appendix 1: Accrediting Non-FACRRM Supervisors

Non-FACRRM supervisors need to demonstrate that they meet ACRRM supervisor's eligibility criteria and FACRRM equivalent training and expertise. Appropriateness of experience/expertise will be assessed by the Vocational Training team, using a 'point' scale against the following criteria: An applicant must be able to demonstrate equivalent training and experience to the value of 16 points to be considered eligible. If the assessment leads to a score of 15 or below, the application will be referred to the Vocational Training Committee for consideration.

1. Fellowship of an AMC accredited Australian or New Zealand Professional College (or recognised equivalent), e.g. FRACGP, FACEM.
    - *Maximum of 8 points available in this category*
    - *Points may be awarded for partial completion*
2. Rural Experience - Time spent in rural and/or remote clinical practice in an academic, peer-reviewed or accredited environment.
    - *Maximum of 6 points available in this category*
    - *2 points can be allocated for every five years spent, up to a maximum of 15 years*
3. Active and confirmed participation in a PDP/ QA program over the last 3 years.
    - *Maximum of 3 points available in this category*
4. Current Clinical Privileges.
    - *Maximum of 4 points available in this category*
    - *1 point for each of Obstetrics and Gynaecology, Anaesthetics, Surgery, Emergency Medicine*
5. Further tertiary level training relevant to Rural and Remote Medicine.
    - *Maximum of 4 points available in this category*
        - Graduate Certificate = 1 point
        - Graduate/Post Graduate Diploma = 2 points
        - Masters Degree = 3 points
        - Professional Doctorate, MD or PhD = 4 points
6. Completion of accredited courses within the last 5 years.
    - *Maximum of 6 points in this category*
        - EMST, APLS, ALSO,PHTLS, EM, REST, ELS = 1 point each
        - Other state-based trauma and acute care courses as recognised by ACRRM censor and promoted via ACRRM's PDP. For example, Radiology and Ultrasound skills based training = 1 point each
7. Leadership and Academic Activity.
    - *Maximum of 3 points in this category*
        - Development of, or leadership in, the relevant specialty or a relevant specialty field of rural and remote medicine at a national or international level = 1 point
        - Ongoing contribution to undergraduate or postgraduate education= 1 point
        - Five publications as primary or secondary author in national or international peer-reviewed scientific journals/books/scientific proceedings = 1 point

# Appendix 2: Educational Resources

The section suggests resources that may be useful to supervisors and registrars.

### Internet based resources

- RRMEO
  - Tele-derm
  - Tele-radiology
  - PDA Guidelines
  - A large variety of other modules are available
- Most State Health Departments provide a gateway to useful electronic resources
- UptoDate
- MD Briefcase
- Harrisons
- The Cochrane Collaboration
- Medline
- PubMed

### Journals

- Australian Journal of Rural Health
- Australian Family Physician
- American Family Physician
- Australian Prescriber
- Archives of Family Medicine
- British Journal of Family Practice
- Canadian Family Physician
- CHECK
- Emergency Medicine Australasia
- Family Practice
- Journal of Rural Health
- Medical Journal of Australia
- Medicine Today
- New Zealand Family Physician
- NPS: RADAR
- Primary Care

## Text books

Key texts are marked with an asterisk *

***Aboriginal and Torres Strait Islander Health***

- Eckermann A. Binan goonj : bridging cultures in aboriginal health. 2nd ed. Syndey ; New York: Churchill Livingstone; 2006.*
- Couzos S, Murray R, Kimberley Aboriginal Medical Services' Council., National Aboriginal Community Controlled Health Organization. Aboriginal primary health care : an evidence-based approach. 3rd ed. Melbourne, Vic.: Oxford University Press; 2008.*

***Cardiology***

- Hampton JR. The ECG made easy. 7th ed. Edinburgh ; New York: Churchill Livingstone/Elsevier; 2008. *

***Core Clinical Skills***

- Flynn JA, Longmore JM. Oxford American handbook of clinical medicine. Oxford ; New York: Oxford University Press; 2007. *
- Bickley LS, Szilagyi PG, Bates B. Bates' guide to physical examination and history taking. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2007. *

***Dermatology***

- Johr R. Dermoscopy : the essentials. Edinburgh ; New York: Mosby; 2004.
- Wolff K, Johnson RA, Fitzpatrick TB. Fitzpatrick's color atlas and synopsis of clinical dermatology. 6th ed. New York: McGraw-Hill, Medical; 2009.

***Emergency Medicine***

- Cameron P. Textbook of adult emergency medicine. 3rd ed. Edinburgh ; New York: Churchill Livingstone Elsevier; 2009. *
- Cameron P. Textbook of paediatric emergency medicine. Edinburgh ; New York: Churchill Livingstone Elsevier; 2006. *

***Ethics***

- Kerridge I, Lowe M, Stewart C. Ethics and law for the health professions. 3rd ed. Annandale, NSW: Federation Press; 2009.*
- Stewart C, Kerridge IH, Parker M. The Australian medico-legal handbook. Marrickville, N.S.W.: Church Livingstone Elsevier; 2008.

***Evidence Based Practice***

- Straus SE. Evidence-based medicine : how to practice and teach EBM. 3rd ed. Edinburgh ; New York: Elsevier/Churchill Livingstone; 2005.

***Foundations of General Practice***

- Balint M. The doctor, his patient, and the illness. 2nd ed. Edinburgh ; New York: Churchill Livingstone; 2000.
- McWhinney IR. A textbook of family medicine. 2nd ed. New York: Oxford University Press; 1997.

***General Practice***

- Murtagh J. John Murtagh's general practice. 4th ed. Sydney ; New York: McGraw-Hill; 2007. *

- Murtagh J. John Murtagh's patient education. 5th ed. North Ryde, N.S.W.: McGraw-Hill Australia; 2008.
- Murtagh J. Murtagh's practice tips. 5th ed. Sydney ; New York: McGraw-Hill; 2008.
- Simon C, Everitt H, Kendrick T. Oxford handbook of general practice. 2nd ed. Oxford ; New York: Oxford University Press; 2005.


***Infectious Disease and Tropical Diseases***


- National Health and Medical Research Council (Australia). The Australian immunisation handbook. 9 ed. Canberra: Australian Govt. Pub. Service; 2009. *
- Sutherland SK, Tibballs J. Australian animal toxins : the creatures, their toxins, and care of the poisoned patient. 2nd ed. South Melbourne ; New York: Oxford University Press; 2001.
- Gill GV, Beeching N. Tropical medicine. 6th ed. / edited by Geoff Gill & Nick Beeching. ed. Oxford: Wiley-Blackwell; 2009.


***Medicine***


- Boon NA, Davidson S. Davidson's principles & practice of medicine. 20th ed. Edinburgh ; New York: Elsevier/Churchill Livingstone; 2006.


***Mental Health***


- Davies T, Craig TKJ. ABC of mental health. 2nd ed. Malden, Mass.: BMJ Books/Blackwell Pub.; 2008. *
- Gelder MG. New Oxford textbook of psychiatry. 2nd ed. Oxford ; New York: Oxford University Press; 2009.


***Obstetrics and Gynaecology***


- Oats J, Abraham S, Llewellyn-Jones D. Llewellyn-Jones fundamentals of obstetrics and gynaecology. 8th ed. Edinburgh ; New York: Elsevier Mosby; 2005.


***Orthopaedics***


- Apley AG, Solomon L, Warwick D, Nayagam S. Apley's concise system of orthopaedics and fractures. 3rd ed. London, New York: Hodder Arnold ;Distributed in the United States by Oxford University Press; 2005.
- McRae R, Esser M. Practical fracture treatment. 5th ed. Edinburgh ; New York: Elsevier Churchill Livingstone; 2008. *


***Paediatrics***


- Thomson K, Tey D, Marks M, Royal Children's Hospital. Paediatric handbook. 8th ed. Oxford; Hoboken, NJ: Wiley-Blackwell; 2009. *


***Public Health***


- Germov J. Second opinion : an introduction to health sociology. 4th ed. South Melbourne, Vic.: Oxford University Press; 2009.
- Heymann DL, American Public Health Association. Control of communicable diseases manual. 19th ed. Washington, DC: American Public Health Association; 2008.
- Farmer RDT, Lawrenson R. Lecture notes. Epidemiology and public health medicine. 5th ed. Malden, Mass.: Blackwell Pub.; 2004.


***Radiology***


- Erkonen WE, Smith WL. Radiology 101 : the basics and fundamentals of imaging. 3rd ed. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins Health; 2009.

***Rural and Remote Health***

- Smith JD. Australia's rural and remote health : a social justice perspective. 2nd ed. Croydon, Vic.: Tertiary Press; 2007.
- Hutten-Czapski P, Magee G, Wootton J, Society of Rural Physicians of Canada. Manual of rural practice. Shawville, Québec: Society of Rural Physicians of Canada; 2006. *
- Liaw S-T, Kilpatrick S. A textbook of Australian rural health. Canberra: Australian Rural Health Education Network; 2008.
- Royal Flying Doctors (RFDS) Manual
- Central Australian Rural Practitioners Association (CARPA) manual

***Surgery***

- Tjandra JJ. Textbook of surgery. 3rd ed. Malden, Mass.: Blackwell Pub.; 2006.

***Therapeutics***

- Australian medicines handbook : AMH. Adelaide, S.Aust.: Australian Medicines Handbook; 2009.
- Therapeutic Guidelines Limited. Therapeutic guidelines : Analgesics. 5. ed. North Melbourne: Therapeutic Guidelines Limited; 2007.
- Therapeutic Guidelines Limited. Therapeutic guidelines: Toxicology and wilderness. 1. ed. North Melbourne, Vic.: Therapeutic Guidelines; 2008.
- Therapeutic Guidelines Limited. Therapeutic guidelines : Oral and Dental. 1. ed. North Melbourne: Therapeutic Guidelines Limited; 2007.
- Therapeutic Guidelines Limited. Therapeutic guidelines: Rheumatology. 1. ed. Melbourne: Therapeutic Guidelines; 2006.
- Therapeutic Guidelines Limited. Therapeutic guidelines: Antibiotic. 13. ed. North Melbourne, Vic.: Therapeutic Guidelines Limited; 2006..
- Therapeutic Guidelines Limited. Therapeutic guidelines: Dermatology. 3. ed. North Melbourne, Vic.: Therapeutic Guidelines; 2009.
- Therapeutic Guidelines Limited. Therapeutic guidelines. Palliative care. 2. ed. North Melbourne, Vic.: Therapeutic Guidelines Ltd.; 2005.
- Therapeutic Guidelines Limited. Therapeutic guidelines: Psychotropic. 6. ed. North Melbourne, Vic.: Therapeutic Guidelines; 2008.
- Therapeutic Guidelines Limited. Therapeutic guidelines: Respiratory. 4. ed. North Melbourne, Vic.: Therapeutic Guidelines Limited; 2009.
- Therapeutic Guidelines Limited.Therapeutic Guidelines: Gastrointestinal. 4. ed. North Melbourne: Therapeutic Guidelines Ltd.; 2006
- Therapeutic Guidelines Limited. Therapeutic guidelines: Cardiovascular. 5. ed. North Melbourne: Therapeutic Guidelines Limited; 2008.
- Therapeutic Guidelines Limited. Therapeutic guidelines: Endocrinology. 4. ed. North Melbourne: Therapeutic Guidelines Limited; 2009.
- Therapeutic Guidelines Limited. Therapeutic guidelines: Neurology. 3. ed. North Melbourne: Therapeutic Guidelines Limited; 2007.
- Therapeutic Guidelines Limited. Therapeutic guidelines: Developmental Disability. 2. ed. North Melbourne: Therapeutic Guidelines Limited; 2005.

# Appendix 3: Teaching Plan Template

**Description of post**

- Hospital/general practice/other
- Location
- Population, town and region
- Medical workforce
- Referral patterns
- Ancillary services
- Orientation

**Roles of the Registrar**

- Hospital - Rounds, OPD, ED, on call roster
- Practice- sessions, consults, procedural
- Other environments

**Supervision**

- Nominated supervisors
- In hours, hospital, practice, other
- After hours, hospital, practice, other

**Teaching**

- Regular planned education
- Ward rounds
- Regular meetings with supervisor re learning plans, problems/ issues
- Observation of consultation
- Feedback formative assessment using miniCEX
- Other teaching RTP, satellite broadcasts, internet access, educational resources, audits, conferences

# Appendix 4: Teaching Plan Example

### Description of the Post

Bushtown offers excellent training in both the Hospital and Private Practice. Bushtown aims to provide a positive supported rural experience.

Bushtown is a town of approximately 6,000 people 500 kilometers south-west of Brisbane close to the Queensland-NSW border servicing a regional population of approximately 11,000.

Bushtown Hospital has an allocation of three full-time Medical Officers. These doctors are all GPs at the local Medical Centre. One position is targeted for a GP Registrar.

Other health services include Community & Child Health, Aboriginal Health, Qld Ambulance, Blue Nursing Service, Optometrist, 2 Physiotherapists, 2 Occupational Therapists, Speech Pathologist, Social Worker, 2 Private Dentists & Visiting Hospital Dental Service, Visiting Mental Health team supported by local mental health worker, Podiatrist, Dietician, Psychologist, 2 Radiographers, Breast Screen QLD mobile van on a bi-annual basis, Nursing Home.

### Roles of the registrar

This registrar position involves 9 sessions per week (usually 38 hours) approximately three sessions at the hospital and six sessions at the Medical Centre.

The Hospital activities include:

- ward rounds every morning Monday to Friday;
- three and a half hours conducting Outpatients twice a week; and
- two and a half hours in Accident and Emergency twice a week.

The private practice activities include:

- three days at the Clinic seeing patients.

A standard weekday working day for the registrar starts with a ward round of all inpatients with the Medical Officer. Following the ward round, the registrar moves to work in Outpatients or the Medical Centre. The after-hours Hospital roster is one in three first on call.

The first on call doctor will be contacted for telephone advice about some non-urgent presentations at the hospital and can direct simple initial management and follow-up. However, there are instances where they must attend. There is a ways a second on call doctor for phone advice and to attend if necessary.

### Supervision

Supervision is provided by senior Medical Officers. The three doctors work by a roster that ensures the required amount of Supervision and teaching is provided. The Hospital and the Medical Centre are only two minutes' drive away from each other, therefore extras supervision/support or back-up is readily available if required. One senior GP is rostered for back up call and assistance at all times, including after hours.

**Teaching**

Registrars are expected to participate in:

- Regular planned education sessions held during consulting hours at the Medical Centre;
- Regular meetings with their nominated GP Supervisor to formulate learning plans and discuss problems;
- Ward rounds where they will present the cases they have admitted; and
- Supervisor observation and feedback on consults.

Other teaching opportunities include:

- Wednesday morning teleconferences through the RTP;
- Satellite broadcasts organized by Rural Health Education Foundation;
- Web cast CME activities;
- Practice audits;
- Conferences;
- Division CME;
- Weekly meetings with Allied Health staff; and
- Educational sessions with the visiting Specialists.

The consulting room at the hospital is equipped and set out much like a private GP room. There is broadband internet access in every consulting room and there are essential texts on computer desk tops. When consulting from the hospital, doctors have remote access to the Medical Centre server for access to Medical Director, patient records, practice email, practice instant messaging and many essential texts electronically.

The registrar has full and free access to the hospital's educational resources, including books, journals and online access to clinical databases.

One supervisor is responsible for the orientation of new registrars, ensuring they are aware of all the educational opportunities available to them, taking part in scheduled educational sessions and the RTP's ongoing monitoring requirements and criteria.

Formative assessment is provided to the registrar on a regular basis during the Supervisory and Educational processes. The ACRRM miniCEX process and scoring sheet is used to structure feedback on observed consultations.

## Appendix 5: Teaching Blueprint

| Domain 1 – Core Clinical knowledge and skills for Generalist Practitioners | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 101 | Function as an effective and appropriate clinician across primary, secondary, and tertiary care settings. | ✓ | | | | | | ✓ |
| 102 | Establish a doctor/patient relationship and use a patient centred approach to care | | ✓ | ✓ | | | | ✓ |
| 103 | Obtain a clinical history that reflects the different contextual issues including: presenting problem, epidemiology culture, and geographical location | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| 104 | Perform an accurate physical examination that is relevant to clinical history, risks, and the age, gender and culture of the patient and the local disease epidemiology | ✓ | ✓ | ✓ | | | | ✓ |
| 105 | Apply and describe diagnostic reasoning to arrive at one or more provisional diagnoses including common, and uncommon yet important, conditions | ✓ | ✓ | ✓ | | | | ✓ |

| Domain 1 – Core Clinical knowledge and skills for Generalist Practitioners | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 106 | Formulate and justify a plan of investigation and management related to the differential diagnosis | ✓ | ✓ | ✓ | | | | ✓ |
| 107 | Consider uncommon but clinically important differential diagnosis | ✓ | | ✓ | | | ✓ | |
| 108 | Apply core procedural skills in clinical practice | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| 109 | Use specialised clinical equipment as required for further assessment and to interpret results | ✓ | | ✓ | ✓ | | ✓ | ✓ |
| 110 | Communicate findings of clinical assessment effectively and sensitively to patients, their families and/or carers | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| 111 | Negotiate a management plan with patients, their families and/or carers | ✓ | ✓ | ✓ | ✓ | | | ✓ |

| Domain 1 – Core Clinical knowledge and skills for Generalist Practitioners | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 112 | Revise the management plan and continually review and follow up as new information becomes available | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| 113 | Use evidence based standard treatment protocols and guidelines to inform decision making | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| 114 | Use the principles of universal precautions against infection in practice | ✓ | | ✓ | ✓ | | | ✓ |
| 115 | Facilitate and coordinate access to services according to the individual patient needs | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 116 | Develop and maintain clinical and service provider networks for effective patient care | ✓ | ✓ | | ✓ | | ✓ | ✓ |
| 117 | Demonstrate capacity to apply quality assurance mechanisms and to appropriately use resources | ✓ | | ✓ | ✓ | ✓ | | ✓ |

| Domain 1 – Core Clinical knowledge and skills for Generalist Practitioners | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 118 | Refer clients for specialist care and other services judiciously | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |

| Domain 2 – Extended Clinical Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 201 | Diagnose and manage complex, advanced or uncommon medical conditions across a broad scope of unreferred practice | ✓ | ✓ | ✓ | | ✓ | ✓ | |
| | 201.1 Justify the diagnosis and differential diagnosis by reference to the aetiology, pathogenesis and epidemiology of the condition | ✓ | ✓ | ✓ | | ✓ | ✓ | |
| 202 | Perform extended office and hospital-based diagnostic and procedural skills | ✓ | ✓ | ✓ | | | ✓ | |
| 203 | Provide secondary and tertiary based care as required | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| 204 | Provide direct and distant clinical supervision and support for other rural and remote health care workers | ✓ | ✓ | | | | | |
| 205 | Work as part of a rural or remote multi-disciplinary team that reflects the extended skills of other health professionals in providing effective patient care | ✓ | ✓ | ✓ | ✓ | | | |

| Domain 2 – Extended Clinical Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 206 | Provide team leadership, inter-agency liaison and participation in risk management programs | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| | 206.1 Know their own limitations and when and how to refer | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| | 206.2 Safety and occupational health | ✓ | | ✓ | ✓ | | | |
| 207 | Demonstrate the ability to undertake the relevant forensic responsibilities | ✓ | ✓ | | | ✓ | ✓ | |

| Domain 3 – Emergency Care in Generalist Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 301 | Undertake initial assessment and triage of patients with acute or life threatening conditions | ✓ | ✓ | | ✓ | | ✓ | |
| 302 | Stabilise critically ill patients and provide primary and secondary care | ✓ | ✓ | | ✓ | | ✓ | |
| 303 | Provide definitive emergency resuscitation and management across the lifespan in keeping with clinical need, own capabilities and available services | ✓ | ✓ | | ✓ | | ✓ | |
| 304 | Perform required emergency procedures and courses | ✓ | ✓ | | ✓ | | ✓ | |
| 305 | Arrange and/or perform emergency patient transport or evacuation when needed | ✓ | ✓ | | ✓ | | ✓ | |
| 306 | Demonstrate resourcefulness in knowing how to access and use available resources | ✓ | ✓ | ✓ | ✓ | | ✓ | |

| Domain 3 – Emergency Care in Generalist Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 307 | Communicate effectively at a distance with consulting or receiving clinical personnel | ✓ | ✓ | | ✓ | | ✓ | |
| 308 | Participate in disaster planning and implementation of disaster plans, and post-incident analysis and debriefing | ✓ | ✓ | | ✓ | | ✓ | |
| 309 | Provide inter-professional team leadership in emergency care that includes quality assurance and risk management in the rural and remote setting | ✓ | ✓ | | ✓ | | ✓ | |

| Domain 4 – Population Health in Generalist Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 401 | Analyse the social, environmental, behavioural, economic and occupational determinants of health that affect the community's burden of disease and community access to health-related services | ✓ | ✓ | ✓ | | ✓ | | |
| 402 | Demonstrate an ability to apply a population health approach suitable to community practice profile | ✓ | ✓ | ✓ | | ✓ | | ✓ |
| 403 | Integrate evidence based prevention, early detection and other health maintenance activities into practice at a systems level | ✓ | ✓ | ✓ | | ✓ | | ✓ |
| | 403.1 Undertake, supervise and monitor early detection strategies | ✓ | ✓ | ✓ | | ✓ | | ✓ |
| | 403.2 Use brief interventions in managing chronic disease | ✓ | ✓ | ✓ | | ✓ | | ✓ |
| | 403.3 Competently use clinical information and recall systems, particularly in the organised management and evaluation of chronic disease across the practice population | ✓ | ✓ | ✓ | | ✓ | | ✓ |

| Domain 4 – Population Health in Generalist Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| | 403.4 Provide health education and health promotion strategies in practice | ✓ | ✓ | ✓ | | ✓ | | ✓ |
| | 403.5 Provide continuity and coordination of care for their own practice population | ✓ | ✓ | ✓ | | ✓ | | ✓ |
| 404 | Comply with statutory population health reporting and notification requirements | ✓ | ✓ | ✓ | | ✓ | | ✓ |
| 405 | Evaluate the quality of health care for practice populations | ✓ | ✓ | ✓ | | ✓ | | |
| 406 | Access and collaborate with agencies responsible for key population health functions, including public health services, employer groups and local government | ✓ | ✓ | ✓ | | ✓ | | |
| 407 | Understand the role of a medical advocate in the design, implementation and evaluation of interventions that address the determinants of that population's health | ✓ | ✓ | ✓ | | ✓ | | |

| Domain 5 – Aboriginal and Torres Strait Islander Health in General Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 501 | Demonstrate an understanding of the links between the social, cultural, historical, economic and political framework that influence the health status of Aboriginal and Torres Strait Islander peoples | | ✓ | ✓ | | ✓ | | |
| 502 | Apply to clinical practice knowledge of the differing profile of disease among Aboriginal and Torres Strait Islanders people | ✓ | ✓ | ✓ | | ✓ | | |
| 503 | Demonstrate an understanding of the differing cultural beliefs, values and priorities of Aboriginal and Torres Strait Islander peoples regarding their health and health care provision | ✓ | ✓ | ✓ | | ✓ | | |
| | 503.1 Reflect on own assumptions, cultural beliefs and emotional reactions in providing culturally safe health care for Indigenous Australians | | ✓ | ✓ | | ✓ | | |
| 504 | Communicate effectively and in a culturally safe manner with Aboriginal and Torres Strait Islander people | ✓ | ✓ | ✓ | | ✓ | | |
| | 504.1 Identify key community contacts, mentors and support structures in the provision of effective health care | ✓ | ✓ | ✓ | | ✓ | | |

| Domain 5 – Aboriginal and Torres Strait Islander Health in General Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 505 | Develop capacity building and skills transfer strategies when working with Indigenous health care workers | | ✓ | ✓ | | ✓ | | |
| 506 | Describe the common patterns and prevalence of disease, and use best evidence in the management of chronic diseases experienced by rural and remote Aboriginal and Torres Strait Islander peoples | ✓ | ✓ | ✓ | | ✓ | | |
| 507 | Appreciate the role and effect of comprehensive Aboriginal community-controlled Primary Health Care including self-determination, collaboration, partnership and ownership | | | ✓ | | ✓ | | |
| | 507.1 Use a primary health care approach in rural and remote indigenous health practice | ✓ | ✓ | ✓ | | ✓ | | |
| | 507.2 Discuss the different power based structures and decision making that need to be taken into account when working in a community controlled organisation | | | ✓ | | ✓ | | |
| 508 | Identify overt, covert and structural forms of discrimination in interactions with patients, health professionals and systems; and advocate for their resolution | | ✓ | ✓ | | ✓ | | |

| Domain 5 – Aboriginal and Torres Strait Islander Health in General Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 509 | Work effectively and respectfully as part of a cross cultural team, and use local protocols for referral and involvement of health workers | | ✓ | ✓ | | ✓ | | |
| | 509.1 Describe the role of the Aboriginal and Torres Strait Islander Health Worker | | | ✓ | | ✓ | | |
| 510 | Apply principles of partnership, community ownership, consultation, capacity building, reciprocity and respect to health care delivery, health surveillance and health research | | | ✓ | | ✓ | | |
| 511 | List potential strategies to address social, economic and environmental determinants of disease among Aboriginal peoples and Torres Strait Islanders, and advocate for change | | | ✓ | | ✓ | | |

| Domain 6 – Professional, Ethical and Legal Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 601 | Manage, appraise and assess own performance in the provision of health and medical care for patients | | | | | | | |
| 602 | Engage in continuous learning and professional development in rural and remote practice | | | | | | | |
| 603 | Engage in education of other medical and health professionals | | | | | | | |
| 604 | Provide accurate and ethical certification when required for sickness, employment, social benefits and other purposes | ✓ | | | | | | |
| 605 | Apply knowledge of billing, insurance and health financing systems in clinical practice | ✓ | | ✓ | | | | |
| 606 | Maintain confidentiality in small communities | ✓ | ✓ | | | | | |

| Domain 6 – Professional, Ethical and Legal Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 607 | Maintain professional and social boundaries | ✓ | ✓ | | | | | |
| 608 | Use and undertake relevant research to inform practice | | | ✓ | | | | |
| | 608.1 Demonstrate an ability to think critically and make informed decisions | | | ✓ | | | | |
| 609 | Use communication technology to network and exchange information with distance colleagues, and for continuing education purposes | | | ✓ | | ✓ | | |
| 610 | Contribute to the management of human and financial resources within a health organisation/medical practice | ✓ | | | | ✓ | | |
| 611 | Identify and apply strategies for self-care, personal support mechanisms, debriefing, and caring for their family in the rural and remote context | ✓ | | | | | | |

| Domain 6 – Professional, Ethical and Legal Practice | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 612 | Recognise unprofessional behaviour and signs of the practitioner in difficulty among colleagues, and respond according to ethical guidelines and statutory requirements | ✓ | | | | | | |
| 613 | Be aware of duty of care issues arising from providing health care to self, family, colleagues, patients, and the community | ✓ | | ✓ | | | | |
| 614 | Apply professional, ethical, and legal guidelines to their practice | ✓ | | ✓ | | | | |
| 615 | Implement and adhere to occupational health and safety guidelines in practice | | | | | ✓ | | |

| Domain 7 – Rural and Remote Context | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Learning Outcome** | | **In practice teaching** | **Logbook/ experience with patients** | **workshops** | **Emergency medicine courses** | **RRMEO modules** | **Self directed learning** | **Formative miniCEX** |
| 701 | Apply knowledge of the social, cultural, historical, economic and political issues facing rural and remote communities to their role as a general practitioner | ✓ | ✓ | | | | | |
| 702 | Demonstrate resourcefulness, independence, and self reliance while working effectively in geographic, social and professional isolation | ✓ | ✓ | | | | | |
| | 702.1 Respond to community needs | ✓ | ✓ | | | | | |
| 703 | Identify and reflect upon their own personal strengths, values, attitudes, priorities and vulnerabilities in being able to maintain balance between personal, social and professional responsibilities and in managing isolation | | | | | | | |
| 704 | Respect local community norms and values in own life and work practices | ✓ | ✓ | | | | | |
| 705 | Identify and acquire extended knowledge and skills as may be required in order to better meet the health care needs of the practice population | ✓ | ✓ | | | | ✓ | |

# Appendix 6: ACRRM Formative MiniCEX Examination Scoring Sheet


**ACRRM FORMATIVE MINICEX**
**EXAMINATION SCORING SHEET**

## Registrar's Details

Name of Candidate: _____ Date: _____

Location: _____ Time: _____

Type of Practice: _____

## Assessor's Details

Name of Assessor: _____

Assessor's Position: _____

☐ FACRRM ☐ Rural Doctor/GP ☐ Specialist ☐ Educator

☐ Other (Please Specify): _____

## Assessment of Registrar's Competence

**Communication Skills**

| Not Observed | Unsatisfactory | Borderline | Satisfactory | Excellent |
|---|---|---|---|---|
| | | | | |

Characteristics of a 'satisfactory' candidate in this area may include: the candidate explores the patient's problem using plain English, is open, honest and empathetic, negotiates a suitable management plan/therapy with the patient, shows respect, compassion, empathy, establishes trust, attends to the patient's needs of comfort, shows awareness of relevant legal frameworks and is aware of their own limitations. Where relevant, the candidate demonstrates an understanding of the differing cultural beliefs, values, and priorities of Aboriginal and Torres Strait Islander people as well as other cultural groupings regarding their health and health care provision and the candidate communicates effectively respecting these cultural differences.

Comments:

**History Taking**

| Not Observed | Unsatisfactory | Borderline | Satisfactory | Excellent |
|---|---|---|---|---|
| | | | | |

Characteristics of a 'satisfactory' candidate in this area may include: the candidate effectively uses appropriate questions to obtain an accurate, adequate history with necessary information and responds appropriately to verbal and non-verbal cues.

***Comments:***

**Physical Examination**

| Not Observed | Unsatisfactory | Borderline | Satisfactory | Excellent |
|---|---|---|---|---|
| | | | | |

Characteristics of a 'satisfactory' candidate in this area may include: the candidate follows an efficient and logical sequence, performs an appropriate clinical examination, explains the process to the patient and is sensitive to the patient's comfort and modesty.

***Comments:***

**Clinical Judgement**

| Not Observed | Unsatisfactory | Borderline | Satisfactory | Excellent |
|---|---|---|---|---|
| | | | | |

Characteristics of a 'satisfactory' candidate in this area may include: the candidate makes an appropriate diagnosis, formulates a suitable management plan, selectively orders or performs appropriate diagnostic studies and considers the risks and benefits to the patient.

***Comments:***

**Organisational/ Efficiency**

| Not Observed | Unsatisfactory | Borderline | Satisfactory | Excellent |
|---|---|---|---|---|
| | | | | |

Characteristics of a 'satisfactory' candidate in this area may include: the candidate knows where to access resources, is resourceful in their use, is well organised, able to prioritise, works respectfully as part of a multi-disciplinary team that reflects the extended knowledge and skills of other health professions and provides timely, succinct advice to patients.

***Comments:***

**Overall Clinical Competence**

| Not Observed | Unsatisfactory | Borderline | Satisfactory | Excellent |
|---|---|---|---|---|
| | | | | |

***Comments:***

## Clinical Problem Category (tick those that apply for this MiniCEX)

| | Curriculum Areas Covered | | Case Summary |
|---|---|---|---|
| | 1. Aboriginal & Torres Strait Islander Health | **Patient Presentation** | |
| | 2. Adult Internal Medicine | | Chronic |
| | 3. Aged Care | | Acute |
| | 4. Anaesthetics | | Emergency |
| | 5. Child and Adolescent Health | | Population/Preventive Health |
| | 6. Dermatology | | Other *(please specify)* |
| | 7. Emergency Medicine | **Patient Age:** | |
| | 8. IM / IT | **Gender:** | |
| | 9. Management | **Complexity of Case** | |
| | 10. Musculoskeletal Health | | Low |
| | 11. Obstetrics/Women's Health | | Medium |
| | 12. Ophthalmology | | High |
| | 13. Oral Health | **Type of Case** | |
| | 14. Palliative Medicine | | New |
| | 15. Population Health | | Follow Up |
| | 16. Principles of Rural/Remote General Practice | **Case Focus** | |
| | 17. Psychiatry/Mental Health | | Communication Skills |
| | 18. Radiology | | History Taking |
| | 19. Rehabilitation | | Physical Examination |
| | 20. Research & EBM | | Clinical Judgment |
| | 21. Strategic Skills in Rural Medical Practice | | Organisation / Efficiency |
| | 22. Surgery | | |

## Clinical Setting (tick those that apply for this MiniCEX)

| Practice | | Hospital | |
|---|---|---|---|
| | Urban | | Urban |
| | Rural | | Rural |
| | Remote | | Remote |
| | Other (please specify) | | Other (please specify) |
| RFDS | | Other (please specify) | |
| | Yes | | |
| | No | | |

## Case Summary (tick if any of the following apply for this MiniCEX)

| | | | |
|---|---|---|---|
| | Patient Age: Infant 0 – 2 years | | Indigenous Patient |
| | Patient Age: Under 16 years | | Chronic Care |
| | Patient Age: Over 65 years | | Condition requiring management at an extended level in a rural or remote context |

## Provide a Brief Description of Case:

## Assessor's Comments

## Registrar's Comments

Assessor's Signature: _____ Date: _____

Registrar's Signature: _____ Date: _____

# Appendix 7: ACRRM Formative MiniCEX Patient Consent Form


**ACRRM FORMATIVE MINICEX**
**PATIENT CONSENT FORM**

**Consulting Doctor:**
**Observing Doctor:**

Dear Patient,

Today I will be participating in an educational assessment known as the Mini Clinical Evaluation Exercise (MiniCEX) assessment, which is conducted by the Australian College of Rural and Remote Medicine. The observing doctor in today's consultation will provide information that will help me, your doctor move forward in attaining higher medical qualifications and is an important part of my ongoing education and training. Your participation as a patient will greatly assist in this process by providing an opportunity for me to demonstrate my medical skills.

The consultation will be unchanged except that a senior doctor will be sitting in with us in the same room and observing this consultation. The observing doctor will not contribute to the consultation. Although the observing doctor may make notes during the consultation, these notes will not include any identifying features so that you will remain an anonymous participant.

If you have any further questions about this process you are welcome to discuss them with me or if you wish with the manager of this program, Lynn Saul, Training & Assessment Manager of the Australian College of Rural and Remote Medicine (contact details at the bottom of this form).

If you decide to participate, you are welcome to withdraw your consent at any time and ask the observing doctor to leave the room. Any decision you make about whether to participate or not will have absolutely no bearing on your medical care by me or anyone else.

Thank you for considering participating in this important event.

Yours faithfully

Dr

## Patient Consent

I agree to participate and understand the issues that have been raised in this document. I understand that I can ask the observing doctor to leave at any time and any decision I make regarding this will have absolutely no bearing on my current or future health care.

Name (please print): _____

Signature: _____ Date: _____

Two copies are required. One copy is for the patient, the second copy is to be retained on file

Australian College of Rural and Remote Medicine
GPO Box 2507
Brisbane
QLD 4001

Tel: 07 3105 8200
Fax: 07 3105 8299
Email: assessment@acrrm.org.au
Website: www.acrrm.org.au

## Appendix 8: Glossary of Terms

| | |
|---|---|
| ACD | Australasian College of Dermatology |
| ACEM | Australasian College of Emergency Medicine |
| AMAC | Australian Medical Acupuncture College |
| ACRRM | Australian College of Rural and Remote Medicine |
| AGPT | Australian General Practice Training |
| AHPRA | Australian Health Practitioner Regulation Agency |
| AHS | Aboriginal Health Services |
| ALS | Advanced Life Support |
| AMC | Australian Medical Council |
| AMSA | Australian Medical Students Association |
| AMS | Aboriginal Medical Services |
| ASGC-RA | Australian Standard Geographical Classification – Remoteness Areas |
| AST | Advanced Specialised Training |
| CCDOG | Conjoint Committee for the Diploma of Obstetrics and Gynaecology |
| CCT | Core Clinical Training |
| CFEP | Client Focused Evaluation Program |
| CPC | College of Physicians Canada |
| CPD | Continuing Professional Development |
| CPMC | Council of Presidents of Medical Colleges |
| COT | Completion of Training |
| DRHMNZ | Division of Rural Hospital Medicine New Zealand |
| DRANZCOG | Advanced Diploma of Royal Australian and New Zealand College of Obstetricians and Gynaecologists |
| DOHA | Department of Health and Ageing |
| ECTV | External Clinical Teaching Visit |
| FACRRM | Fellowship of Australian College of Rural and Remote Medicine |
| FARGP | Fellowship Australian Rural General Practice |
| GEM | Generalist Emergency Medicine |
| GP | General Practitioner |
| GPET | General Practice Education and Training |
| GPRA | General Practice Registrars Association |
| GPMHSC | General Practice Mental Health Standards Collaboration |
| IMG | International Medical Graduate |
| IP | Independent Pathway |
| JCC | Joint Consultative Committee |
| JCU | James Cook University |
| JFPP | John Flynn Placement Program |
| MCQ | Multiple Choice Question |
| MiniCEX | Mini Clinical Evaluation Exercise |
| MSOAP | Medical Specialist Outreach Assistance Program |
| MOPS | Maintenance of Professional Standards |
| MSF | Multi Source Feedback |
| NRHSN | National Rural Health Students Network |
| OSCE | Observed Structured Clinical Examination |
| OTGP | Overseas Trained General Practitioner |
| PDP | Professional Development Program |
| PESCI | Pre-Employment Structured Clinical Interview |
| PGMEC | Post Graduate Medical Education Committee |
| PGPPP | Prevocational General Practice Placements Program |
| PGY | Post Graduate Year |
| PMC | Procedural Medicine Collaboration |
| PRRT | Primary Rural and Remote Training |

| | |
|---|---|
| PVT | Prevocational Training Programs |
| RACGP | Royal Australian College of General Practitioners |
| RACP | Royal Australasian College of Physicians |
| RACS | Royal Australasian College of Surgeons |
| RANZCP | Royal Australian and New Zealand College of Psychiatrists |
| RANZCOG | Royal Australian and New Zealand College of Obstetricians and Gynaecologists |
| REST | Rural Emergency Skills Training |
| RDAA | Rural Doctors Association of Australia |
| RGP | Rural Generalist Program |
| RNZCGP | Royal New Zealand College of General Practitioners |
| RRMA | Rural, Remote, Metropolitan Areas |
| RPL | Recognition of Prior Learning |
| RRMEO | Rural and Remote Medical Education Online |
| RLO | Registrar Liaison Officers |
| RTP | Regional Training Provider |
| RVTS | Remote Vocational Training Scheme |
| RWAV | Rural Workforce Agency Victoria |
| StAMPS | Structured Assessment using Multiple Patient Scenarios |
| VPP | Vocational Preparation Pathway |
| VR | Vocational Recognition |
| WAVE | Western Australia Vocational Education |

# Guide for supervisors

Australian General Practice Training Program

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