Guide for Supervisors

Primary Rural and Remote Training

FELLOWSHIP

Australian College of
Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

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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.

ACRRM definition of General Practice

ACRRM has a broader definition of general practice that reflects the needs of rural and remote communities in Australia.

The general practitioner is the doctor with core responsibility for providing comprehensive and continuing medical care to individuals, families and the broader community. Competent to provide the greater part of medical care, the general practitioner can deliver services in the ambulatory care setting, the home, hospital, long-term residential care facilities or by electronic means - wherever and however services are needed by the patient.

The general practitioner applies broad knowledge and skills in: managing undifferentiated health problems across the lifespan in an un-referred patient population; providing continuing care for individuals with chronic conditions; undertaking preventive activities such as screening, immunisation and health education; responding to emergencies; providing in-hospital care; delivering maternal and child health services; and applying a population health approach at the practice and community level. General practitioners work across a dynamic and changing primary and secondary care interface, typically developing extended competencies in one or more discrete fields of medicine, thereby ensuring community access to the range of needed services in a supportive network of colleagues and health care providers.

As the medical expert with the broadest understanding of a patient's health in their cultural, social and family context, the general practitioner has a key role in coordinating the care pathway in partnership with the patient, including making decisions on the involvement of other health personnel. He or she practices reflectively, accessing and judiciously applying best evidence to ensure that the patient obtains benefit while minimising risk, intrusion and expense. The general practitioner contributes clinical leadership within a health care team and is skilled in providing clinical supervision, teaching and mentorship.

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:

- Current full and unrestricted registration with the National Medical Board of Australia;
- Fellowship of ACRRM or has experience and qualifications which are assessed by ACRRM to be equivalent (see appendix 1);
- Not less than five years full-time equivalent experience in rural and remote medicine or other rural specialist practice (including training time);
- 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
- 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 https://www.acrrm.org.au/teaching-posts)

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.gpet.com.au/GP-supervisors/GPET-Supervisor-Resources

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 Terms and Conditions for the Employment of GP Registrars) 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 Department of Health 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 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. https://www.acrrm.org.au/pdp

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.

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 2 and 3.

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 eleven 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. The Department of Health 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 abilities 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 18 discipline specific curriculum statements that make up the discipline of rural and remote medical practice. Each curriculum statement defines specific learning abilities, knowledge and skills, expressing what rural doctors need to be able to do in that discipline.

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 11 disciplines; Anaesthetics, Academic Practice, 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.

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 (30 questionnaires required), and an online self-assessment. MSF participants receive a detailed 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 can enrol in the summative MSF after completing 12 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 and to enrol in MSF, 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 required to complete a minimum of six formative miniCEXs during 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 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 sample MCQ examination questions are available on the ACRRM website by visiting http://www.acrrm.org.au/assessment. Once enrolled, the registrar will also be provided to access to a 50 question online MCQ familiarisation activity.

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 or face to face and consists of eight scenarios, each of 10 minutes duration. Registrars remain in one place at their videoconference facility or exam centre 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.

Mock exams and study groups are offered by ACRRM. Information may be found on the assessment webpage. Practice StAMPS scenarios are available on the ACRRM website by visiting https://www.acrrm.org.au/assessment

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 **1946-1962**	**Generation X** **1963-1981**	**Generation Y** **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 experts	Pragmatic 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 4 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: 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 3: 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 4: Teaching Blueprint

DOMAIN 1 - Provide medical care in the ambulatory and community setting									
Abilities		**In practice**	**Logbook**	**Virtual classrooms**	**Workshop/s**	**EM courses**	**RRMEO modules**	**Self-directed learning**	**Formative mini-CEX**
1.1	Establish a doctor-patient relationship and use a patient-centred approach to care.	X			X	X		X	X
1.2	Obtain a clinical history that reflects contextual issues including: presenting problems, epidemiology, culture and geographic location.	X	X		X	X		X	X
1.3	Perform a problem-focussed physical examination relevant to clinical history and risks, epidemiology and cultural context.	X	X		X	X		X	X
1.4	Use specialised clinical equipment as required for further assessment and interpret findings.	X	X		X	X	?	X	
1.5	Order and/or perform diagnostic tests where required to confirm a diagnosis, monitor medical care and/or exclude treatable or serious conditions.	X	X		X	X	?	X	X
1.6	Apply diagnostic reasoning to arrive at one or more provisional diagnoses, considering uncommon but clinically important differential diagnoses.	X	X	X	X	X	X	X	X
1.7	Communicate findings of clinical assessment effectively and sensitively to the patient and/or carer.	X			X	X		X	X
1.8	Formulate a management plan in concert with the patient and/or carer, judiciously applying best evidence and the advice of expert colleagues.	X	X	X	X		X	X	X

1.9	Manage uncertainty and the need to evaluate the risks versus the benefits of clinical decisions.	X		X	X	X	X	X	X
1.10	Refer, facilitate and coordinate access to specialised medical and diagnostic and other health and social support services.	X			X			X	X
1.11	Provide and/or arrange follow-up and continuing medical care	X			X			X	X

DOMAIN 2 – Provide medical care in the hospital setting									
Abilities		**In practice**	**Logbook**	**Virtual classrooms**	**Workshop/s**	**EM courses**	**RRMEO modules**	**Self-directed learning**	**Formative mini-CEX**
2.1	Manage admission of patients to hospital in accordance with institutional policies.	X	X					X	X
2.2	Develop, implement and maintain a management plan for hospitalised patients in concert with the patient and/or carer.	X						X	X
2.3	Apply relevant checklists and clinical management pathways.	X	X	X	X	X	X	X	X
2.4	Monitor clinical progress, regularly re-evaluate the problem list and modify management accordingly.	X			X	X		X	X
2.5	Maintain a clinically relevant plan of fluid, electrolyte and blood product use with relevant pathology testing.	X				X		X	X
2.6	Order and perform a range of diagnostic and therapeutic procedures.	X		X	X	X		X	X
2.7	Maintain timely and accurate patient documentation in hospital records including drug prescription and administration.	X						X	X
2.8	Communicate effectively with the health care team, patient and/or carer including effective clinical handover.	X			X	X		X	X
2.9	Recognise and respond early to the deteriorating patient.	X				X		X	X
2.10	Anticipate and judiciously arrange safe patient transfer to other facilities, considering clinical indications, service capabilities, patient preferences, transportation and geography.	X		X	X	X	X	X	X
2.11	Undertake early, planned and multi-disciplinary discharge planning.	X						X	X

2.12	Contribute medical expertise and leadership in a hospital team.	X			X	X	X	X	X
2.13	Provide direct and remote clinical supervision and support to nurses, junior medical staff and students.	X			X			X	X
2.14	Recognise, document and manage adverse events and near misses.	X	X					X	
2.15	Participate in institutional quality and safety improvement and risk-management activities.	X						X	

DOMAIN 3 – Respond to medical emergencies									
Abilities		**In practice**	**Logbook**	**Virtual classrooms**	**Workshop/s**	**EM courses**	**RRMEO modules**	**Self-directed learning**	**Formative mini-CEX**
3.1	Undertake initial assessment and triage of patients with acute or life threatening conditions.	X				X	X	X	X
3.2	Stabilise critically-ill patients and provide primary and secondary care.	X	X			X	X	X	X
3.3	Provide definitive emergency resuscitation and management across the lifespan in keeping with clinical need, own capabilities and available resources.	X	X			X	X	X	X
3.4	Perform required emergency procedures.	X	X			X	X	X	X
3.5	Arrange and/or perform emergency patient transport or evacuation when needed.	X	X			X	X	X	X
3.6	Demonstrate resourcefulness in knowing how to access and use available resources.	X	X	X	X	X	X	X	X
3.7	Communicate effectively at a distance with consulting or receiving clinical personnel.	X			X	X	X	X	X
3.8	Participate in disaster planning and implementation of disaster plans, and post-incident analysis and debriefing.	X						X	
3.9	Provide inter-professional team leadership in emergency care that includes quality assurance and risk management assessment.	X				X		X	

DOMAIN 4 – Apply a population health approach									
Abilities		**In practice**	**Logbook**	**Virtual classrooms**	**Workshop/s**	**EM courses**	**RRMEO modules**	**Self-directed learning**	**Formative mini-CEX**
4.1	Analyse the social, environmental, economic and occupational determinants of health that affect the community burden of disease and access to health-related services.	X		X	X		X	X	X
4.2	Apply a population health approach that is relevant to the clinical practice profile.	X		X	X		X	X	X
4.3	Integrate evidence-based prevention, early detection and health maintenance activities into practice at a systems level.	X		X	X		X	X	X
4.4	Provide continuity and coordination of care for own practice population.	X			X			X	X
4.5	Evaluate quality of health care for practice populations.	X		X	X			X	
4.6	Fulfil reporting requirements in relation to statutory notification of health conditions.	X		X	X			X	X
4.7	Access and collaborate with agencies responsible for key population health functions including public health services, employer groups and local government.	X			X			X	
4.8	Participate as a medical advocate in the design, implementation and evaluation of interventions that address determinants of population health.	X						X	AST project if relevant

DOMAIN 5 – Address the health care needs of culturally diverse and disadvantaged groups									
Abilities		**In practice**	**Logbook**	**Virtual classrooms**	**Workshop/s**	**EM courses**	**RRMEO modules**	**Self-directed learning**	**Formative mini-CEX**
5.1	Apply knowledge of the differing profile of disease and health risks among culturally diverse and disadvantaged groups.	X		X	X		X	X	X
5.2	Communicate effectively and in a culturally safe manner, using interpreters, key community contacts and networks as appropriate.	X		X	X			X	X
5.3	Reflect on own assumptions, cultural beliefs and emotional reactions in providing culturally safe care.	X		X	X		X	X	
5.4	Apply principles of partnership, community ownership, consultation, capacity building, reciprocity and respect to health care delivery, health surveillance and research.	X						X	
5.5	Harness the resources available in the health care team, the local community and family to improve outcomes of care.	X		X	X			X	
5.6	Work with culturally diverse and disadvantaged groups to address barriers in access to health services and the determinants of health.	X						X	

DOMAIN 6 – Practise medicine within an ethical, intellectual and professional framework									
Abilities		**In practice**	**Logbook**	**Virtual classrooms**	**Workshop/s**	**EM courses**	**RRMEO modules**	**Self-directed learning**	**Formative mini-CEX**
6.1	Establish a doctor-patient relationship and use a patient-centred approach to care.	X		X	X			X	X
6.2	Maintain appropriate professional boundaries.	X		X	X			X	X
6.3	Be aware of duty of care issues arising from providing health care to self, family, colleagues, patients and the community.	X		X	X			X	
6.4	Recognise unprofessional behaviour and signs of the practitioner in difficulty among colleagues and respond according to ethical guidelines and statutory requirements.	X		X	X			X	
6.5	Keep clinical documentation in accordance with legal and professional standards.	X		X				X	X
6.6	Demonstrate commitment to teamwork, collaboration, coordination and continuity of care.	X			X			X	
6.7	Contribute to the management of human and financial resources within a health service.	X						X	
6.8	Work within relevant national and state legislation and professional and ethical guidelines.	X		X	X	X	X	X	X
6.9	Provide accurate and ethical certification when required for sickness, employment, social benefits and other purposes.	X		X	X			X	X
6.10	Manage, appraise and assess own performance in the provision of medical care for patients.	X		?				X	

6.11	Develop and apply strategies for self-care, personal support and caring for family.	X			X			X	
6.12	Teach and clinically supervise health students, juniors and other health professionals.	X						X	
6.13	Engage in continuous learning and professional development.	X	X	X	X	X	X	X	
6.14	Use and undertake relevant research to inform practice.	X		X			X	X	

DOMAIN 7 – Practice medicine in the rural and remote context									
Abilities		**In practice**	**Logbook**	**Virtual classrooms**	**Workshop/s**	**EM courses**	**RRMEO modules**	**Self-directed learning**	**Formative mini-CEX**
7.1	Demonstrate resourcefulness, independence and self-reliance while working effectively in geographic, social and professional isolation.	X	X	X	X	X	X	X	X
7.2	Provide effective clinical care when away from ready access to specialist medical, diagnostic and allied health services.	X	X	X	X	X	X	X	X
7.3	Arrange referral to distant services in concert with the patient and/or carer considering the balance of potential benefits, harms and costs.	X			X	X	X	X	X
7.4	Provide direct and distant clinical supervision and support for other rural and remote health care personnel.	X						X	
7.5	Use information and communication technology to provide medical care or facilitate access to specialised care for patients.	X		X	X		X	X	X
7.6	Use information and communication technology to network and exchange information with distant colleagues.	X		X	X		X	X	
7.7	Respect local community norms and values in own life and work practices.	X			X			X	
7.8	Identify and acquire extended knowledge and skills as may be required to meet health care needs of the local population.	X		X	X	X	X	X	

Appendix 5: 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	Department of Health
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