The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

The Division of Rural Hospital Medicine

Effective 1 December 2019

Fellowship Pathway Regulations

Contents

Fellowship Pathway Regulations

The Division of Rural Hospital Medicine (the 'Division') is established as a Chapter under the Royal New Zealand College of General Practitioners (the 'College', Rules 2017, Clause 20.4), and Fellowship of the Division is granted in terms of the criteria specified in clause 10.3 of the College Rules (2017).

The Division's objectives are to:

- Promote excellence in rural hospital medical care
- Train rural hospital doctors to a high standard, with an appropriate range of generalist skills and special interests.
- Promote rural hospital medicine as a vocation
- Advocate for rural health and education
- Promote rural health research
- Promote and develop professional relationships
- Provide ongoing professional support
- Acknowledge Māori rural communities as important part of the rural health and strive for equality in access and health outcomes for rural Māori.

The Division's Council, through the Board of Studies, monitors standards for the award of the RHM qualification. The Division's training programme is accredited through the Medical Council of New Zealand (MCNZ).

1. The discipline and specialty of Rural Hospital Medicine

1.1. The scope of Rural Hospital Medicine

The vocational scope of rural hospital medicine (RHM) is determined by its social context, the rural environment. The demands of this environment include professional isolation, geographic isolation, limited resources and special cultural and sociological factors. The single factor that most determines this scope of practice, its depth and its nature, is that it is practiced at a distance from comprehensive specialist medical and surgical services and investigations. A broad body of knowledge, skills and attitudes, not common to any other medical vocational group, is required to deliver optimum secondary care patient outcomes in rural hospitals. Working in a rural area demands high levels of individual responsibility and clinical judgement.

In contrast to rural general practice, the other rural medical scope of practice, rural hospital medicine is oriented to secondary care, is responsive rather than anticipatory and does not continue over time.

1.2. The definition of Rural Hospital Medicine

Rural hospital medicine is defined by its breadth. It involves the set of skills needed to deal, at least initially, with any presenting medical problem. It is defined by an inability, as a consequence of distance, to confine a doctor's scope of practice to a particular range of illnesses or acuity of presentation (as is done by practitioners in most other branches of medicine).

It requires skills in the diagnosis and treatment of clinical presentations that would, in an urban hospital, fall within the scope of practice of many different specialties. This list includes: Emergency Medicine / General Medicine / General Surgery / Orthopaedics / Geriatrics / Rehabilitation Medicine / Paediatrics / Palliative Care/ Gynaecology and Obstetrics / Psychiatry / Radiology / Anaesthetics / Medical Administration and Leadership.

It includes intermediate care, such as the inpatient period of rehabilitation following surgery, injury or a major medical illness and elective inpatient assessment.

Shared care arrangements with urban-based specialists are frequently needed to safely manage patients over such a broad scope of practice. This requires the rural hospital generalist to be particularly skilled at communicating with distant specialists and in the use of tele-medicine and tele-radiology.

The scope includes a wide range of procedural skills at the secondary care level including hospital level resuscitation skills.

The scope includes skills in managing complex cases with limited resources. This includes limited investigations (imaging and laboratory) and personnel (access to onsite specialists, specialised nursing and allied health professionals). There is a high reliance on basic clinical skills and judgement.

Limited local resources and distances to base hospitals mean patients frequently face an inevitable delay to definitive care. Rural hospital generalists need particular skills at recognising serious illness at an early enough stage to ensure that patients can be safely and appropriately transferred to an appropriate place of definitive care. Rural hospital generalists frequently need to be able to predict any significant clinical deterioration before it occurs. This requires a high level of understanding of the likely course of major medical problems and high levels of clinical judgement especially where a single practitioner is providing care.

The scope includes particular skills in assessing the appropriateness of referral or continued patient management within the skill and resource constraints of the rural hospital environment. This includes balancing the potential clinical benefits of referral to a base hospital against the risks of transfer and removing the patient from their own community. It includes effectively communicating this to the patient in order to allow them to make informed choices.

The scope includes particular skills in deciding on the appropriate means of inter-hospital transfer, making transfer arrangements and preparing patients for transfer. This involves a thorough understanding of the risks of transfer, the potential treatment needs of the patient during the period of transfer and the limitations of treatment during transfer.

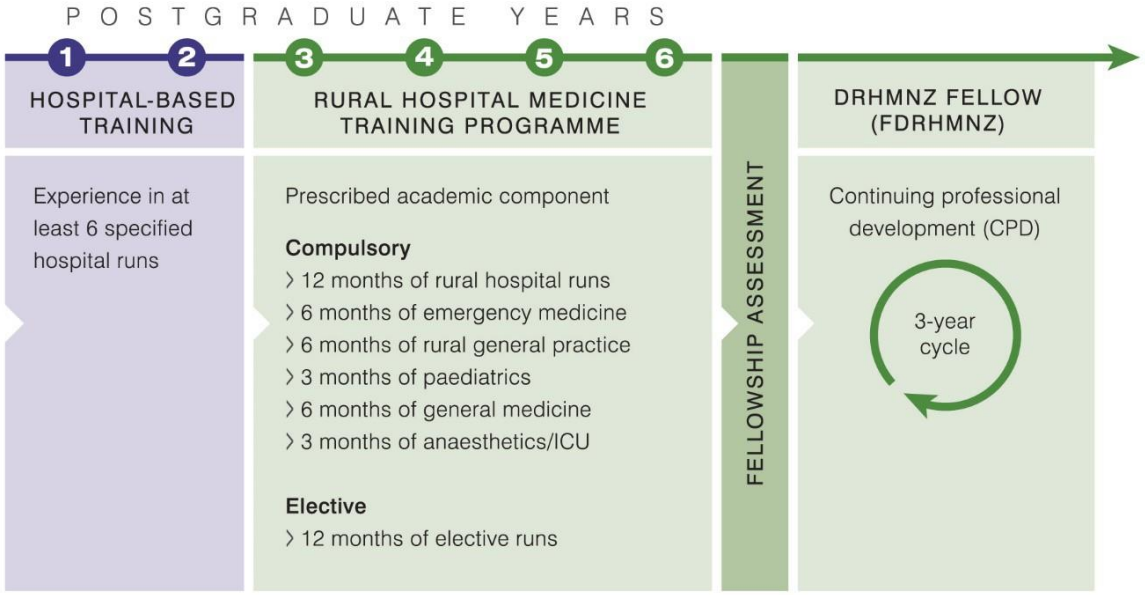
Many rural hospital generalists have a set of specialist skills. These specialist skills include surgery, anaesthetics, emergency medicine, palliative care, various areas within internal medicine and others. These skills may be procedural or knowledge-based and frequently compliment others within the rural hospital medical team, considerably increasing the range and quality of services the team as a whole can provide. This is achieved by directly providing patient care or by acting as a resource for other members of the team. Because these skills are in addition to the core generalist skills, the doctor is still able to contribute fully to the generalist medical cover of the hospital.

Like other modern branches of medicine, rural hospital medicine is dependent on effective teamwork. This includes not only general practitioners and specialist colleagues, but nursing, ambulance, occupational therapists, physiotherapists, social workers, Māori health workers, and others.

2. Fellowship of the Division of Rural Hospital Medicine New Zealand

2.1. Pathways to Fellowship

The standard pathway to Fellowship of the Division is to complete a four-year full-time equivalent (FTE) training programme, with a Fellowship Assessment at the end of the programme. This is shown in the diagram below:



The Division also has a Prior Specialist Training Pathway to Fellowship for doctors who have completed recognised rural hospital medicine training programmes in other countries. The requirements for this pathway are outlined in section 6 below.

2.2. Criteria for the award of Fellowship

To be awarded Fellowship of the Division (FDRHM) through the Rural Hospital Medicine Training programme (RHM) Registrars must:

(a) Complete programme clinical experience requirements – refer to section 3.3

(b) Complete programme academic component requirements – refer to section 3.4

(c) Complete programme learning activities – refer to section 3.5

(d) Fulfil programme resuscitation skills course requirements – refer to section 3.6

(e) Fulfil programme assessment requirements – refer to section 3.8. This includes the final rotational supervisor report which may be provided after the Fellowship Assessment visit has occurred

(f) A pass in the Fellowship Assessment visit – refer to section 4

(g) Hold a Certificate of Professional Status (COPS) from the Medical Council of New Zealand (MCNZ)

(h) Be in good financial standing with the College.

Decisions regarding the award of Fellowship are taken by the Board of Studies or approved delegate. Unsuccessful candidates may be required to undertake further activities before reconsideration.

3. Rural Hospital Medicine training programme Regulations

3.1. General requirements

These regulations apply to all registrars beginning the RHM training programme on 1 December 2019 or after. Programme regulations for individual registrars are governed by the rules in place at the time of first registration into RHM, unless

- There has been a break in active participation in the programme for a period of a year (cumulative) or longer (this includes registrars 'on hold' from the programme); and/or
- The registrar has failed to complete the programme in the maximum time permitted.

(Registrars who started the training programme prior to December 2015 are governed by the Regulations outlined in the Training Programme Handbook at the time of their registration with the programme.)

In either case, if the registrar is re-admitted or permitted to continue in the programme, the registrar may be required to transfer to the Programme Regulations in place at the time of recommencing their training or to undertake an alternate programme in discussion with the Division.

The maximum period that a registrar can remain on the programme, except with the permission of the Board of Studies or approved delegate, is eight years.

Outcomes of all decision processes may be appealed using the mechanisms outlined in the Division's Reconsideration and Appeal Policy. Candidates progressing through the Fellowship pathway and who wish to appeal assessment decisions should contact the Division regarding the appropriate processes. All appeals are decided on an individual basis and do not set precedents for future appeals.

3.2. Admission to the programme

The minimum requirements for admission to the programme are:

- Citizenship or permanent residency status in New Zealand
- Registration with the MCNZ which allows work in rural hospital medicine and general practice in the general scope of practice
- Two years full-time equivalent (FTE) appropriate medical experience after having gained a primary medical qualification. This must include experience in at least six of the following: Cardiology / Dermatology / Ear, nose, throat / Emergency medicine / General medicine / General practice / General surgery / Geriatrics / Musculoskeletal / Obstetrics and Gynaecology / Ophthalmology / Orthopaedics / Paediatrics / Palliative care / Psychiatry / Rehabilitation / Respiratory Medicine / Rheumatology / Rural hospital / Rural general practice. Except with the permission of the Board of Studies or approved delegate, it is normally expected that a year of this time be undertaken in New Zealand.
- At least one year of experience, after the primary medical degree, obtained in the New Zealand context (except with the permission of the Board of Studies or approved delegate).
- At the time of entry to the programme, a Certificate of Professional Status (COPS) from the MCNZ which is dated not more than three months prior to the programme entry date, and which indicates that the doctor is in good professional standing. Good professional standing must be maintained for the duration of the training programme, and the registrar must notify the Division immediately if there is any change to this status.

Entry to the programme is via a competitive selection process and is not guaranteed. The admission requirements and process are set out in the Division's Admission Policy.

3.3. Clinical experience requirements

(a) The full-time rural hospital medicine training programme consists of a total of 48 months FTE clinical experience. This is comprised of six compulsory runs (36 months FTE), and 12 months FTE of elective runs.

(b) Except where otherwise defined, FTE is defined as an eight tenths or more clinical workload (approximately 32 hours or more a week) in an approved clinical position.

(c) Leave taken may contribute to FTE time to a maximum of 15 leave days per six months.

(d) Whilst on the programme, registrars must be in clinical practice for a minimum of at least four-tenths FTE a week. This is referred to as the minimum clinical time requirement of the programme. This applies to all registrars, including in cases where the specific clinical experience requirements have been completed.

(e) Registrars who are working less than the minimum FTE clinical time required (see section 3.3d) will be registered in the programme as 'on hold'. If the registrar is the holder of a current practising certificate, they will be required to comply with MCNZ requirements for recertification (as outlined in section 3.7) during their 'on hold' period.

(f) The maximum time allowed 'on hold' is three years cumulative total. If the registrar is 'on hold' for a period of longer than a year (cumulative), on return to the programme they may be required to transfer to new programme rules or to undertake an alternate programme in discussion with the College.

(g) All clinical experience during the training programme is expected to be undertaken in New Zealand. Prior approval may be given by the Board of Studies or approved delegate for up to 12 months' relevant and appropriate overseas clinical attachment.

(h) Clinical experience undertaken after entry into the training programme will only be recognised if undertaken whilst actively participating in the training programme.

(i) Runs must be undertaken in Division-accredited or -recognised placements.

(j) All registrars must be in a collegial relationship during their clinical runs with a specialist who is registered in the vocational scope in which they are working.

The minimum compulsory and elective runs for the programme are detailed in the table below.[1]

Compulsory runs	**Elective runs**
All of the following must be completed: • **Two runs** (twelve months FTE) in **rural hospital medicine** undertaken at different sites. At least one of the rural hospital runs must be in a Level three rural hospital.[2] • **One run** (six months FTE) in **general medicine** (three months may be cardiology or respiratory medicine) • **One run** (six months FTE) **in rural general practice**[3] • **One run** (six months FTE) in **emergency medicine**[4] • **0.5 run** (three months FTE) **paediatrics** • **0.5 run** (three months FTE) **anaesthetics / intensive care**	An additional **two runs** (12 months FTE) of elective time must be completed. This may include: • Further experience in any of the compulsory runs above • Urban General Practice • Surgery • Palliative care • Rehabilitation medicine • Geriatrics • Māori Health Provider • Obstetrics and/or gynaecology • Orthopaedics. Prior approval of the DRHM Board of Studies or approved delegate is required for any other attachment.

3.4. Academic component requirements

Registrars on the training programme are required to complete the academic papers listed in the table below:

1	**GENA 724 The Context of Rural Hospital Medicine** PGDipRPHP University of Otago Examines the context of clinical care in rural hospitals in relation to the person and profession of the doctor, the hospital and the community.
2	**GENA 725 Communication in Rural Hospital Medicine** PGDipRPHP University of Otago Clinical skills, knowledge and values required in the rural hospital setting for psychiatry, palliative care, rehabilitation medicine and communication with patients including Maori patients.

[1] Registrars may gain more clinical experience than the minimum required.

[2] If possible, one of the rural hospital medicine runs should be done early on in the programme, and the other at the end of the programme. The second rural hospital run is used for the Fellowship assessment visit. A description of hospital levels can be found in the Division Training Handbook.

[3] The recognition of a placement as being rural is at the discretion of the Board of Studies or approved delegate.

[4] This must be a registrar position which reports directly to a consultant.

3	**GENA 726 Obstetrics and Paediatrics in Rural Hospitals** PGDipRPHP University of Otago Covers the management of paediatrics, neonatal care, and obstetric and gynaecological emergencies in a rural hospital setting.
4	**GENA 727 Surgical Specialties in Rural Hospitals** PGDipRPHP University of Otago Covers the management of common surgical problems appropriate to be managed in a rural hospital setting. Includes general surgery, urology, vascular surgery, ophthalmology and ENT. OR **POPLPRAC 740* Urgent Primary Surgical Care** Auckland University.
5	**GENA 728 Cardiorespiratory Medicine in Rural Hospitals** PGDipRPHP University of Otago Covers the management of cardiology and respiratory problems in a rural hospital setting. Includes acute coronary syndromes, arrhythmias, valvular heart problems, airways obstruction and respiratory infections.
6	**GENA 729 Medical Specialties in Rural Hospitals** PGDipRPHP University of Otago Covers the management of acute and chronic common medical problems in a rural hospital setting. Includes gastroenterology, endocrinology, neurology, oncology, rheumatology and infectious diseases.
7	**GENA723 Trauma and Emergencies in Rural Settings** PGDipRPHP University of Otago Equips rural practitioners with the knowledge, skills and framework with which to manage emergency and trauma patients in a rural practice setting. OR The Emergency Medicine Certificate from the College of Emergency Medicine.

(*The University of Auckland may require registrars to undertake the prerequisite paper POPLHTH 709 before being accepted onto POPLPRAC 740.)

Prior learning exemptions may apply – see section 5.2 below.

3.5. Learning activities

For the duration of the programme, registrars are required to:

(a) Maintain a learning plan and reflection log of their learning experiences

(b) Discuss and review cases with the Rotational Supervisor for each attachment

(c) Complete a skills log of clinical experiences obtained

(d) Meet with their Education Facilitator four times a year (except in the case of registrars on the dual Fellowship training pathway who are engaged in GPEP1 training).

3.6. Resuscitation skills course requirements

Registrars are required to complete the following resuscitation skills courses during training:

(a) Emergency Management of Severe Trauma (EMST) or Advanced Trauma Life Support (ATLS).[5]

- Advanced Cardiac Life Support (ACLS). Registrars are required to complete a College endorsed resuscitation course appropriate to their training programme.

(b) Advanced Paediatric Life Support (APLS) or Paediatric Advanced Life Support (PALS).[6]

At the point of obtaining Fellowship these courses must be current at the time of Fellowship award.

3.7. Professional development activities required until Fellowship is obtained

In order to comply with MCNZ recertification requirements, registrars who have put their training programme 'on hold', or who have completed either the academic or the clinical component of training, but who have not yet completed the other requirements, must complete all of the following professional development activities until either Fellowship is obtained[7] or they return to the programme (i.e. no longer 'on hold')

- Development and implementation of a professional development plan – one per year, to be reviewed and agreed to by the Education Facilitator
- Audit of medical practice – one per year
- Peer review meeting attendance of at least 10 hours per year
- At least 15 hours of continuing medical education per year
- At least one hour per year of activities aimed at developing cultural competence
- Multisource colleague feedback once every three years
- Maintenance of a collegial relationship with an appropriate vocationally registered rural hospital medicine practitioner, comprising a minimum of four meetings with a minimum of eight hours of interaction per year.

(Registrars who are engaged in academic studies may claim these activities towards meeting their professional development requirements.)

Confirmation that CPD activities have been completed as required will be obtained from the College's CPD team.

3.8. Assessment requirements

The assessments required before Fellowship assessment are as follows:

- Assessment components of the academic papers
- Twelve mini clinical evaluation exercises (MiniCEX)
- Rotational supervisor reports
- Education Facilitator reports
- Multisource colleague feedback

[5] The Primary Response in Medical Emergencies (PRIME) course can be taken as an alternate.

[6] For the purposes of this programme, EMST and APLS courses are regarded as current for five years from date of issue. ACLS courses are regarded as current for three years from date of issue.

[7] Further information can be found in the Division's Continuing Professional Development booklet, available on Learning Zone.

- Structured Assessment using Multi-Patient Scenarios (StAMPS) assessment8.

Specific requirements for each component are given below.

3.8.1. Assessment component of the academic papers

The requirements for the assessment components of the academic papers are:

(a) Each paper must be passed.

(b) For any grade below B-, the registrar will be identified for additional support in the particular area. The remedial requirements in each case will be determined by the Board of Studies or approved delegate.

(c) University letters confirming course results should be submitted to Division Programme Advisor as soon as possible after completing a paper, and a full academic transcript must be submitted once all components are completed.[9]

3.8.2. MiniCEX examinations

The requirements for the MiniCEX examinations are:

(a) Twelve MiniCEX examinations must be successfully completed over the course of the training programme.

(b) MiniCEX examinations must be undertaken by Rotational Supervisors (except in the case of 3.8.2d and 4.2a below). The Rotational Supervisor may delegate this responsibility to an appropriately qualified doctor.

(c) It is the registrar's responsibility to request that the Rotational Supervisor conducts the MiniCEX.

(d) For registrars on the dual Fellowship programme, a maximum of two MiniCEXs done during the GPEP1 year may be counted towards the MiniCEX requirements, providing that they are conducted by a College teacher.

3.8.3. Rotational Supervisor reports

(a) A Rotational Supervisor report must be obtained on completion of each of the clinical runs in the training programme.

(b) The report must indicate that the Rotational Supervisor is satisfied that the run has been completed successfully in order for the run to be credited to programme requirements.

(c) It is the registrar's responsibility to ensure that the Rotational Supervisor has completed the report, and that the completed report has been received by the Division Programme Advisor.

3.8.4. Educational Facilitator reports

(a) A report from the registrar's Educational Facilitator must be obtained annually.

(b) The report must indicate that the registrar is making progress in meeting their learning plans, and that the Educational Facilitator has no significant concerns regarding the registrar's practice.

[8] The StAMPS exam is run by the Australian College for Rural and Remote Medicine.

[9] It is the registrar's responsibility to ensure that the Division Programme Advisor receives the transcript. This must be an original transcript, or a copy certified by a Justice of the Peace.

3.8.5. Multisource colleague feedback

(a) In the final six months of training, registrars are required to undertake a multi-source feedback colleague survey.

(b) Results on this tool must indicate no significant colleague concerns regarding the registrar's practice.

3.8.6. StAMPS assessment

(a) The registrar must successfully complete the StAMPS examination, comprising eight scenario questions.

(b) The StAMPS examination must be undertaken no earlier than twelve months prior to the completion of the training programme.

(c) The StAMPS examination is run through the Australian College of Rural and Remote Medicine (ACRRM). The examination is run through a choice of teleconference (at a limited number of venues) or face to face examination. Registrar travel to attend the examination may be required, at the registrar's expense.

(d) Places on the examination are limited. It is the registrar's responsibility to ensure that they are booked into an appropriate examination session. Registrars should inform the Division of their intentions to sit the examination at the beginning of the year in which they intend to do this.

4. Fellowship assessment

4.1. General requirements

(a) The purpose of the Fellowship assessment visit is to examine a registrar's practice to ensure that it is safe, competent and meets the standard for Fellowship. The visit normally takes place in the final two months of the registrar's final clinical placement for the programme and will not take place before this.

(b) The Fellowship assessment visit is conducted by a senior Fellow of the College.

(c) The assessment visit for Fellowship must take place in an approved run in an approved and accredited rural hospital setting (see section 3.3) in which the registrar has previously worked.

(d) Decisions on the award of Fellowship are made by the Board of Studies or approved delegate. The Board of Studies or approved delegate may stipulate that further assessment of the candidate is required, and / or may require that the candidate undertake further training before being re-assessed for Fellowship.

(e) All criteria for the award of Fellowship (outlined in section 2.2) must be attained within 18 months of the assessment visit or another assessment visit will be required.

4.2. Eligibility for the Fellowship assessment visit

Registrars are eligible for Fellowship assessment when:

(a) They have satisfactorily completed all programme requirements, with the exception of:

  i. any MiniCEX examinations which can, with the prior approval of the Fellowship Assessor, be completed on the day.

  ii. the final Rotational Supervisor report which must be provided prior to the award of Fellowship.

(b) They are recommended to progress to assessment by a Clinical Leader and their Education Facilitator.

4.3. Fellowship assessment visit requirements

The following documents must be available at the time of the visit:

(a) Registrar portfolio, including all of the following:[10]

- An updated curriculum vitae
- Results of university examinations
- Results of other external examinations (if applicable)
- Certificates from all resuscitation skills courses attended
- Record of clinical attachments
- Rotational Supervisor reports from all except the current placement (see section 4.3b below, and section 2.2)
- Results of all miniCEX assessments undertaken
- StAMPS results
- Multisource feedback colleague survey results
- Documentation confirming participation (or results of assessments) from any other courses, conferences or training activities attended
- Learning plan and reflection log
- Clinical skills log
- Annual Educational Facilitator reports.

(b) An interim report from the Rotational Supervisor of the registrar's clinical placement at the time of the visit.

(c) Results from a multi-source feedback assessment conducted within 12 months of the date of the visit.

In addition, candidates for Fellowship assessment must:

(a) sign a declaration that they do not have a pending criminal proceeding, or an investigation under the Health and Disability Commissioner Act 1994 (unless they have a Letter of Standing from the MCNZ which states that the complaint under investigation is of a minor nature).

(b) declare any conditions on their practicing certificate for consideration. Visit eligibility will be determined by the Division Council.

5. Recognition of prior learning

Doctors who do not qualify for admission to the Prior Specialist Training Pathway to Fellowship (see section 6 below) may apply to the Board of Studies or approved delegate for exemption from individual components of the training programme where these are substantially similar to components undertaken previously.

5.1. Clinical experience

Doctors with clinical experience at PGY3 and above obtained before enrolling in the rural hospital medicine programme may apply to the Board of Studies or approved delegate to have their programme clinical experience requirements reduced, provided the clinical experience is equivalent to the requirements of the programme.

[10] All of these documents, with the exception of the learning plan and reflection log and the skills log, will be collated by the Division from documents that have been submitted over the course of the programme. The learning plan and reflection log and the skills log must be provided by the registrar on the day of the visit. Templates for these documents are available on Learning Zone.

Clinical experience obtained in a position overseas may be recognised if deemed comparable to New Zealand clinical experience.

Recognition may be granted for a maximum of 24 months, depending on the relevance and recency of the clinical experience. In some cases, recognition may be given for particular clinical experiences without detracting from the overall time required in the programme.

Recognition of previous clinical experience will normally, except in cases of special consideration, be given only for work done whilst at a Registrar or Senior House Officer level.

All doctors who receive recognition of clinical experience must still meet the programme minimum clinical practice time requirements while enrolled in the programme (see section 3.3d).

At the discretion of the Board of Studies or approved delegate, specific programme requirements may be set for individuals who have been granted recognition of clinical experience obtained prior to the programme.

5.2. Academic component requirements

Doctors who have completed a postgraduate course relevant to rural hospital medicine before entering the programme may apply to the Board of Studies or approved delegate for recognition of prior learning to determine whether they are eligible for exemption from a specific academic component. Applications will be considered on a case-by-case, based on the level of study, the education provider, the country and its relevance to rural hospital medicine.

Specific exemptions that may be granted are as follows:

- Doctors who have passed GPEP Clinical and Written Examinations will be exempt the requirement to complete GENA 725.
- Doctors who have passed Royal Australasian College of Physicians (RACP) Part 1 will exempt the requirement to complete GENA 728 and GENA 729.
- Doctors who have passed both the Postgraduate Certificate in Women's Health and the Postgraduate Certificate in Child Health will be exempt from the requirement to complete GENA 726.

5.3. Resuscitation skills course requirements

Doctors who hold current resuscitation skills courses (refer section 3.6) are not required to repeat these courses. All resuscitation skill course certificates must be current at the time of Fellowship.

5.4. Assessment requirements

Assessment requirements for doctors who have received recognition of prior learning exemption from some programme requirements are the same as those outlined in section 3.8, except that, at the discretion of the Board of Studies or approved delegate, exemption may be awarded for a limited number of miniCEX assessments if clinical time on the programme has been reduced.

6. Recognition of prior specialist training in Rural Hospital Medicine

6.1. Ad eundum gradum recognition of FACRRM

Doctors who hold Fellowship of the ACRRM and who gained this qualification via the ACRRM training and assessment pathway will be entitled to apply for consideration for Division Fellowship ad eundum gradum, if they are working in New Zealand and have twelve months of experience, either during or after training, in a rural hospital environment. Applicants for Fellowship ad eundum gradum need to:

- Complete an application form
- Provide a certified copy of their ACRRM Fellowship certificate
- Provide a letter from ACRRM confirming their current financial and professional good standing
- Provide evidence that they have at least twelve months experience during or after training in a rural hospital environment
- Provide confirmation that they hold a current Practicing Certificate from the Medical Council of New Zealand;
- Provide confirmed details regarding their employment in New Zealand; and
- Pay the relevant College/ Division membership fees.

Fellowship of the DRHMNZ will be granted once the necessary documentation has been received and approved.

7. General practice dual Fellowship training pathway

7.1. General requirements

Applicants wishing to undertake dual Fellowship training in RHM, and general practice must be independently accepted to each training programme.

All general programme requirements specified in the Fellowship Pathway Regulations for each of the training programmes will apply also to the dual training pathway, and to the activities relevant to each pathway. This includes appeal processes, leave recognised, minimum clinical time required and time allowed on hold.[11][12]

The maximum period that a registrar can remain on the dual training programme, except with the permission of the Board of Studies and the College, is eight years.

7.2. Clinical experience requirements

Registrars who are undertaking a dual Fellowship in RHM and general practice may claim up to 18 months against the DRHM clinical experience requirements for general practice experience gained on the General Practice Education Programme (GPEP) programme, provided that at least six months of GPEP training must be undertaken in rural general practice.

This clinical experience component is credited against the Division clinical experience requirements for compulsory six months in rural general practice and twelve months of elective experience.

[11] The College Fellowship Pathway Regulations are available on the College website and on Learning Zone.

The clinical experience requirements for the dual Fellowship training pathway are as follows:

Compulsory runs
All of the following must be completed: • **Two runs** (12 months FTE) in **general practice** undertaken whilst fulfilling the GPEP1 programme requirements. At least one run (six months FTE) must be in in **rural general practice.** • **Two runs** (12 months FTE) in **rural hospital medicine** undertaken at different sites. One of the rural hospital runs must be in a Level 3 rural hospital.[12][13] One rural hospital run is usually taken early in the training programme, the other is undertaken at the end of training and is the site for the RHM Fellowship assessment visit. • **One run** (six months FTE) in **general medicine** (three months may be cardiology or respiratory medicine). • **One run** (six months FTE) in **emergency medicine**. • **0.5 run** (three months FTE) in **paediatrics**. • **0.5 run** (three months FTE) in **anaesthetics / intensive care.** • A further **one run** (six months FTE) in **general practice**, during which the general practice Fellowship assessment visit is conducted.[14]

7.3. Academic component requirements

Registrars on the dual Fellowship programme must complete the academic papers required for Division Fellowship, listed under 3.4 above, as per the requirements set out in section 3.8.1 above.

Completion of any of the required courses for the Division training pathway will fulfil the academic component requirement for the GPEP programme.

7.4. Learning activities

In addition to the learning activities listed in 3.5 above, registrars on the dual Fellowship training pathway are required to undertake the following formative activities:

(a) During GPEP1:

- seminar attendance – a minimum attendance of 32 (out of 40) FTE educational days, including any compulsory sessions (or College-approved alternative sessions organised by the registrar)
- research and presentation of two vignettes and one match questions and one 'what the evidence base suggests' (WEBS) resource over the course of the year
- four video consultations reviewed with the teacher or in the seminar group over the course of the year
- one in-practice visit per attachment

[12] The rural hospital levels are described in the Division Training Handbook.

[13] One of the rural hospital runs is normally undertaken at the end of the training period to accommodate the Fellowship assessment visit process.

[14] Normally undertaken after 30 – 36 months of training.

- patient feedback survey
- an audit of medical practice on a topic of choice, to be presented to the practice, teacher or seminar group
- five after-hour sessions conducted per attachment. These sessions are expected to be four - five hours and should have a focus on acute care rather than scheduled patients. Sessions may be taken in local after-hours clinics or Accident and Medical clinics, provided that supervision (by a Fellow of the College or appropriately vocationally registered doctor) has been arranged.
- a log detailing community visits undertaken to community service providers. A minimum of five visits are expected per attachment.

In addition, registrars are expected to:

- meet with an assigned supervisor of training (GPEP teacher) on a weekly basis
- undertake research and prepare a seminar presentation
- undertake any other activities recommended by the GPEP teacher.

(b) During the third general practice run:

- professional development plan
- in-practice visit from a medical educator
- patient feedback survey
- referral audit
- medical record review (or approved alternate audit of medical practice)
- learning group attendance – minimum of six hours of meeting time.

7.5. Resuscitation skills course requirements

Registrars on the dual training pathway must meet the resuscitation skill course requirements set out in section3.6 above.

7.6. Assessment requirements

The assessment requirements for the dual training pathway are as detailed in section 3.8 above, with the addition of:

- GPEP written examination
- GPEP clinical examination.

General requirements regarding the GPEP examinations are detailed in the College Fellowship Pathway Regulations. Recognition is not normally given for activities undertaken more than eight years previously.

7.7. Fellowship assessment

Registrars on the dual Fellowship training pathway must meet the Fellowship assessment requirements of each pathway. The requirements for the Division are set out in section 2.2 and 4 above. The requirements for College Fellowship are outlined in the College Fellowship Pathway Regulations.

8. Registration within the vocational scope of rural hospital medicine

Once Fellowship has been granted, Fellows of the Division may apply to the MCNZ for registration within the vocational scope of rural hospital medicine.

9. Continuing professional development requirements

The Division continuing professional development programme is designed to meet the MCNZ's recertification requirements for the maintenance of registration within the vocational scope of rural hospital medicine. It also helps general practitioners demonstrate their commitment to quality improvement and lifelong learning.

Further information

For further information, contact the Division:
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