Division of Rural Hospital Medicine
NEW ZEALAND
Te Whare Taiwhenua

Effective 27 January 2025

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 2021, Clause 20.4), and Fellowship of the Division is granted in terms of the criteria specified in clause 10.3 of the College Rules (2021).

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 an important part of 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. Because of distance, a doctor's scope of practice is unable to be confined to a range of illnesses or acuity of presentations (as occurs in 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.

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 a delay to definitive care. Rural hospital generalists need 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. This requires a high level of understanding of the likely course of major medical problems and knowledge of the risks and requirements of various modes of transfer and retrieval. Sound clinical judgement is necessary, especially where a single practitioner is providing care.

The scope includes 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 to allow them to make informed choices. Shared-care arrangements with urban-based specialists are frequently utilised to safely manage patients over such a broad scope of practice, requiring the rural hospital generalist to be proficient in communication and 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. Many rural hospital generalists have a set of specialist skills. These specialist skills may 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 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

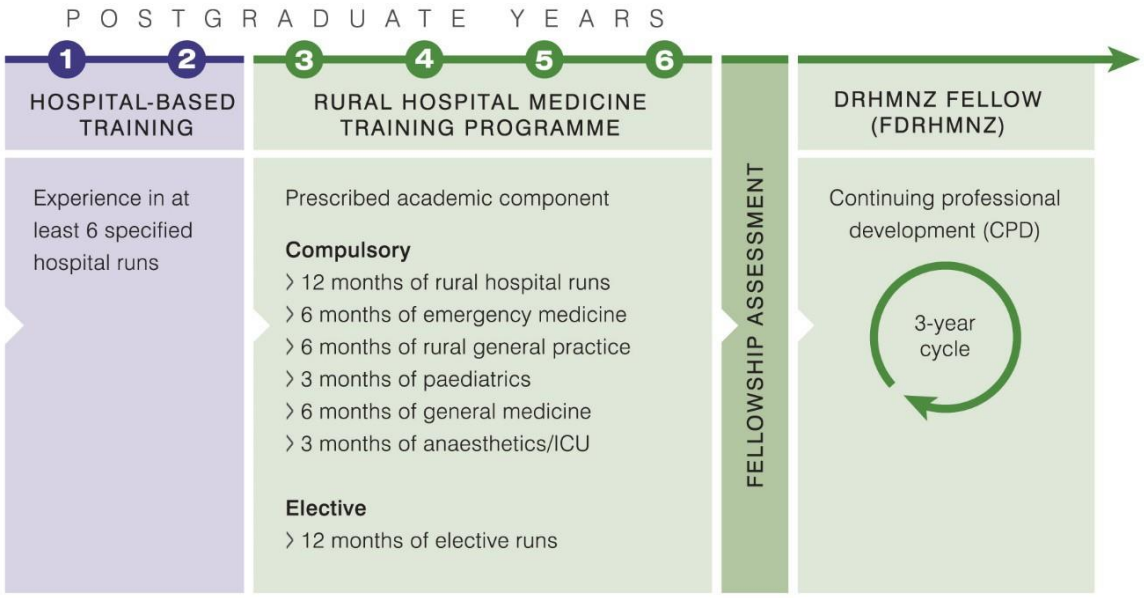

diagram below:

The Division also has a Prior Specialist Pathway to Fellowship for doctors who have completed other recognised training programmes. 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 formative and summative assessment requirements – refer to sections 3.8 and 3.9. 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 current Certificate of Professional Status (COPS) from the Medical Council of New Zealand (MCNZ)[1]

(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 27 January 2025 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 January 2025 are governed by the DRHM Fellowship Regulations current at the time of their enrolment 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 (excluding a maximum time of 3 years 'on hold').

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.

[1] Current means no more than 3 years old at the time of Fellowship

3.2. Admission to the programme

The admission requirements and process for programme admission 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 relevant and appropriate overseas attachments up to 12 months FTE, including Recognised Prior Learning. This does not include Rural Hospital Medicine or Rural General Practice (compulsory) runs which must be completed in New Zealand. Clinical experience undertaken after entry into the training programme will only be recognised if undertaken whilst actively participating in the training programme.

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

(i) All registrars must be supervised during their clinical runs by a specialist who is registered in the vocational scope in which they are working and must report directly to this specialist.

(j) Rural Hospital Medicine runs must be completed in 6-month FTE continuous runs. The minimum duration for runs within other specialities is 3 months FTE (i.e., runs cannot be completed in blocks of less than 3 months FTE).

The minimum compulsory and elective runs for the programme are detailed in the table below.[2]

Compulsory runs	**Elective runs**

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

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.[3][4] • **One run** (six months FTE) in **General Medicine** (three months may be Cardiology or Respiratory Medicine, three months may be relief) • **One run** (six months FTE) **in Rural General Practice**[5] • **One run** (six months FTE) in **Emergency Medicine** • **0.5 run** (three months FTE) in **Paediatrics** • **0.5 run** (three months FTE) in **Anaesthetics and/or Intensive Care**	An additional **two runs** (12 months FTE) of elective time must be completed. This may include: • Further experience at Senior House Officer (SHO) level or above in any of the compulsory runs listed • Urban General Practice • Surgery • Palliative Care • Rehabilitation Medicine • Geriatric Medicine • Māori Health Provider • Obstetrics and/or Gynaecology • Orthopaedic Surgery/Musculoskeletal Medicine 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 Healthcare** 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 Reflections in Rural Clinical Practice** PGDipRPHP University of Otago Clinical skills, knowledge and values required in the rural hospital setting for psychiatry, palliative care, and communication with patients in New Zealand's bicultural and multicultural society.
3	**GENA 726 Obstetrics and Paediatrics in Rural Settings** PGDipRPHP University of Otago Covers the management of paediatrics, neonatal care, and obstetric and gynaecological emergencies in a rural hospital setting.

[3] If possible, one of the rural hospital medicine runs should be done early in the programme, and the other at the end. 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.

[4] It is recommended that one of the runs be undertaken at a level 1 or 2 hospital.

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

4	**GENA 727 Surgical Specialties in Rural Settings** 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**[7] **Urgent Primary Surgical Care** Auckland University.
5	**GENA 728 Cardiorespiratory Medicine in Rural Settings** 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 Settings** 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, rehabilitation medicine, and infectious diseases.
7	**GENA723 Trauma and Emergencies in Rural Settings** PGDipRPHP University of Otago Covers the management of trauma, medical and surgical emergencies in the rural setting. Includes immediate, intermediate and continuing care for the injured or critically ill patient. OR The Emergency Medicine Diploma from the Australasian College of Emergency Medicine.

Prior learning exemptions may apply – see section 5.2 below.

3.5. Learning activities

3.5.1. 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) Notify the Senior Education Coordinator of their training intentions prior to commencement of each rotation. This must include:

- Details of the rotation (site, specialty, dates to ensure the rotation is appropriate).
- Details of the supervision arrangement (to ensure appropriately qualified supervision is in place).
- Academic paper intentions.

(d) Grades of unsatisfactory or borderline must be discussed with the clinical leadership team and may prompt the need for additional assessment, further clinical assessment, further support.

[7] The University of Auckland may require registrars to undertake the prerequisite paper POPLHTH 709 before being accepted onto POPLPRAC 740

Accreditation of such rotations may be deferred pending further assessment.

3.5.2. For the duration of the programme, registrars are recommended to:

(a) Meet with their educational facilitator four times per year, to assist and mentor with components of the programme (such as the development of the learning plan). Notes from these meetings can be included in the reflective log.

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)[8]

(b) Advanced Cardiac Life Support (ACLS). Registrars are required to complete a College-endorsed resuscitation course appropriate to their training programme. [9]

(c) Advanced Paediatric Life Support (APLS) or Paediatric Advanced Life Support (PALS).

(d) Newborn Life Support (NLS) Advanced.

These courses must be current at the time Fellowship is awarded. For the purposes of this programme, EMST, APLS and NLS 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.

3.7. Formative professional development activities required until Fellowship is obtained

Registrars who have put their training programme 'on hold' whilst working, or who have completed either the academic or the clinical component of training but not other requirements, will be automatically enrolled in the College's Te Whanake Annual Maintenance Programme (AMP). Registrars in these circumstances must complete requirements proportional to the time spent in the College's Te Whanake AMP. Registrars who have placed their programme on hold while continuing to work must can only participate in the AMP for up to six months maximum, at which point they must either return to their training programme (for example, no longer 'on hold') or enrol in Inpractice to maintain recertification requirements.

During their time on the AMP, there will be an emphasis on:

- setting at least four learning goals that are linked to each of the learning categories at the beginning of the annual period. These goals, which are discussed with the registrar's supervisor towards the end of the year, make up the Professional Development Plan activity.
- the completion of an annual conversation with the registrar's supervisor towards the end of the annual period.
- recording and reflecting on learning activities and learning as part of the registrar's professional development records.

[8] Advanced registrars (see definition in section 3.10) may take the Emergency Trauma Management (ETM) course as an alternate.

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

- engaging in a minimum number of activities across the AMP learning categories including cultural safety and health equity.
- maintenance of a collegial relationship with an appropriate vocationally registered Fellow, comprising a minimum of six meetings per year (a minimum of 1 hour per meeting).

Confirmation that the College's AMP requirements have been met will be confirmed as part of the registrar's online records.

3.8. Formative Assessment requirements

The formative assessments required before Fellowship assessment are as follows:

- Combination of twelve (12) mini clinical evaluation (MiniCEX) and direct observation of procedural skills (DOPS) exercises.
- Rotational supervisor reports
- Multisource colleague feedback

Generally, formative assessment requirements must be completed while a registrar is active in the training programme (i.e., not 'on hold').

Specific requirements for each component are given below.

3.8.1. DOPS and MiniCEX

The requirements for the DOPS and MiniCEX are:

(a) A combination of 12 DOPS and MiniCEXs must be successfully completed over the course of the training programme and sent to the College within 2 weeks of completion. This needs to include at minimum 4 DOPS, which must include one of each of the three mandatory procedures and one from the Optional Procedures list.

(b) DOPS and MiniCEXs must be successfully completed every 3 months during the relevant runs (i.e., one DOPS or MiniCEX during a 3-month FTE run, two during a 6-month FTE run, four during a 12 FTE month run). Exemptions may apply to registrars who have been awarded RPL (refer section 5.4).

(c) DOPS and MiniCEXs must be undertaken by Rotational Supervisors (except in the case of 3.8.1e and 4.2a below). The Rotational Supervisor may delegate this responsibility to an appropriately qualified doctor. Appropriately qualified are vocationally registered consultants, FDRHMNZ or an advanced registrar. All MiniCEXs or DOPS assessed by advanced registrars need to be signed off by a vocationally registered doctor.

(d) It is the registrar's responsibility to request that the Rotational Supervisor conducts the DOPS and MiniCEX

(e) For registrars on the dual Fellowship pathway, a maximum of two MiniCEXs completed during GPEP Year 1 may be counted towards the MiniCEX requirements, providing that they are conducted by a College teacher.

3.8.2. Rotational Supervisor reports

(a) A Rotational Supervisor report must be obtained within two weeks of the 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 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.

3.8.3. Clinical Lead review

(a) Registrars are required to meet with their Clinical Lead once a year to review their learning plan, reflection log, Rotational Supervisor reports, DOPS, MiniCEX, and skills log.

(b) The Clinical Lead must be satisfied that the registrar is making adequate progress through the training programme and has no significant concerns regarding the registrar's practice.

3.8.4. 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.

3.8.5. Skills Log

The skills log must be completed over the course of clinical training time, including sign-off of mandatory skills by relevant supervisors.

3.9. Summative Assessment requirements

The summative assessments required before the Fellowship Assessment are as follows:

- Structured Assessment using Multi-Patient Scenarios (StAMPS) assessment.[10]
- Assessment components of the academic papers

Generally, summative assessment requirements must be completed while a registrar is active in the training programme (i.e., not 'on hold'), however, the academic component may be completed whilst the registrar is on hold.

Specific requirements for each component are given below.

3.9.1. 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 after the completion of 36 months FTE clinical time on the training programme The StAMPS examination is run through the Australian College of Rural and Remote Medicine (ACRRM).

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

(c) 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.

3.9.2. 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.[11]

3.10. RHM Advanced Trainees

Registrars achieve the status of *Advanced Trainee* when they successfully complete:

- a minimum of half of the required academic papers (60 points) for the Academic Component[12] of the programme[13] and;
- a minimum of half[12] of the required clinical time component of the programme (24 months FTE).

1212

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) Following the Fellowship Assessment visit, the Chief Assessor undertakes moderation of the Fellowship Assessment Report and provides their recommendation to the Board of Studies or approved delegate.

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

[12] Includes recognition of prior learning (RPL) papers/courses and clinical experience awarded for RHM.

[13] For registrars on the Dual pathway a successful completion of the GPEP Clinical and Written Examinations equates to half of the minimum academic point requirement.

(e) 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.

(f) 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.

(g) Registrars may have up to three attempts at successfully completing the Fellowship assessment visit. Further attempts will require the approval of the Board of Studies or approved delegate, and may require the completion of additional training determined by the College.

(h) A summary report of the Fellowship Assessment visit will be provided to the registrar.

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. 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 the following:[14]

- 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

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

(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 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. An application fee will apply and must be paid prior to assessment.

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.

Clinical experience obtained in a position overseas may be recognised if deemed comparable to New Zealand clinical experience, for up to 12 months FTE. This does not include Rural Hospital Medicine or Rural General Practice (compulsory runs).

Recognition may be granted for a maximum of 24 months, depending on the relevance and recency of the clinical experience. The clinical experience will need to have been completed within five years prior to the entry to the programme.

Recognition of previous clinical experience will only 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.

Applications for RPL must be accompanied by supervisor's reports relevant to the rotation, and any summative assessment undertaken during a specialist medical training 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 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 include:

- 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) Adult Medicine Clinical and Written Examinations will be 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. Formative assessment requirements

Registrars who have received Recognition of Prior Learning (RPL) for clinical time completed within a formal specialist training programme relevant to rural hospital medicine may apply to have DOPS or MiniCEXs completed during this time credited towards the DOPS and MiniCEX requirement of the RHM programme. A maximum of four DOPS or MiniCEXs (two per 12 months of RPL) may be credited with approval from the Division Board of Studies or delegate.

6. Recognition of prior specialist training in Rural Hospital Medicine

6.1. Ad eundum gradum recognition of FACRRM

Doctors who hold Fellowship of the Australian College of Rural and Remote Medicine (ACRRM) and who gained this qualification via the ACRRM training and assessment pathway, independent pathway, or the specialist pathway will be entitled to apply for consideration for Division Fellowship ad eundum gradum[15] 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 the application form (available on the College website)

[15] Doctors who have gained FACRRM by ad eundum gradum are not eligible.

- Provide a certified[16] 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 MCNZ
- 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.

6.2. Prior Specialist Pathway to Fellowship

It is well recognised and appreciated that many doctors who commit to Rural Hospital practice in New Zealand have completed their training in other specialties and/or countries. There is no recognised equivalent overseas qualification to New Zealand RHM, and therefore the only pathway to vocational registration in RHM through the MCNZ is via Fellowship of the Division.

Doctors who have trained and qualified in prescribed specialties relevant to RHM, either in New Zealand or a country that the MCNZ regards as having a comparable health system, and who have held their qualification for two or more years, are eligible to apply for the Prior Specialist Pathway. In this process, prior qualifications and experience are evaluated against the requirements of the RHM training programme to identify where these can be deemed equivalent and where further education and/or experience may be required to meet Fellowship standards.

It is anticipated that with understanding of the Prior Specialist Pathway requirements, doctors who apply to it may achieve more extensive recognition of their previous relevant clinical education and experience than the maximum two years recognised prior learning permitted in the Registrar training programme. This can allow for an accelerated pathway to RHM Fellowship providing core and individualised requirements are met, as agreed to by both the doctor and the Division's Board of Studies (or delegated committee) following the application and assessment process. It is important to note that the exit criteria for the Prior Specialist Pathway are the same as those for the Registrar training programme (although the number of some assessments required may vary on a pro-rata basis for time required to complete).

6.2.1. Admission to the Pathway

Doctors eligible to apply to the Prior Specialist Pathway are those with Fellowships in Primary Care, Emergency Medicine, or Internal Medicine. Qualifications are eligible from the following countries:

- New Zealand
- Australia
- Belgium
- Canada
- Netherlands
- Norway
- Singapore
- South Africa

[16] Must be certified by a Justice of the Peace or a Fellow of the Division.

- Denmark
- Hong Kong
- Ireland
- Sweden
- United Kingdom
- United States of America.

Applicants for the Prior Specialist Pathway need to:

- Complete an application form (annual applications are due twice on February 1st and August 1st, digital forms available from the College website).
- Pay an application fee (covers initial evaluation of prior training, education, and experience)[17]

Documentation required:

- Confirmation of New Zealand citizenship or permanent residency status
- Confirmation of current MCNZ Practising Certificate
- Confirmation of current New Zealand employment details
- Certified[16] copy of Specialist qualification
- Any additional required as part of PSP application form completion

The documentation received is reviewed by a Fellow of the Division ('Evaluator'). The applicant's relevant clinical and educational experiences are assessed against the required components of the registrar training programme. A summary of where equivalencies to these components are either met, potentially (partially or fully) met, or not met is provided to the applicant. If the applicant decides to proceed a further fee is payable to cover the cost of an assessment interview.. The Assessment committee is made up of: one Board of Studies member, one Clinical Lead and one representative Fellow of the Division. The committee holds an interview with the applicant intended to verify clinical experience, understanding and commitment. If the application is successful, a Pathway to Fellowship is provided to the doctor which involves core and individualised components and a time limit to complete. If accepted, the doctor must pay the relevant College/Division membership fee.

6.2.2. Pathway Requirements

The core components are as follows:

- Completion of University of Otago papers GENA724, GENA725 - unless exemptions apply[18]
- 12 months supervised New Zealand Rural Hospital practice (with quarterly supervisor reports)

[17] Non-refundable.

[18] Refer to section 5.2 above.

- Exit assessments
  - MiniCEX (number pro-rata to clinical time to complete)
  - Multi-source feedback
  - Current EMST, ACLS, APLS
  - Pass in StAMPs Exam
  - Fellowship assessment visit

Individualised components such as further clinical and/or academic requirements will be determined on a case-by-case basis, factoring in the doctor's prior education and experience[19].

Doctors will be eligible to apply for Fellowship of the Division once all prescribed core and individualised components are complete. Doctors applying for Fellowship must be in good financial standing with the College and provide a current[1] Certificate of Professional Status (COPS) from the MCNZ.

6.2.3. Fellowship Assessment

6.2.3.1 General Requirements

(a) The purpose of the Fellowship assessment visit is to examine a doctor's practice to ensure that it is safe, competent and meets the standard for Fellowship.

(b) The visit normally takes place when a doctor has successfully completed all prescribed core and individualised pathway components.

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

(d) The assessment visit for Fellowship must take place in an approved run in an approved and accredited rural hospital setting in which the doctor has previously worked.

(e) 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 doctor is required, and/or may require that the doctor undertake further training before being re-assessed for Fellowship.

(f) All criteria for the award of Fellowship (outlined in section 6.2.3.3 below) must be attained within 18 months of the assessment visit or another assessment visit will be required.

6.2.3.2 Fellowship Assessment Visit requirements

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

(a) An updated curriculum vitae

(b) All DOPS and miniCEX reports completed

(c) All supervisor reports completed

[19] If more than 12 months clinical time is required in addition to rural hospital time, the Prior Specialist Pathway is not appropriate. Doctors are still eligible to apply for the RHM training programme and recognition of prior learning.

(d) Record of clinical attachments

(e) Multisource feedback colleague survey results

(f) StAMPS results

(g) Certificates from all resuscitation skills courses attended

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.

6.2.3.3 Criteria for the award of Fellowship

To be awarded Fellowship of the Division (FDRHM) through the Prior Specialist Pathway, doctors must:

(a) Complete all prescribed core and individualised components – refer to section 6.2.2

(b) A pass in the Fellowship Assessment visit – refer to section 6.2.3

(c) Hold a current resuscitation certificate – refer to section 3.6 for a list of Division approved resuscitation courses

(d) Hold a current[1] Certificate of Professional Status (COPS) from the Medical Council of New Zealand (MCNZ)

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

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 both the Rural Hospital Medicine Training Programme and the General Practice Education Programme (GPEP).

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.[20]

The maximum period that a registrar can remain on the dual training pathway, except with the permission of the Board of Studies and the College, is eight years (excluding time 'on hold').

[20] The Fellowship Pathway Regulations for both programmes are available on the College website.

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 GPEP, provided that at least six months of GPEP training is 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.

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 GPEP Year 1 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.[21][22] 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 or relief).
- **One run** (six months FTE) in **Emergency Medicine**.
- **0.5 run** (three months FTE) in **Paediatrics**.
- **0.5 run** (three months FTE) in **Anaesthetics and/or Intensive Care.**
- A further **one run** (six months FTE) in **General Practice**, during which the general practice Fellowship assessment visit is conducted.[23]

Further information on dual Fellowship can be found in Appendix 1 of this document.

7.3. Academic component requirements

Registrars on the dual Fellowship pathway must complete the academic papers required for Division Fellowship, listed under 3.4 above, as per the requirements set out in section 3.9.2 above.

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

[21] It is recommended that one of the runs be undertaken at a level 1 or 2 hospital.

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

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

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 GPEP Year 1:

- 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 four vignettes, or match questions or 'what the evidence base suggests' (WEBS) resources 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
- 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-hours clinic sessions per attachment. These sessions are expected to be 4 – 5 hours and should have a focus on acute care rather than scheduled patients. Sessions may be taken in a registrar's current clinic (for example, a 'duty doctor; or 'acute care' list), local after-hours clinics, Accident and Medical clinics, or Urgent Care clinics. On-site supervision is always required, which must be provided by a Fellow from one of the following disciplines: General Practice, Urgent Care, Emergency Medicine or Rural Hospital. If a clinic does not have on-site supervision by a Fellow from one of these disciplines, approval from the College must be gained prior to undertaking the after-hours sessions
- 10 community visits of 4 hour duration undertaken to community service providers or to specialist general practice clinics per year. All visits to be logged and reflected on. A minimum of five visits are expected per attachment
- (i) at least one Hauora Māori case reflection
- In addition, registrars are expected to:
- develop an agreed learning plan with their GPEP teacher
- meet with an assigned supervisor of training (GPEP teacher) on a weekly basis to check on their progress
- undertake research and prepare a seminar presentation
- undertake any other activities recommended by the GPEP teacher

(b) During the third general practice run:

- Development and implementation of a professional development plan
  - One in-practice visit from a medical educator
  - One patient feedback survey
  - One colleague multisource feedback survey undertaken in general practice
  - One medical record review (or approved alternate audit of medical practice)
  - Peer 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 section 3.6 above.

7.6. Assessment requirements

The assessment requirements for the dual training pathway are as detailed in section 3.8 and 3.9 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 programme. The requirements for the Division are set out in section 2.2 and section 4 above. The requirements for College Fellowship are outlined in the College Fellowship Pathway Regulations[20].

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's 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 rural hospital doctors demonstrate their commitment to quality improvement and lifelong learning.

Further information

For further information, contact the Division:
Phone: (04) 496 5999
Fax: (04) 496 5997
Email: DRHMNZ@rnzcgp.org.nz
Website: www.rnzcgp.org.nz

Appendices

- Appendix 1: Dual Fellowship Training Pathway Guidelines

10. Appendix 1: Dual Fellowship Training Pathway Guidelines

Overview

These guidelines are to be read in conjunction with the General Education Programme (GPEP) and the Division of Rural Hospital Medicine **(**DRHM) Fellowship Pathway Regulations.

The following information provides a detailed explanation of specific sections and processes for the two set of Regulations, and how they are applied to registrars that are completing the Dual Pathway.

DRHM Fellowship Pathway Regulations

Section 7.2 Clinical experience requirements: Provides a table that gives a clear definition of the compulsory runs that must be completed while in the Dual Training Programme:

Compulsory runs
All of the following must be completed: • **Two runs** (12 months FTE) in G**eneral Practice** undertaken whilst fulfilling the GPEP Year 1 programme requirements. At least one run (six months FTE) must be in in R**ural 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.[1],[2] 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 G**eneral Medicine** (three months may be cardiology or respiratory medicine or relief). • **One run** (six months FTE) in E**mergency Medicine**. • **0.5 run** (three months FTE) in P**aediatrics**. • **0.5 run** (three months FTE) in A**naesthetics / Intensive Care.** • A further **one run** (six months FTE) in G**eneral Practice**, during which the general practice Fellowship assessment visit is conducted.[3]

Guidance for table:

- The first bullet point refers to time that needs to be completed in GPEP Year 1 (2 runs = 12 months in GP). As per the regulations, one of these runs must be in a rural general practice.
- The last bullet point in the table refers to time to be completed in GPEP Year 3.
- The remaining bullet points refer to runs completed in Rural Hospital Medicine.

Section 7.3 Academic component requirements:

Dual registrars are still required to complete the academic papers required for DRHM Fellowship. These papers are outlined in section 3.4. The completion of these papers will exempt the registrar from the GPEP academic component of the programme.

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

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

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

GPEP Fellowship Pathway Regulations

Section 3.5.6 Formative activities for registrars on the dual programme:

Provides a breakdown of the GPEP formative requirements that must be completed on the Dual pathway programme. This section does not mention the combination of GPEP Year 2 (modules and clinical time) and half of GPEP Year 3 (clinical time) that are required. This is explained under Section 3.4.1g (outlined below).

Section 3.3 GPEP clinical experience requirements:

Provides a table with a detailed list of the clinical experiences that are counted towards the Dual programme. The column titled 'Other vocational scopes' is most relevant to the Dual pathway. It provides a breakdown of what can be cross credited from DRHM to GPEP. Cross crediting is an important aspect of the Dual pathway, as it allows registrars to reduce the overall time needed to gain Fellowship in both GPEP and DRHM.

Cross-Crediting:

In addition to the required 18 months of clinical experience gained in unrestricted general practice (this would be the 12 months in GPEP Year 1 and 6 months in GPEP Year 3), a maximum of 18 months FTE of runs undertaken in DRHM can be used towards GPEP. The clinical areas recognised for cross-crediting are outlined under the 'Other vocational scopes' column. The 18 months that are cross credited from DRHM represent the 12 months of GPEP Year 2 and the 6 months of GPEP Year 3.

Example - if a registrar had completed two runs (12 months) in Rural Hospital Medicine, and one run (6 months) of General Medicine whilst in DRHM, they could apply to the College to have these cross credited towards GPEP.

Registrars need to gain approval from the College for any cross credits towards GPEP. This approval process is done through the College's Delivery Advanced Registrars Team, Academic Assurance Team, and the Clinical Lead's for GPEP.

Registrars that have their DRHM runs cross credited do not need to complete GPEP Year 2 (both modules and 12 months clinical time), and six months of the required 12 months of GPEP clinical time is reduced.

NOTE: Modules for GPEP Year 3 plus 6 months of clinical time are still a requirement of the Dual programme.

Recognition of Prior Learning (RPL):

RPL that has been approved by the College for registrars cannot be used for cross-crediting purposes. For example, if a registrar had gained 12 months of RPL for Paediatric runs completed prior to beginning DRHM, they would not be able to use those 12 months to cross credit towards the 18 months required. Section 3.4.1(g) allows up to 18 months of time completed **whilst on the DRHM programme** to (with College approval) be counted towards the overall clinical time.

This also means that if RPL has been granted for various DRHM runs, they may need to complete some again whilst active in DRHM in order for that time to be cross credited towards GPEP – this would be considered on an individual case-by-case basis by the College.

Examples of Dual pathways

There are various options for a registrar to complete their Dual training programme. A registrar could complete their modules/time requirements within 4 years (not including Fellowship visits), but it normally takes a registrar approximately 5-6 years to complete the programme and be awarded Dual Fellowship.

Because dual Fellowship candidates must apply separately to both DRHM and GPEP, they are likely to start their programme on whichever of the two programmes they are accepted onto first.

For example, if a Dual registrar was accepted on to GPEP first before deciding to do Dual, they might:

1. Complete GPEP Year 1 first
2. Complete 24 months[24] of time in DRHM (of which 18 months could be cross credited to GPEP)
3. Return to GPEP Year 3 to complete GPEP modules/6m clinical time + GP Fellowship
4. Return to DRHM to complete any outstanding requirements + StAMPS exam + DRHM Fellowship

OR

1. Complete GPEP Year 1 first
2. Return to DRHM to complete DRHM requirements + StAMPS exam + DRHM Fellowship

[24] This option would enable a Registrar's years to align with the GPEP Year 1 start date.

3. Return to GPEP Year 3 to complete GPEP modules/6m clinical time + GP Fellowship.

Placements:

GPEP Year 1 registrars who are considering a Dual pathway are required to complete one attachment in a rural general practice (as outlined above in the compulsory runs table). It is therefore vital that registrars complete one rural attachment in GPEP Year 1 in order to meet the requirements for the Dual Pathway. The Admissions and Registrar Support Team are responsible for assisting the registrar in securing a rural placement.

A registrar may decide to do Dual pathway after they have completed GPEP Year 1. For these cases, a 6-month rural practice placement would need to be allocated

A registrar may be accepted on to DRHM first before deciding to do a Dual pathway. In this case they may:

1. Complete 24 months of DRHM runs (of which 18 months could be cross credited to GPEP)
2. Complete GPEP Year 1 (if accepted on to the programme)
3. Complete GPEP Year 3 modules/6m clinical time + GP Fellowship
4. Return to DRHM to complete any outstanding requirements + StAMPS exam + DRHM Fellowship

OR

1. Complete DRHM requirements + StAMPS exam + DRHM Fellowship
2. Complete GPEP Year 1 (if accepted on to the programme)
3. Complete GPEP Year 3 modules/6m clinical time + GP Fellowship

The examples provided in these guidelines are not exhaustive. The College at times may need to work with registrars on a case-by-case basis to provide advice and options to enable opportunities for them to achieve Dual Fellowship.