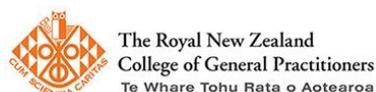


TRAINING PROGRAMME HANDBOOK 2017



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The Scope of Rural Hospital Medicine

In 2008 the Medical Council of New Zealand (MCNZ) recognised rural hospital medicine as a distinct vocational scope of practice and accepted the following definition:

“The vocational scope of rural hospital medicine practice 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 orientated to secondary care, is responsive rather than anticipatory and does not continue over time.”

The breadth of rural hospital medicine is a defining feature. Rural hospital medicine 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 specialities. 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, Maori health workers, and others.

Rural Hospitals in New Zealand

The MCNZ accepts the following definition of a rural hospital:

“A rural hospital is a hospital staffed by suitably trained and experienced generalists, who take full clinical responsibility for a wide range of clinical presentations. While resident specialists may also work in these hospitals, cover is limited in scope or less than full time.”

Around 10% of all New Zealanders depend on a local rural hospital for the delivery of some hospital level care. Approximately half of the rural hospital medical workforce work fulltime in the hospital and about half share their time between the hospital and rural general practice.

It is recognised that there is considerable variation in rural hospitals across New Zealand. The variation is in the level of service provided, staffing, diagnostic and other support services. Much of that variation is an appropriate response to the variation in the needs of rural communities based on their geography and social and cultural composition. The Division however recognises three broad levels of rural hospital.

- | | |
|---------|--|
| Level 1 | Visiting medical cover once a day, with on call medical cover at other times. Some of the afterhours on call may be supplied by appropriately trained nursing staff with medical backup at a distance. No onsite laboratory services. Radiology services are limited and often involve non radiographers working under special licences or a visiting radiographer. Acute inpatients beds. |
| Level 2 | Onsite medical cover during normal working hours. On call medical cover at other times. A combination of off-site laboratory services and point of care testing. 24 hour access to on call radiographer. Acute inpatients beds. |
| Level 3 | Onsite 24 hour medical cover. 24 hour access to radiology and laboratory services. There may be limited specialist cover. Acute inpatients beds. |

List of Rural Hospitals in New Zealand

The following is a list of rural hospitals in New Zealand (only the hospitals marked RHM below are currently accredited for rural hospital runs - see section on accreditation, p.20):

	Level 1	Level 2	Level 3
Akaroa	√		
Ashburton (RHM)			√
Clutha Health First hospital (Balclutha)		√	
Bay of Islands hospital (Kawakawa)			√
Buller hospital and Reefton Health Services (West Coast)(RHM)		√	
Chatham Islands Health Centre	√		
Dannevirke		√	
Dargaville (RHM)		√	
Dunstan (RHM)			√
Golden Bay Community Hospital (Takaka)		√	
Gore		√	
Grey Base Hospital (RHM)			√
Hawera (RHM)			√
Hokianga Hospital (Rawene)(RHM)		√	
Kaikoura	√		
Kaitia (RHM)			√
Lakes District Hospital (Queenstown)(RHM)			√
Maniototo	√		
Opotiki Community Health Centre	√		
Oamaru			√
Pohlen Hospital (Matamata)		√	
Rhoda Reid Hospital (Morrinsville)	√		
Stratford Health Centre	√		
Taihape Rural Health Centre	√		
Taumaranui			√
Taupo (RHM)			√
Thames (RHM)			√
Te Aroha and District Community Hospital	√		
Te Kuiti (RHM)		√	
Te Puia Springs	√		
Tokoroa (RHM)			√
Wairoa (RHM)		√	
Whangaroa Health Services Trust (Kaeo)	√		

The Rural Hospital Generalist Chapter known and operating as The Division of Rural Hospital Medicine New Zealand

The Division of Rural Hospital Medicine sits as a semi autonomous body within the existing Royal New Zealand College of General Practitioners (RNZCGP)¹. Rural hospital medicine is a recognised independent scope of medicine and the Division has Vocational Education and Advisory Body status with the Medical Council of New Zealand and sets the standards for the vocational scope of rural hospital medicine.

All doctors with an interest in rural hospital medicine are free to join the Division as members or associates. Membership is included in the fees you will pay the RNZCGP each year.

Governance is provided by a council of elected members along with consumer and Maori representatives, clinical leaders and a registrar representative.

The Board of Studies (BOS) comprises the elected council members and representatives from other specialist colleges including General Practitioners, Physicians, Surgeons, Emergency Medicine and Anaesthetics as well as a registrar representative, Clinical Leaders and an academic liaison person. You may be asked to elect a member of your group as registrar representative.

The Divisions Annual General Meeting is usually held annually in association with the Rural General Practice Network Conference..

The DRHM coordinator should be your first point of contact for most matters relating to the Division and the training programme:

DRHM coordinator
C/- Royal NZ College of General Practitioners
PO Box 10440
Wellington 6143
Email: drhmnz@rnzcgp.org.nz
Phone: 04 496 5999
Fax: 04 496 5997

¹ The Division is established under the RNZCGP 2012 Rule 17(b) and 17.4 as the Rural Hospital Generalist Chapter, known and operating as the Division of Rural Hospital Medicine of the Royal New Zealand College of General Practitioners (the Division).

Division of Rural Hospital Medicine NZ Council & Board of Studies

DRHMNZ Council:

Dr Stephen Main	Chair
Dr Abigail Rayner	Council member
Dr James Reid	Council member
Dr Janine Lander	Council member
Dr Jennifer Keys	Council member
Dr Scott Wilson	Council member
Dr Janine Lander	Council member
Dr Sarah Clarke	Council member
Dr Jeremy Webber	Council member
Dr Patrick McHugh	Clinical Leader, North Island
Dr Pragati Gautama	Clinical Leader, South Island
Dr Amanda van Zyl	Council member and Registrar Representative
To be appointed	Council member - Consumer Representative
Sarah Holland	Council member - Te Akaronga A Maui Representative

DRHMNZ Board of Studies:

Dr James Reid	Chair
Dr Abigail Rayner	BOS member
Dr Janine Lander	BOS member
Dr Jennifer Keys	BOS member
Dr Scott Wilson	BOS member
Dr Steve Main	BOS member
Dr Sarah Clarke	BOS member
Dr Jeremy Webber	BOS member
Dr Amanda van Zyl	Registrar Representative
Dr Paul Holt	RACP Representative
Dr John Kyngdon	RACS Representative
Dr Mohammed Safih	ACEM Representative
Dr Vaughan Laurenson	ANZCA Representative
Dr Patrick McHugh	Clinical Leader
Dr Pragati Gautama	Clinical Leader
Dr Kati Blattner	Academic Liaison Person
To be appointed	Chief Examiner

Principles underlying the development of the Rural Hospital Medicine Training Programme

In developing the programme the Division of Rural Hospital Medicine adopted the following principles.

Sustainability

The size of the rural hospital workforce is small, as will be numbers of registrars. It is too small to sustain an entirely new, stand alone, training scheme. It was therefore decided to make use of existing opportunities provided by the universities and other colleges including the Australian College of Rural and Remote Medicine.

Flexibility

Rural hospital generalists (RHG) are likely to want to move into a variety of other areas of medical practice in their careers. While rural hospital practice is defined by a particular social context, it is important that training for this scope does not 'trap' the doctor and their family in that social context. Considerable flexibility is therefore needed both at entry to and exit from rural hospital training and practice, as well as during the training programme. This is achieved by accrediting relevant parts (such as part 1 examinations) of other training programmes and making it possible to train in rural hospital medicine and another scope of practice concurrently (e.g. general practice or accident and medical practice).

The need to shift between urban and rural centres during training risks adding additional stress to registrars and their families. Registrars need to be able to undertake particular parts of the programme in an order that best suits them and their family. It should also be possible to train part time or take breaks from training for family or lifestyle reasons.

Recognition prior learning

Registrars are likely to come from a variety of backgrounds and bring a breadth of knowledge and experience. The programme should avoid forcing registrars to repeat training in areas in which they already have proven competence.

Core Skills and Advanced Skill Sets

Successful rural hospital medical teams are dependent on all members having a set of core generalist skills and individual members of the team having particular sets of more advanced specialist skills.

Competence based assessment

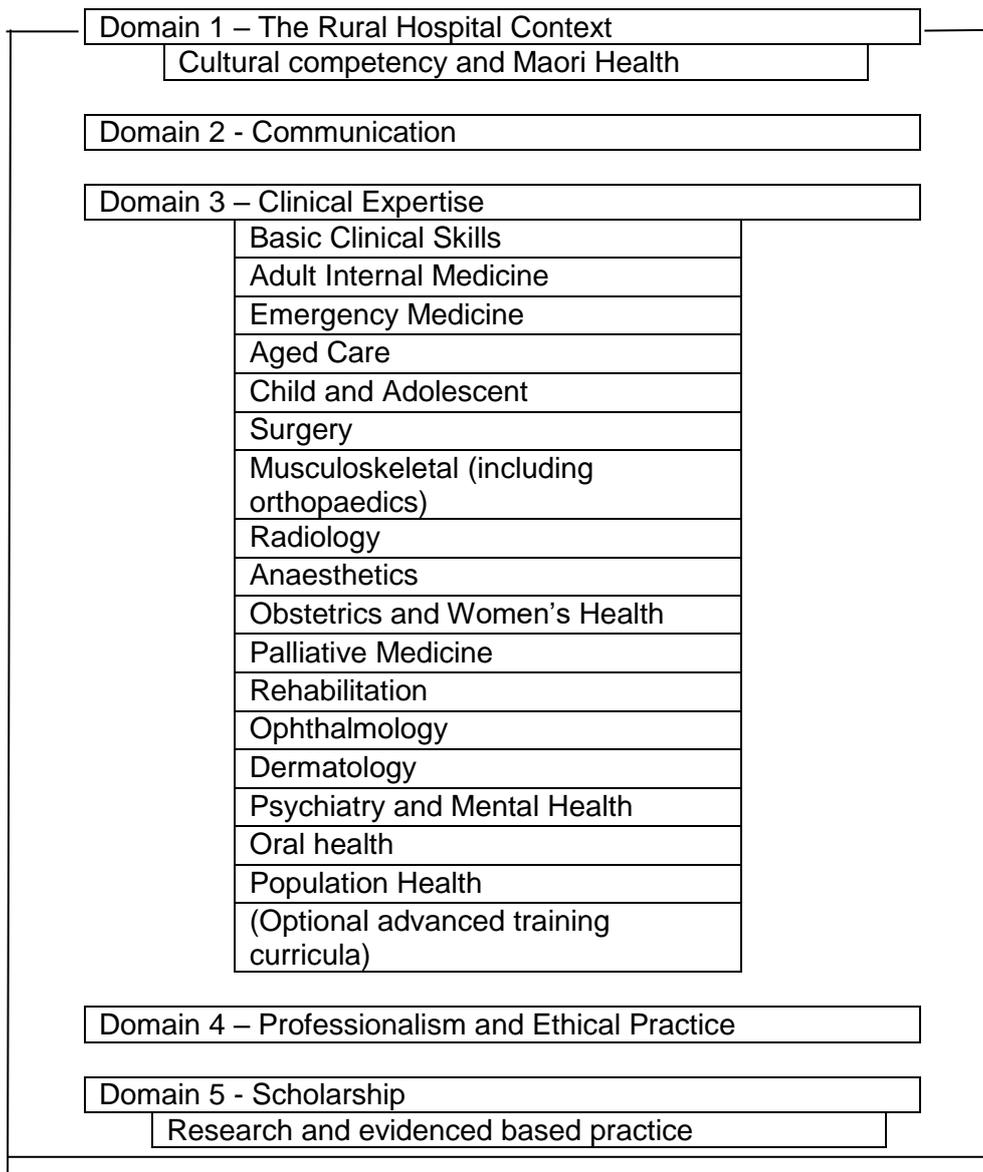
Assessment should be competence and practise-based rather than knowledge based.

Curriculum

The Division is grateful to the Australian College of Remote and Rural Medicine (ACRRM) who have allowed us to adapt their curriculum to suit the New Zealand context.

In adapting the curriculum it has been organized into five domains, which are closely aligned with the domains of the RNZCGP curriculum.

Domain One provides the 'milieu' in which the other domains are practised, and cultural aspects are covered in this domain because they too impact across all the other domains. *Domain Two* 'overarches' the clinical elements covered in *Domain Three*, which in turn are underpinned by *Domains Four* and *Five*.



You will be provided with a copy of the curriculum which should act as the framework for both the academic and clinical components of your training. It is viewed as a living document that will change as the scope evolves.

Entry into the Programme²

Registrars will normally enter the programme at PGY3 or later after two full-time years of appropriate postgraduate medical experience. This must include experience in at least six of the following:

Cardiology / Dermatology / ENT / 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.

Preference will be given to registrars who have had prior exposure to rural health and the rural environment.

Working Part Time³

We recognise that some registrars will want to work part-time for family or lifestyle reasons. There is no prohibition on doing this and we will work to accommodate part-time training wherever possible. The limiting factor may be your ability to find suitable part-time clinical attachments.

Some registrars will temporarily leave the programme and return at a later date. This may be because they spend time in another programme such as the General Practice Education Programme (GPEP) in order to work towards fellowship of both scopes of medicine. Or it may be for family or lifestyle reasons. As long as there is clear ongoing commitment to a career in rural hospital medicine the Division will attempt to take as flexible approach as it reasonably can to registrars who wish to leave the programme and rejoin at a later date. Registrars who intend to do this should inform the Division of their intentions so that their programme registration can be placed 'on hold' for the period that they are away.

The maximum period that a registrar can remain on the programme, unless with permission, is 8 years.

² See section 3.2 of the DRHM Fellowship Pathway Regulations

³ See section 3.3 of the DRHM Fellowship Pathway Regulations

Educational Facilitator

When you first start the programme you will be assigned an Educational Facilitator (EF). They will be a vocationally registered rural hospital generalist.

The Educational Facilitator acts as a mentor. They are the person with whom you discuss the direction your training is taking, the results of various assessments and any problems that you might have. When you meet with them remember to update your reflective portfolio, review your skills log book and note any changes you might make to your training plan.

You should meet with your EF four times a year to review progress. Unless circumstances dictate otherwise (e.g. you are on an elective overseas) at least two of these meetings should be face to face. Two may be by telephone or video-calling. It is likely you will have a meeting at the Rural GP Network Conference. One of you may need to travel for the second face to face meeting.

The relationship with your EF should be central to your training. This collegial relationship is particularly important in rural hospital medicine, where doctors frequently work in relative professional isolation and where many of your clinical attachments will be supervised by doctors from other branches.

You should aim to do one of your rural hospital clinical attachments with your Educational Facilitator.

Once a year your Education Facilitator will provide the Board of Studies with a report on your progress.

The Medical Council requires all junior doctors to have a collegial relationship. The doctor providing this will need to sign your application for an annual practicing certificate. This role can be undertaken either by your Educational Facilitator or one of the senior medical staff in the hospital you are working that year.

Clinical Leader

The Clinical Leader(s) for the training programme are

- Dr Patrick McHugh (North Is) mchugh@tdh.org.nz
- Dr Pragati Gautama (South Is) pragatigautama@gmail.com

The Clinical Leader acts as a conduit between the registrar representative and the Division. At the same time, particularly at this early stage of the training programme whilst registrar numbers are small and the Educational Facilitator system is still being developed, the Clinical Leader can also provide advice and support for any individual registrar.

Their other roles include liaison with Educational Facilitators, the Division and College staff, and other specialties in planning placements. The Clinical Leaders are also responsible for recommendations to the BOS on the accreditation on RHM clinical training posts and, for the academic side of the programme, relevant university papers.

Academic Programme⁴

Overview

The academic programme consists primarily of papers from the Postgraduate Diploma in Rural and Provincial Hospital Practice (PGDipRPHP - University of Otago) and from the Postgraduate Diploma in Community Emergency Care - Auckland University. You can do the academic part of the programme in as little as two years but this would be a very heavy workload and you are better to spread it out over three or four years.

Most papers are distance taught using a combination of readings, internet teaching, audio conferences and residential courses. On the Otago papers you will spend about five weeks of time at residential courses in week or weekend blocks.

Most of these papers are available only every second year. It is obviously preferable to try and do the academic and clinical parts of the programme concurrently but this will not always be possible.

You will be charged university fees to undertake these papers. These fees can normally be claimed back from your employer along with reasonable expenses. Please check your own employment contract.

The Division will seek feedback from registrars on the academic component of their training.

Schedule of University Papers for the RHM Registrar Training Programme

1.	GENA 724 The Context of Rural Hospital Medicine PGDipRPHP University 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 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.
3.	GENA 726 Obstetrics and Paediatrics in Rural Hospitals PGDipRPHP University 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 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

⁴ See section 3.4 of the DRHM Fellowship Regulations

	POPLPRAC 740* Urgent Primary Surgical Care Auckland University
5.	GENA 728 Cardiorespiratory Medicine in Rural Hospitals PGDipRPHP University 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 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.	Otago University GENA 723 Trauma paper OR The Emergency Medicine Certificate from the College of Emergency Medicine

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

Pass grades and criteria:

- Each section of a paper must be passed
- **The minimum pass grade for each paper for DRHM will be B-**
- For any grade below B-, the registrar may be required to undertake some remedial training in a particular area determined by the DRHM Board of Studies
- University letters confirming course results should be submitted to DRHM coordinator as soon as possible after completing a paper, and a full academic transcript must be submitted once all components are completed. This must be an original transcript or a copy certified by a Justice of the Peace. Although care will be taken, no guarantee is made regarding the return of original documents submitted. (It is the registrar's responsibility to ensure that the DRHM coordinator receives the transcript).

To enrol in the University of Otago papers, please contact⁵:

Bron Hunt

Rural Postgraduate Administrator
General Practice
Dunedin School of Medicine, University of Otago
www.otago.ac.nz

⁵ For Regulations for the Postgraduate Diploma in Rural and Provincial Hospital Practice University of Otago please visit the University website <http://www.otago.ac.nz/>

Email: bron.hunt@otago.ac.nz
Phone: 03 440 4345
Mobile: 027 225 2987

To enrol in the University of Auckland papers, please contact:
www.fmhs@auckland.ac.nz/postgrad

Recognition of prior learning (RPL) - Academic⁶

Avoiding unnecessary repetition of training and learning is an important principal of this training programme.

Registrars who have passed AMPEX will be exempt the requirement to complete GENA 723.

Registrars who have passed GPEP year 1 Clinical and Written Examinations will be exempt the requirement to complete GENA 725 and GENA 726

Registrars who have passed RACP part 1 will exempt the requirement to complete GENA 728 and GENA 729

Trainees who have passed ACEM part 1 will be exempt the requirement to complete GENA 723.

A registrar who has undertaken other postgraduate papers may apply to have these recognised and seek exemption from parts of the academic programme. For example, a registrar who has passed papers from the Diploma in Child Health (Otago) would not be required to pass GENX 726. Registrars are encouraged to develop an area of special interest or set of advanced skills in addition to their core generalist skills. It is expected some registrars will do this by undertaking a further Postgraduate diploma (or part thereof).

Resuscitation skills courses⁷

You need to complete the following resuscitation skills courses during your training:

- Emergency Management of Severe Trauma (EMST) or Advanced Trauma Life Support (ATLS)
- Advanced Cardiac Life Support (ACLS). This need to be at level 7 of the New Zealand Resuscitation Council Standard, and taken through a RNZCGP-endorsed provider.⁸
- Advanced Paediatric Life Support (APLS) or Paediatric Advanced Life Support (PALS).

⁶ See DRHM Fellowship Pathway Regulations section 5.3

⁷ See DRHM Fellowship Pathway Regulations section 3.5

⁸ Please see the College website (www.rnzcgp.org.nz) for up to date information on RNZCGP-endorsed courses.

If possible, try to undertake these courses at an appropriate time in your training (e.g. do the APLS during your paediatric attachment). Rural hospital attachments are an appropriate time to do any of the courses.

The courses need to be current at the time you finish your training and gain Fellowship. You will need to keep them current throughout your career as a rural hospital generalist.

These courses are invaluable education for rural hospital generalists. They are well structured, educationally sound and collectively cover the early management of most major medical problems. They teach 'the modern language of emergency care' that we need to effectively communicate with our specialist colleagues. They are an opportunity to learn alongside doctors from other scopes. From the perspective of the Division's Board of Studies they provide an opportunity to apply a set of recognised standards to rural hospital emergency care.

We recommend you also consider doing ALSO (Advanced Life Support in Obstetrics), BASIC (Basic Assessment and Support in Intensive Care), ELS (Emergency Life Support), and PROMPT (Practical Obstetrics Multi-Professional Training) courses. They are not compulsory but are excellent courses that will add to your training.

Course contact details:

EMST (Early Management of Severe Trauma)

These courses are run by the RACS. They tend to have a long waiting list; often more than a year, so enrol early. The certificate remains valid for 5 years at which time you will have to do a refresher course.

Register online: www.surgeons.org

1. Go to Education and training
2. Skills training courses
3. EMST
4. Register online

APLS Course (Advanced Paediatric Life Support)

The certificate remains valid for 5 years at which time you will have to repeat the course. Please contact:

Jo Jones email jo@apls.org.nz

Phone: 07 312 9574

ACLS (Advanced Cardiac Life Support)

The course you do must be at the advanced level of the NZ Resuscitation Council standard, and endorsed by the RNZCGP. If you are unsure where to get one of these courses then ask the DRHM coordinator for an up-to-date list of providers. ACLS courses remain valid for three years.

ALSO (Advance Life Support in Obstetrics) Course

Visit the website www.also.co.nz or www.also.net.au for course dates and information.

BASIC (Assessment and support in Intensive Care)

Designed to teach practical management of critically ill patients, particularly doctors working in smaller units. Topics include the assessment of the seriously ill patient, mechanical ventilation, severe trauma, severe sepsis and septic shock, interpretation of arterial blood gases, sedation and analgesia.

Sandra Bee

Course coordinator

Phone: 06 878 8109 extn. 4567

Mobile: 027 245 3692

Email: sandra.bee@hbdhb.govt.nz

ELS

The ELS course provides two days of instruction on medical emergencies, and covers a broader content area than other resuscitation skills courses.

www.elscourse.com.au

PROMPT

This is an evidence based multi-professional training package for obstetric emergencies.

<http://www.promptmaternity.org/>

Clinical Attachments⁹

Overview

The clinical attachments will provide the broad experience you need to practice safely and independently as a rural hospital generalist. They take a total of four years full time to complete and are made up of compulsory, recommended and elective runs.

Currently you can undertake these attachments in whatever order you wish. We know that during your training you and your family are likely to have to make several shifts. By giving you as much flexibility as possible we are hoping to minimise the disruption associated with this. There is also flexibility around where you do your clinical attachments. However it is likely that generalist runs in provincial base hospitals will provide better training opportunities than more specialised attachments in large tertiary hospitals.

During your attachments you should be accepting an appropriate level of clinical responsibility. This means operating at registrar or SHO level and reporting directly to the responsible consultant.

Your employer should grant you study leave to attend university and other courses that are part of the training programme as well as to attend the Rural GP Network Conference.

Compulsory attachments

You must complete all of the following six runs:

- Two runs in rural hospital medicine (at different sites), totalling 12 months full time or 24 part time months. The rural hospital attachments must be approved by the Division. One of the rural hospital runs must be in a Level three rural hospital.
- Six months in general medicine (three months may be cardiology or respiratory medicine)
- Six months in rural general practice
- Six months in emergency medicine (three months may be orthopaedics)
- Three months paediatrics.
- Three months anaesthetics / intensive care (note many hospitals will require that you commit to a six month run)

⁹ See DRHM Fellowship Pathway Regulations section 3.3

Recommended attachments

You must complete at least three months from the following list:

- Further experience in any of the compulsory runs above or in
- Urban General Practice
- Surgery
- Palliative care
- Rehabilitation medicine
- Geriatrics
- Maori Health Provider
- Obstetrics and/or gynaecology.

Elective runs

The programme incorporates nine months of elective time. You have considerable freedom in deciding how to use your elective training time, although if you choose attachments different to those on the compulsory and recommended lists above you will require prior approval of the Division. Some registrars will use the elective time to develop an advanced set of skills such as completing the proposed rural anaesthetics programme, or working as a registrar in a medical or surgical speciality. Others may use the time to gain overseas experience. Those intending to gain dual fellowships in both General Practice and Rural Hospital Medicine, or Accident and Medical and Rural Hospital Medicine may use the time to meet the requirements of RNZCGP General Practice Education Programme or AMPA part two.

Advanced Skills

Many registrars will take the opportunity to gain sets of advanced specialist skills, particularly during their elective year. This is in line with rural vocational training in other countries such as Canada and Australia.

You will have considerable freedom to choose the area you wish to develop. Examples might include anaesthetics, palliative care, rehabilitation medicine, paediatrics, emergency medicine and cardiology, indeed almost any branch of medicine or surgery.

Training in some advanced skill sets may be offered through programmes run by ACRRM in partnership with the relevant Australasian specialist colleges. Curriculum and assessment processes already exist for several of these, and more are likely to be developed in the future.

Recognition of Prior Learning (RPL) - Clinical¹⁰

The principal of recognition of prior learning applies to the clinical attachment in the same way that it does to the academic programme.

Where you believe you have prior clinical experience equivalent to the requirements of this programme you can apply for exemption from those components of the programme.

Previous experience will normally mean working at registrar or SHO level. In some circumstances the BOS may also consider PGY2 (postgraduate year 2) attachments. Typically this will be when the house officer accepts a higher level of responsibility for patient care because there is no registrar or SHO on the run.

If you have been exempted from some programme requirements by means of recognition of prior learning, this will shorten the minimum time you need to spend in the training programme. At the discretion of the DRHM Board of Studies, exemption may be granted from some of the miniCEX requirements.

You can have a maximum of 24 months of prior clinical experience exempted. The minimum experience required for fellowship remains at four years FTE, starting at PGY3.

Applications to the BOS for recognition of prior learning are normally made in the first few months of joining the programme.

Rotational Supervisor

You will have a rotational supervisor for each attachment. This will normally be the specialist to whom you are clinically responsible.

While your rotational supervisor will have expertise in their particular speciality they may have less understanding of the scope and context of rural hospital medicine and as a result your learning needs. For each attachment you should formulate a clear set of learning goals, the knowledge, experience and skills you wish to learn. Your educational facilitator will help you do this. You should discuss these learning goals with the rotational supervisor at the start of the attachment and review them at the end. Whenever you are faced with a clinical problem try and think about how you would manage it in the rural hospital setting (with limited resources and potential bad weather that may prevent the helicopter retrieval service getting to you).

You should have dedicated time with your rotational supervisor every week. Towards the end of the attachment the rotational supervisor should do a mini-CEX with you. At the end of the attachment they will complete an evaluation form that will form part of your formative assessment.

¹⁰ See DRHM Fellowship Pathway Regulations section 5.1

Accreditation¹¹

The Division has a responsibility to ensure the clinical attachments meet your learning needs. This includes ensuring you see an appropriate range of conditions, have appropriate levels of responsibility and supervision and have dedicated time and resources for learning. All attachments must be taken in accredited sites.

The Division will recognise the site accreditation granted by another College for the training of their registrars. For example if an emergency department is accredited to train emergency medicine registrars by ACEM (Australian College of Emergency Medicine) the Division will automatically accept that they have the necessary supports in place to teach rural hospital medicine registrars.

However if a department is not accredited by another College the Division will undertake its own accreditation. This will apply to all rural hospitals and may apply to some smaller provincial hospital departments. Formal accreditation by the Division will occur once every five years. As part of this process we will seek your feedback on the quality of the learning experience at the completion of each attachment.

Don't let the accreditation status stand in the way of you organising a clinical attachment you think will provide you with useful experience. Ask if the department is accredited to train registrars in other branches of medicine. If they aren't then let the Rural Programme Advisor know, and the Division will work with the hospital/department to arrange accreditation. An up-to-date list of rural hospitals that are currently accredited is available on the learning management system.

Rotational supervisors for rural hospital medicine runs and GP runs will be with vocationally registered RHGs and GPs who have undergone RNZCGP teacher training.

Arranging Clinical Attachments

Clinical attachments are funded by means of contracts between the Clinical Training Agency (Health Workforce New Zealand) and DHB's. Some base and rural hospitals already offer specific attachments for rural hospital medicine registrars. Many registrar and SHO runs around the country are suitable at training attachments and will attract the same Health Workforce New Zealand funding.

It is your responsibility to find jobs by applying for registrar and SHO posts in the normal fashion. **When you are applying for a job you need to inform your employer that you are a rural hospital medicine registrar.** You must also let the DRHM coordinator and your EF know your work intentions. This is so that the DHB, the Health Workforce New Zealand and the Division can make arrangements for the accreditation and funding of your post.

In Learning Zone, under the heading programme information a list of DRHM accredited rural hospitals is available. If you require any further information, please contact the DRHM coordinator.

¹¹ See DRHM Fellowship Pathway Regulations section 3.3

Overseas training

Overseas experience can form a valuable part of your training. Where it is clear overseas clinical attachments will meet your training needs they will be recognised by the Division. To ensure this is the case you should seek approval from the Division prior to taking up an overseas post.

Australian posts recognised as suitable by ACRRM and other Australasian Colleges for the training of their registrars will also be recognised by our training programme.

Paperwork

In order for the DRHM to support and guide your progress to Fellowship, it is imperative that you keep up with the paperwork. All forms are available in Learning Zone.

For every clinical attachment you must:

1. At the start of the attachment give your rotational supervisor a copy of the introduction letter.
2. Sit down with rotational supervisor and work out what your learning goals are for the attachment and write these into your reflective portfolio.
3. Email the DRHM coordinator and tell them what run you are doing, how long it is and whether or not you have any doubts about the accreditation status of that run. Even better, do this for all your runs as soon as you have organised them.
4. Email the DRHM coordinator, the name and contact details of your rotational supervisor as soon as you know who they will be.
5. At roughly three monthly intervals arrange for your rotational supervisor to do a Mini-CEX* with you. Ensure that their comments are included.
6. At the end of the attachment give your rotational supervisor a copy of the "End of Attachment Registrar Assessment"* and ensure they complete it with comments and return it to you. Send a copy of your completed "End of Attachment Registrar Assessment" form to the DRHM coordinator.
7. At the end of the attachment complete the "Registrar Feedback"* form and send a copy of your completed form to the DRHM coordinator.
8. Sit down with rotational supervisor and review the learning goals for the attachment and record this in your reflective portfolio.
9. Copies of all these forms are contained in your portfolio or can be downloaded from the learning management system.

ONCE COMPLETED PLEASE RETAIN A COPY OF ALL THESE FORMS (*) IN YOUR PORTOLIO AND POST A COPY TO THE DRHM Coordinator

Portfolio

The portfolio consists of four parts.

1) Formal Reports

The first is a collection of the formal records associated with your training and should include all of the following:

- 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
- Documentation confirming participation (or results of assessments) from any other courses, conferences or training activities attended

It is the registrar's responsibility to check that all required information is provided prior to the Fellowship Assessment visit. The DRHM coordinator can assist you in collating your portfolio, if you have sent copies of all your formal records to the DRHM coordinator.

2) Reflective Portfolio

This second part of your portfolio is central to your training.

Why are you required to maintain a reflective portfolio?

Rural hospital medicine training is intentionally very flexible. This offers you considerable opportunities as a registrar to seek out the training opportunities that will best meet your learning needs. But at the same time you must take considerable personal responsibility for identifying your learning needs and planning your training.

Much of your training will be undertaken in a different context (the base hospital) to where you will eventually be working (the rural hospital). You need to consciously reflect on the difference.

The scope of rural hospital medicine is very broad. At the end of your training, you will not be an expert in managing every condition that will present to you. You will continue to learn and develop your knowledge and skills to meet the demands of the work you are currently undertaking throughout your career.

What is a reflective portfolio and what should it contain?

It is a written record that is regularly updated. The writing of it represents a form of 'conversation with self' that is enhanced by discussions with others, principally your Educational Facilitator, rotational supervisors and colleagues.

Start by developing a Training Plan. Do this in conjunction with your EF.

The **Curriculum** for the RHM registrar training programme will help you develop your training plan. The curriculum is available in Learning Zone.

- First identify areas of prior learning. What are the areas where you feel you already have adequate experience and / or qualifications and experience? Is further training in these areas really necessary? Decide what parts of the programme (academic and clinical attachments) you would like accredited and complete the recognition of prior learning form so that it can be considered by the Board of Studies and clinical leaders.
- Then identify your skills and knowledge gaps and from this your learning needs.
- Finally work out a programme of intended clinical attachments, academic qualifications and courses that will meet your learning needs and the requirements for Fellowship.

If possible you should review the health service gaps that exist in the community you intend to eventually work in. This review will include both the health needs of that community and skill gaps in the existing medical team. You should consider these when developing and reviewing your training plan.

Add to your reflective portfolio frequently. The minimum should be an entry at the start, the midpoint and the end of each clinical attachment. The entries need not be long but should show evidence that you have thought about your learning. Be creative, capturing the reflection, deliberation and insights that are the essence of professionalism

At the start of the attachment review your learning needs and after discussion with your new rotational supervisor decide on what you want to achieve during that attachment (your learning goals).

With each later entry:

- Think about the *experience* – what cases you managed, skills you learnt, what you observed your supervisors doing.
- What have you *learnt* – how will your practice change in the future as a result of these experiences?
- How have your *learning needs* changed, where do you need to go next?
- What future *learning opportunities* do you need to seek? Make appropriate changes to your training plan

Will the reflective portfolio form part of the formative assessment?

Yes. You and your EF should use the reflective portfolio as an important formative assessment tool. It gives you the chance to reflect on feedback from teachers and peers. By providing the opportunity to review and reflect on your progress, and

through this, to reset objectives and goals, it will be possible to monitor and shape your learning.

Will the reflective portfolio form part of the summative assessment?

Yes and No. At the time of your assessment visit the assessor will discuss your portfolio with you. They will assess the process. They will look for evidence that you can identify your learning needs and take the appropriate steps to meet with them. But they will not assess the contents of the portfolio. They will not use it to determine whether or not you have met your learning needs or attained the skills and knowledge needed for Fellowship, other than the skills to reflect on your practice.

3) Skills Logbook

The Clinical Skills Logbook is the third and more prescriptive part of your portfolio. It details the key psychomotor procedural skills, and the level of competency required for independent rural and remote practice.

Your rotational supervisor will sign off in the skills logbook when they have observed you satisfactorily complete a skill.

You should review your skills log book when you meet with your EF and make plans to remedy any gaps prior to the completion of training.

It is important to keep all the documentation in a safe place as you will need to show you have met all the requirements for Fellowship.

4) Multi-Source Feedback

Multi-Source Feedback (MSF), also known as the 360⁰ assessment, is a well-recognised, validated and reliable measure used widely across the globe in a variety of educational settings. The specific tool we use is a web based one developed by the Royal College of Physicians. Your performance in professional contexts will be independently assessed by a range of individuals you have working relationships with, including medical colleagues, other clinical colleagues, administrators and patients. When used formatively, the MSF process provides a focus for discussion and learning. MSF will assess interpersonal and professional behaviour and development. MSF will be undertaken within the last six months of the training programme.

Assessment¹²

The purpose of assessment is twofold. Firstly it provides you with feedback that you can use to identify areas in which you are strong and areas which will benefit from further learning (formative assessment). Secondly it allows us to ensure you have met the standard needed for Fellowship and vocational registration in rural hospital

¹² See DRHM Fellowship Pathway Regulations section 3.7

medicine (summative assessment). Some of the assessment tools are formative, some are summative and some are both.

There is a strong emphasis on modern competence based assessment. We are more interested in how competently and safely you practice rural hospital medicine, than your ability to memorise a lot of factual knowledge.

The assessment process will largely remain 'in step' with the ACRRM assessment process. This reflects the common origins of the curriculum and the intention to develop mutual recognition of qualifications. ACRRM has invested heavily in developing a series of modern, competence based assessment tools for rural practice.

Each domain is assessed by several tools, in order to improve the sensitivity and reliability of assessment.

Assessment Tools

External Assessment

The Division relies on the universities and other colleges to assess candidates for the components of the training programme run by them. You need a pass mark (B -) in all the required university papers.

MiniCEX

The Mini Clinical Evaluation Exercise (Mini CEX) is a practice-based assessment where different assessors (on different occasions) observe you at work. It is an important formative assessment tool but also forms part of the summative assessment.

You need to get your Rotational Supervisor to undertake four MiniCEX examinations a year, normally one every three months except in the elective year. They will observe you taking a history, conducting an examination, and then ask about diagnosis and management. They will assess competency in communication skills, history-taking, physical examination, clinical judgment, organisation and efficiency, and overall clinical competence. They will provide you with immediate feedback and complete a rating form. Please ensure that your rotational supervisor includes comments for all the comment boxes of your MiniCEX form.

You need to keep the results of your MiniCEX examinations in your portfolio (send a copy to the DRHM coordinator) and review them with your EF.

You are required to have passed twelve MiniCEX examinations in order to qualify for Fellowship. Any outstanding MiniCEX examinations will be undertaken at the time of the summative assessment visit.

Two MiniCEX's done during a GPEP year one period will be able to count towards the compulsory twelve assessments, as long as the assessor is a RNZCGP teacher.

The twelve Mini CEX's are a crucial tool for the Fellowship Assessor when you undergo your final Fellowship visit, so please ensure that all your MiniCEX's are filled in and completed with as many details as possible by your Rotational Supervisor/Assessor.

Reports from rotational supervisor

Your rotational supervisor will be asked to complete a report on your performance at the completion of each run. These are part of the formative assessment and should be reviewed in conjunction with your EF.

StAMPS

Structured Assessment using Multi Patient Scenarios (StAMPS) is a new OSCE / viva-type examination developed by Professor Tim Wilkinson from the Christchurch School of Medicine, for ACRRM. It provides rural and remotely located candidates with a reliable, affordable, flexible, acceptable and contextually relevant assessment method. It is designed to assess, at a distance, your ability to discuss, within a realistic period of time, the implications arising from several defined clinical scenarios. Candidates remain in one place while the examiners (all in one location) rotate around the candidates. StAMPS assesses learning outcomes such as communication and interpersonal skills, diagnostic reasoning skills, flexibility in response to new information, management of complex problems in the rural and remote context, and developing an appropriate management plan that incorporates relevant contextual factors.

StAMPS will be undertaken no earlier than twelve months prior to the end of training. There are limited places available for the StAMPS examination. Please notify the DRHM coordinator and clinical leaders, if you intend to sit the StAMPS examination before you apply online.

Most registrars choose to travel to Australia to do the exam in person, while others prefer to undertake the exam in New Zealand by videoconferencing.

Fellowship Assessment Visit

The final assessment for the programme is an assessment visit. This visit will normally take place in the final two months of your last clinical placement (and will not take place before this). The visit cannot be undertaken until all programme requirements (with the exception of any miniCEX examinations that can be conducted on the day, and the final rotational supervisor report) have been completed.

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

- Registrar portfolio, including all of the components listed on p.22
- An interim report from the rotational supervisor of the clinical placement which you are employed at the time of the visit
- StAMPS results
- Multi-source feedback results.

The visit is undertaken by a Fellowship Assessor appointed by the BOS. The assessor will undertake any outstanding miniCEX examinations, review your portfolio and skills logbook to ensure all elements in them have been completed to a satisfactory standard and review your MSF and StAMPS.

The assessor will either recommend to the BOS that you have met the standards required for Fellowship, or advise which aspects of your practice must be improved in

order to reach these standards. If the BOS decides it is necessary, a second assessment visit will take place.

Poor Performance

Your Educational Facilitator (EF) will inform you if you are not making satisfactory progress in the programme. They will work with you to develop a remedial course of action. Education is the initial focus of assistance.

In the unlikely event remedial action fails the EF will inform the BOS that the registrar is not meeting the requirements of the training programme.

A registrar may at any time appeal against a decision they receive regarding any part of the programme directly administered by the Division by writing to the DRHM coordinator in the first instance.

Candidates can appeal against decisions made by the universities or other colleges using the appeal mechanisms of those bodies.

You are welcome to request assessment summary sheet for more info from the DRHM coordinator.

The NZ Rural GP Network and Conference

All rural hospital generalists including registrars are welcome to join the NZ Rural GP Network. Membership is also open to rural GPs and nurses. You can join online at www.rgpn.org.nz.

Attendance at the Rural GP Network conference is part of the training programme and you should make every effort to attend. This conference is the one national meeting that rural hospital doctors try to attend each year. It includes sessions aimed at our CME needs as well as the Division of Rural Hospital Medicine AGM and Dinner. It is likely to be preceded by sessions specifically for RHM registrars.

It is generally a very social event and the chance to meet others in the rural hospital community.

The NZ Rural GP Network conference is usually held over the last weekend in March or in April. More details to be found on the NZ Rural GP Network website www.rgpn.org.nz

Voluntary Bonding Scheme

The government offers scholarships for RHM registrars. This used to apply only to registrars working in some hard to staff DHBs and Hospitals. It has however been extended to apply to RHM registrars working in any community. Check out the website.

Further information can be found at www.moh.govt.nz/bonding. Applications close May each year.

Fees

Like other hospital based vocational training programme the rural hospital medicine programme is funded by Health Workforce New Zealand (HWNZ). HWNZ has contracts with DHBs that cover the costs of your training such as release time for formal and informal teaching, consultant 'slow down time' that occurs as a result of teaching and external costs such as university and college fees.

In 2017 the Division is charging a full time programme fee of \$4775 + GST per annum for its contribution to your training plus \$1351.05 which gives you associate membership of the RNZCGP and the D RHMNZ. The fees may be subject to change.

Please refer to The University of Otago and The University of Auckland for fees of academic papers.

In most cases, these fees can be legitimately claimed back from your employer.

Dual Fellowship training pathway

Registrars who are undertaking a dual Fellowship in rural hospital medicine and general practice may claim up to 18 months against 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 DRHM clinical experience requirements for compulsory 6 months in rural general practice, 3 months of recommended elective experience and 9 months of elective experience.¹³

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 **rural general practice**¹⁴
- **TWO runs** (12 months FTE) in **rural hospital medicine** undertaken at different sites. The rural hospital attachments must be approved by the Division.¹⁵ One of the rural hospital runs must be in a Level 3 rural hospital.^{16,17} One rural hospital run is usually taken early in the training programme, the other is undertaken at the end of training.
- **One run** (six months FTE) in **general medicine** (three months may be cardiology or respiratory medicine)
- **One run** (six months FTE) in **emergency medicine** (3 months may be orthopaedics)
- **0.5 run** (three months FTE) **paediatrics**.
- **0.5 run** (three months FTE) **anaesthetics / intensive care**
- A further **one run** (12 months FTE) in general practice, during which the general practice Fellowship assessment visit is conducted¹⁸.

DRHM coordinator

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Programme Leader GPEP

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¹³ Information about the dual pathway requirements is available on Learning Zone, or through the DRHM Coordinator.

¹⁴ The recognition of a placement as being rural is at the discretion of the Division. If you are in any doubt, contact the Division Coordinator for advice.

¹⁵ The approval process is through communication with the Division Coordinator, in the first instance.

¹⁶ A document listing the rural hospital levels is available on the Learning Zone, or through the DRHM Coordinator.

¹⁷ One of the rural hospital runs is normally undertaken at the end of the training period to accommodate the Fellowship assessment visit process.

¹⁸ Normally undertaken after 30 – 36 months of training.

