Postgraduate Medical Council of Victoria

National Accreditation Framework for General Practice and Community Settings Project

Final Report

Revised May 2009

A national project supported by the Medical Training Review Panel

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Acknowledgment:
This project was undertaken by the Postgraduate Medical Council of Victoria Inc. and made possible by a project grant from the Medical Training and Review Panel.

Additional copies of the report:
A copy of this report is available from the Confederation of Postgraduate Medical Councils (CPMEC) website at: www.cpmec.org.au

Glossary

Accreditation	The process by which certification is granted to an organisation which meets the standards and criteria upon which it is reviewed
ACCRM	Australian College for Rural and Remote Medicine
ACFJD	Australian Curriculum Framework for Junior Doctors
ACSQHC	Australian Commission on Safety and Quality in Health Care
AMC	Australian Medical Council
CPMC	Committee of Presidents of the Medical Colleges
CPMEC	Confederation of Postgraduate Medical Education Councils
DCT	Director of Clinical Training; a clinician responsible for overseeing education of prevocational doctors
Feeder hospital	The hospital providing a prevocational doctor on rotation to a general practice
HMO	Hospital Medical Officer; relates to the industrial agreement and salary level rather than years of experience and training following graduation; also called JMO or RMO in other states
IMET	Institute of Medical Education and Training
Intern	Doctors in the first postgraduate year of training after graduation from medical school; also called PGY1
JMO	Junior Medical Officer, usually PGY 1-3 (see also HMO and RMO)
MTRP	Medical Training Review Panel
PGPPP	Prevocational General Practice Placements Program
PGY	Postgraduate year

PGY1	The first postgraduate year of training after medical school graduation; called internship or intern year
PGY2	Postgraduate Year 2; second postgraduate year of training immediately following intern year
PGY3	Postgraduate Year 3
PMAF	Prevocational Medical Accreditation Framework
PMC	Postgraduate Medical Council
PMCQ	Postgraduate Medical Council of Queensland
PMCSA	Postgraduate Medical Council of South Australia
PMCV	Postgraduate Medical Council of Victoria (Incorporated)
PMCWA	Postgraduate Medical Council of Western Australia
PMIT	Postgraduate Medical Institute of Tasmania
Prevocational doctor	A medical practitioner in their early years of clinical practice (PGY1/2/3/4+) who has not yet entered a vocational training program
RACGP	Royal Australian College of General Practitioners
RMO	Resident Medical Officer, usually PGY1-3
Rotation	A defined period of employment on a unit/department/medical centre
RRAPP	Rural and Remote Area Placements Program
RTP	Regional Training Provider
Standards	The specific objectives, processes or procedures to be achieved and the rationale for the objectives to provide quality education to prevocational doctors.
SIT	Supervisor of Intern Training; a clinician responsible for overseeing the intern training program in hospitals

Survey Team	A group of Surveyors chosen for their individual expertise to undertake a Survey Visit of a health service/facility.
Surveyor	An individual trained in all aspects of the Accreditation Program who acts on behalf of the PMC or equivalent to visit a health service/facility and assess its compliance with the Standards.

Executive Summary

This report summarises the progress made in the National Accreditation Framework for General Practice and Community Settings Project. The project arose out of a need to ensure consistency between the training prevocational doctors receive in general practice and community settings, and the public hospital sector. This topic is significant given the expected increase in the number of medical graduates and the need to find high-quality training posts for them, where they can gain a broad range of clinical skills.

The project sought to document consistencies and inconsistencies between general practice and hospital accreditation standards and requirements for education and supervision. This was achieved by reviewing the accreditation standards and training curricula of the Royal Australian College of General Practice (RACGP) and the Australian College for Rural and Remote Medicine (ACRRM). The Colleges accreditation standards were mapped to those of the Postgraduate Medical Council of Victoria (PMCV), and the curricula were mapped to the Australian Curriculum Framework for Junior Doctors (ACFJD). This approach enabled the formulation of a number of recommendations regarding the development of national standards and accreditation criteria for junior doctors training in general practice and community settings in Australia, which will be forwarded to the Confederation of Postgraduate Medical Education Councils (CPMEC).

The accreditation standards of the Royal Australian College of General Practice (RACGP) and the Australian College for Rural and Remote Medicine (ACRRM), and the accreditation standards and survey instruments of each state postgraduate medical council (PMC) (or equivalent) were reviewed. This allowed similarities and gaps between general practice and hospital accreditation standards and education and supervision requirements across the country to be documented. Considerable similarity was found between the accreditation tools and survey instruments used by the PMCs (see sections 3.2.2 and 3.2.3). There was also a large degree of overlap between the accreditation standards of the RACGP, ACRRM and the PMCV, however, because the former are primarily tailored to the Colleges' vocational training programs they do not address a number of issues relevant to the training of prevocational doctors. Ensuring the integration of the general practice term within the overall prevocational training program, and continuity of educational experience and support for junior doctors while on a general practice rotation (see Recommendation 6) are important areas that need to be addressed within the prevocational accreditation standards. The postgraduate medical councils are the bodies with the expertise to ensure appropriate coordination and oversight of prevocational training, however, it will be necessary for them to work with the Colleges to enhance the development of general practice rotations for junior doctors and ensure they fit well within an overall prevocational training program.

A tool was developed to accredit prevocational general practice training posts and was piloted in two general practices in Victoria. This tool was based on the standard accreditation survey instrument used by the PMCV, but included a number of accreditation criteria of specific relevance to general practice and addressed the issues identified during the review of the various accreditation standards. The tool was found to be acceptable by the general practice supervisors and accreditation team members involved in the pilots. The GP supervisors also indicated that the tool and documentation required were sufficiently different from accreditation through the RACGP, ACRRM and Regional Training Providers (RTPs) as to prompt beneficial review of their supervisory and educational programs. A report on the outcomes of the pilot visits and a set of proposed accreditation standards will be submitted to

the National Technical Group to inform and assist with the development of the overall Prevocational Medical Accreditation Framework (PMAF) for junior doctors.

Learning opportunities available to prevocational doctors within general practice were identified by mapping components of the RACGP and ACRRM curricula to the Australian Curriculum Framework for Junior Doctors (ACFJD). Although only a small number of the Colleges' curricula statements were mapped, their compatibility with the ACFJD is clear. The results of the preliminary mapping also establish a format and protocol which can be used to further map the curricula. A position description for prevocational General Practice rotations was developed, which follows the format of the position descriptions for other core prevocational rotations in Victoria offered to junior doctors during their prevocational training, and matches possible learning objectives for general practice to the ACFJD. This position description will be beneficial for junior doctors to help clarify their expectations of general practice rotations, and for general practice supervisors to help align the training they provide with the overall prevocational program.

This report proposes ten recommendations for appropriate action of the Confederation of Postgraduate Medical Education Councils. The intention of these recommendations is to ensure that there is consistency between the standards that govern prevocational general practice and other prevocational training rotations, and that these standards reflect the needs of junior doctors (as identified by the CPMEC), and also be acceptable to the RACGP, ACRRM, training providers and Fund Holder Organisations. The recommendations also reflect the need for ongoing monitoring, evaluation and review, and for these processes to be adequately resourced.

Recommendations:
It is recommended that Confederation of Postgraduate Medical Education Councils act on the following:

Recommendations	**Report Section**
1) That CPMEC ensures all prevocational general practice and community rotations are consistent with the principles of the Prevocational Medical Accreditation Framework.	3.2.1
2) That CPMEC continue to advocate that PMCs be nationally recognised as the organizations with the expertise and responsibility for the accreditation of all prevocational training positions including general practice and community rotations.	3.2.2
3) To minimise the accreditation burden, CPMEC work with the Royal Australian College of General Practitioners, the Australian College for Rural and Remote Medicine, and other relevant Fund Holder organisations to: • exchange information relevant to the accreditation of GP training practices with respect to prevocational training positions, • explore the possibility of sharing accreditation visits, • articulate similarities and differences between the PMC and other accreditation processes, and • explore possibilities for recognition of prior accreditation status granted by the respective accreditation bodies.	3.2.4

Recommendations (cont)	Report Section
4) That CPMEC explore with the relevant Colleges the possible development of a process to deliver a common pool of accreditation assessors who can work across the training continuum. These assessors should be: • familiar with the requirements of the different organizations, • able to participate in accreditation visits as the representative of more than one organization, and • able to facilitate effective communication between relevant organisations.	3.2.4
5) That CPMEC explore with the National PGPPP Advisory Committee the development of processes that enhance the involvement of Fund Holder organizations (such as Regional Training Providers, Divisions, Rural Clinical Schools) in partnering general practices through the accreditation process.	3.2.4
6) Ensure that accreditation standards for prevocational general practice rotations assess: • coordination of the management of prevocational doctors by the feeder hospital, general practice and Fund Holder organisation (e.g. regional training provider), • the integration of JMOs learning plan / objectives in the general practice rotation into their overall experience as a junior doctor, • the feedback process for JMOs about their experiences while on their general practice placement, and • the mechanisms for ensuring the continuity of support for prevocational doctors while in the general practice rotation and away from their parent hospital.	3.4
7) That CPMEC promote the Australian Curriculum Framework for Junior Doctors and the Prevocational Medical Accreditation Framework to general practitioners who provide training to prevocational doctors.	3.5.2
8) That CPMEC continue to evaluate the accreditation of prevocational general practice training posts through the implementation of the project recommendations.	3.5.2
9) That CPMEC be provided with resources to undertake this work in conjunction with the Postgraduate Medical Councils and the relevant Colleges.	3.5.2
10) That CPMEC affirm the benefits of providing junior doctors with training rotations in general practice and extended primary care and work towards enhancing prevocational training opportunities in the primary health care sector.	4.1

Final Report

1. Introduction

It is estimated that the number of domestic medical graduates will expand by 81% between 2005 and 2012 (Pearce, et al., 2007), consequently there is an increasing demand to deliver medical education in general practice and community-based placements. Prevocational doctors have had the opportunity to work in general practice for a number of years, through the Prevocational General Practice Placements Program (PGPPP) and its predecessor program the Rural and Remote Area Placements Program (RRAPP). These placements were initially at the level of PGY2 and PGY2+. Whilst the Colleges have developed extensive curricula and processes for quality assurance and improvement, and the accreditation of training, they differ from those of the postgraduate medical councils which were originally designed for intern training positions within public hospitals.

The impending requirements for the national registration and accreditation of health professionals, and work undertaken by the CPMEC in developing the ACFJD, both highlight the need to align general practice training curricula, governance structures and accreditation criteria with those of the public hospital sector. Examining general practice placements for prevocational doctors provides insights into both the vertical and horizontal requirements for accrediting training positions. The educational and support needs of prevocational doctors undertaking general practice rotations should be seen as part of a vertical continuum of training within general practice from undergraduate to the continuing professional development of vocationally registered practitioners. Similarly, the different requirement of prevocational doctors in general practice and community placement as compared with those working in the hospital sector provides insight into a horizontal continuum stretching between health sectors. Developing a comprehensive understanding of the distinct, yet interlinked training, governance and accreditation requirements of these two spectrums will advance the project of developing appropriate national training, accreditation and registration standards.

2. National Advisory Committee

To ensure alignment with the work being undertaken by CPMEC and within other states, a National Advisory Committee was established to provide guidance for this project. Membership was drawn from the National Technical Group of CPMEC, state postgraduate medical councils, ACRRM, the RACGP, and Regional Training Providers. The Committee also included a junior doctor who had recently undertaken a prevocational general practice rotation, and the Chair of the General Practice Students Network (University of Melbourne). The Advisory Committee met by teleconference on four occasions. Committee members assisted with the identification of key issues relevant to the project and reviewed the work undertaken as part of the project, including the revised accreditation tool. In addition, Committee members were contacted individually to provide information, advice and resources, according to their area of expertise. Ms Carol Jordon and Dr Rodney Fawcett also made significant contributions to the written report. Members of the National Advisory Committee are set out below:

Table 1 NAC Members

Name	Organisation
Dr Rod Fawcett	Chair, PMCV Accreditation subcommittee/Director of Medical Education and Training, Barwon Health (Chair)
Ms Carol Jordon	Executive Officer, PMCV
Dr Peter Stevens	Principal, Heyfield Medical Centre
Dr Clare Murtagh	JMO (Intern), Barwon Health
Ms Penelope Watson	Accreditation Manager, PMCV
Mr Joe Anthony Rotella	Chair, General Practice Students Network
Dr Jagdishwar (Jag) Singh	CPMEC, General Manager
Prof Dick Ruffin	Chair, PMCSA
Prof Lou Landau	Chair, PMCWA
Ms Sheree Keech	Coordinator, PMCWA
Ms Debra LeBhers	Chief Executive Officer, PMCQ
Dr Morton Rawlins	Director of Educational Services, RACGP
Ms Marita Cowie	Chief Executive Officer, ACRRM
Ms Trish Johnson Smith*	Acting PGPPP Coordinator, ACRRM
Dr Nick Cooling	PMIT nominee; Director of Training, General Practice Training Tasmania
Dr Susan Paul	IMET representative, IMET Accreditation Committee, member IMET PGPPP Working Group
Dr Emily Mauldon	Project Manager

*Replaced Ms Leanne Renfree, former PGPPP Coordinator, ACRRM.

3. Achievement of project aims and milestones/outcomes

The project has successfully achieved the stated aims and met, or made significant progress towards, the project milestones and outcomes.

3.1 Achievement of Project Aims

The agreement requires the Postgraduate Medical Council of Victoria to report on the achievement of the aims of the project. The specific aims of the project were to:

- map the training opportunities in general practice to the Australian Curriculum Framework for Junior Doctors (ACFJD),
- document the training opportunities available to prevocational doctors by reviewing the accreditation standards and training curricula of the Royal Australian College of General Practice (RACGP) and the Australian College for Rural and Remote Medicine (ACRRM),
- document consistencies and inconsistencies between general practice and hospital accreditation standards and requirements for education and supervision,
- develop an accreditation instrument and pilot the instrument in general practice and community settings in Victoria and another State,
- report on the outcomes of the pilot visit and set of proposed accreditation standards for prevocational training in general practice and community settings, and
- make recommendations on the development of national standards and accreditation criteria which can apply to junior doctors training in general practice and community settings in Australia to relevant stakeholders (including the CPMEC).

In order to achieve these aims it was proposed that the following activities would be undertaken:

- a review of the accreditation standards in each State, and the standards and training curricula offered by both the Royal Australian College of General Practice (RACGP) and the Australian College for Rural and Remote Medicine (ACRRM),
- an analysis of the similarities and gaps between general practice and hospital accreditation standards, and education and supervision requirements,
- an accreditation tool was to be developed and piloted in general practice and community settings in Victoria and another State (to be determined in consultation with CPMEC), and
- a report on the outcomes of the pilot visits and a set of proposed accreditation standards was to be submitted to the National Technical Group to inform and assist with the development of the overall Prevocational Medical Accreditation Framework (PMAF) for junior doctors.

Two of these tasks were not fully completed, or completed as originally planned. The training curricula of the RACGP and ACRRM are extensive and it was not possible within the timeframe of the project to fully review and map these curricula (discussed in more detail in section 4.1). Secondly, although it was originally planned to pilot the tool in two states, because of the time-constraints, pilot accreditation visits only took place in Victoria. This difficulty was primarily due to the short window of time available during which piloting could take place. However, changes to the PGPPP funding announced during the project also impacted on the recruitment of general practices for the pilot (discussed further in section 3.5). Notwithstanding the partial completion of both of these activities generated sufficient data to meet the project requirements and to justify the project recommendations.

The project facilitated interaction between state PMCs and relevant stakeholders across the continuum and enabled the development of a set of accreditation standards to be put forward to the CPMEC. The National Advisory Committee involved a range of stakeholders, and there was consultation at each stage of the project with committee members. In addition to committee members, the project manager consulted with other staff from the various state postgraduate medical councils, the RACGP, ACRRM and two Regional Training Providers (getGP and General Practice Training Tasmania) in relation to different elements of the project.

It was a requirement that the project contribute to the development of the Prevocational Medical Accreditation Framework for junior doctors, and to the education and training of prevocational doctors through articulating standards for the appropriate supervision and educational requirements of prevocational general practice rotations. This requirement has been achieved through the production of an accreditation survey tool designed specifically to help advance the Prevocational Medical Accreditation Framework. The tool has been validated through pilot accreditation visits, and has received thorough review by members of the PMCV Accreditation Subcommittee and the project National Advisory Committee (including members of CPMEC's National Technical Group). Commentary was also provided on the tool by the New South Wales member of the National Advisory Committee who was involved in an accreditation visit to a general practice in NSW. Because of the extensive review it received, we are confident the accreditation tool will be a useful contribution to the development of the

processes and procedures that support the Prevocational Medical Accreditation Framework.

3.2 Achievement of project milestones/outcomes

3.2.1 Literature Review: Current developments in designing accreditation processes.

A literature review was undertaken and three different types of source material were identified as being relevant to this project. These were scholarly articles relating to the training; the provision of training positions and the assessment of junior doctors; reviews, discussion papers and theoretical literature detailing good accreditation practice and a range of specific accreditation standards and survey instruments. Table 2 below summarises the results of the structured literature search.

1) Scholarly articles:

A structured literature search was conducted using the search facilities of 'Web of Knowledge'. The search was limited to English language journals and checked literature dating from 2002 (5 year limit, given some journals do not provide immediate web access to current issues). The following terms were combined in order to identify relevant literature:

Table 2 Results of the structured literature search

Search term AND	Search term	No. found	No. saved after initial review
Prevocational*	Assessment*	18	3
	Standard*	13	3
	Accreditation*	1	1
	Placement*	1	1
	Education*	0	0
Junior doctor*	Assessment*	Hundreds identified – not systematically reviewed	
	Accreditation*	7	2
	Placement*	9	1
	Training*	306	48

These search results were collated, a preliminary assessment undertaken and a subset of 25 articles were selected for review. The majority of this literature was comprised of reviews, editorials, discussion papers and letters that detailed existing and proposed characteristics considered necessary for safe and high quality training for junior doctors (for example Paltridge, 2006, Crotty, 2005, Dowton, 2005, Dowton et al., 2005, Vickery & Tarala, 2003, Van Der Weyden, 2007, and Reid, 2004). Of the remaining research articles most used qualitative methods such as focus groups, interviews and semi-structured questionnaires to elicit the attitudes of junior doctors (or those providing training) to different clinical rotations, and to what constituted a positive or negative training experience. The sample sizes used for these studies were typically small, for example, Mugford et al., (2001) who report on two interns placed in rural general practice training posts, or Cantillon & MacDermott (2008) who interviewed interns and other medical staff regarding the general practice training positions offered through one

particular hospital training program. A number of studies reported on interventions in the form of program development and evaluation but controls were not used and qualitative criteria (such as JMO attitudes) were used as indices of success or failure (for example Martin et al., 2007, Tolhurst, 2006). No research articles were identified that evaluated particular accreditation frameworks or processes as they applied to the training of junior doctors. Taken collectively, the limited body of scholarly literature identified by using the above search strategy, outlines a range of practical and theoretical issues regarding the provision of medical education that could contribute to the development of an accreditation framework. This literature did not, however, provide guidance as to how the themes identified could be translated into accreditation standards and criteria, nor evidence of the effectiveness of accreditation processes. These issues were, however, well canvassed within reviews, discussion papers and theoretical literature on accreditation and quality improvement (see below).

The disjunction between the themes identified within the scholarly literature, the way they are taken up within accreditation standards, and how effective accreditation processes are at tracking and improving the provision of quality training, is indicative of the finding that there is limited robust evaluation of accreditation standards and processes (ACSQHC, 2003, pp 11-12 and 2006, p.14, Greenfield & Braithwaite, 2007b p.13). Further, the contention that the evaluation of accreditation processes usually involves case reports was borne out in the papers reviewed for this project (ACSQHC, 2006 p.14). Notwithstanding this, because of the highly context-specific nature of accreditation (with different standards and processes being adapted for different settings) case-study based evaluation is appropriate. In addition, best practice in healthcare accreditation stresses the need for continuous quality improvement, an inherently open-ended process where benchmarks and performance indicators are continually evolving (Heywood, 2007). For these reasons generating generalizable 'hard data' on the efficacy of particular accreditation processes or standards will continue to be challenging.

Some of the key features identified as contributing to positive experiences for prevocational doctors in general practice include:

- the wide range of patient presentations (Martin et al., 2007),
- opportunities to gain practical and procedural skills (Martin et al., 2007, Thistlethwaite et al., 2007)
- patient assessment and management skills (Martin et al., 2007) Thistlethwaite et al., 2007, Cantillon & MacDermott, 2008)
- communication skills (Martin et al., 2007, Thistlethwaite et al., 2007, Cantillon & MacDermott, 2008),
- balancing service provision and training (Martin et al., 2007, Vickery & Tarala, 2003, Cantillon & MacDermott, 2008),
- increasing responsibility and autonomy (Martin et al., 2007, Cantillon & MacDermott, 2008),
- effective coordination of stakeholders, including RTPs, GP supervisors, DCTs, and universities (Vickery & Tarala, 2003, Thistlethwaite et al., 2007, Rosenthal et al., 2004),
- social support and adequate networking with peers (Vickery & Tarala, 2003),
- nature and quality of supervision (Pearce et al 2007, Cantillon & MacDermott, 2008, Dick et al., 2007, Rosenthal et al., 2004, Crotty & Brown, 2007),

- culture of teaching practice (Pearce et al., 2007, Cantillon & MacDermott, 2008, Dick et al., 2007, Rosenthal et al., 2004) including;
- adequate infrastructure (Thistlethwaite et al., 2007, Dick et al., 2007, Crotty & Brown, 2007),
- adequate funding and administrative support (Vickery & Tarala, 2003), Pearce et al., 2007, Thistlethwaite et al., 2007, Dick et al., 2007),
- accommodation (Vickery & Tarala, 2003),
- space to practice (Pearce et al., 2007, Crotty & Brown, 2007),
- vertical integration of training (Pearce et al 2007, Thistlethwaite et al., 2007, Dick et al., 2007, Rosenthal et al., 2004).

One feature of the Australian literature on prevocational training in general practice is the extent to which it has been seen as a recruitment strategy, particularly for rural practice (for example Martin et al., 2007, Vickery & Tarala, 2003, and Mugford et al., 2001). Indeed, the Rural and Remote Area Placements Program (RRAPP) and subsequently the PGPPP, were developed with this specific objective in mind. A continuing emphasis on 'showcasing' general and rural practice to junior doctors may result in positive training experiences for them as GP supervisors and training organisations vie for potential vocational trainees.

2) Good practice in accreditation

Although there is limited scholarly literature relating specifically to accreditation standards and processes for prevocational training (as identified above) there is an extensive body of work relating to the accreditation of health services and professionals. For the purposes of this project the work completed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) provided an entry into the field. This includes an extensive literature review (2003), a discussion paper (2006), a major national review of safety and quality accreditation standards (2008a), and the development of a proposed alternative model for the accreditation of health services (2008b). The Australian Commission on Safety and Quality in Health Care is a peak body committed to the ongoing development and improvement of safety and quality across the health care system in Australia and through their program has supported the development of accreditation process in health. These resources are available from the ACSQHC website:
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-07
While this body of work does not address the accreditation of training for health professionals it is the current major public-sector initiative in relation to accreditation in health services.

Key features identified as being significant for the development of an accreditation process include:
- self-assessment, and external evaluation from trained peer reviewers or evaluation team,
- an evaluation of the findings by the accrediting body and opportunity for a response by the organisation being accredited,
- consistent application to all service providers,
- management by an accrediting body that is industry-based (or represented) and that has a degree of autonomy from direct government control,
- development of standards with expert and consumer involvement,

- outcome oriented, with clear and measurable objectives, and
- emphasis on continuous quality improvement (Mathews Pegg, 2003, p.6, see also Swerissen et al., 2000).

In 1996 the Australian Medical Council, in consultation with state Medical Boards, produced a booklet, *National Guidelines for Intern Training and Assessment.* The publication was the result of a request from the Australian Health Ministers' Conference in 1991 for advice on guidelines that would assist with clarifying appropriate circumstances for mutual recognition of different state internships. Requirements that were deemed necessary for such mutual recognition included that:

- an intern training has a structured program that encourages an appropriate balance between education and service components,
- the general goals and specific objectives of the intern training program are clearly articulated,
- practical processes are identified for achieving the goals and objectives,
- appropriate supervision is provided, and
- processes for both informal and formal assessment match the goals and objectives of the program (AMC, 1996, p.5).

Since it was established in 1998 the Confederation of Postgraduate Medical Education Councils (CPMEC) has had a strong focus on developing and implementing accreditation standards for prevocational training. The paper *Uniformity of Accreditation* (Marel & Harlen, 1999) built on previous work on training standards for prevocational doctors by extending the discussion to include the needs of junior doctors working at the level of PGY2 and above. The principles outlined by Marel & Harlen reflect broader requirements for accreditation of health services, but also included an emphasis on the educational needs of, and the importance of feedback from, junior doctors. They also acknowledge the importance of developing a consistent approach to accrediting medical education through aligning the basic requirements for accreditation with those identified by the specialist colleges. The paper discusses in very general terms the purpose of accreditation (to ensure and improve quality of clinical education and thus, patient care), structural and procedural issues (in relation to administration through the PMCs and health services providing training), and identifies particular requirements that accreditation processes should address. The principles and requirements identified in the 1996 AMC booklet and by Marel & Harlen were refined and expanded upon in the *National Training and Assessment Guidelines for Junior Medical Doctors* (see below), and continue to inform the development of the current Prevocational Medical Accreditation Framework.

The *National Training and Assessment Guidelines for Junior Medical Doctors PGY1 and 2* (CPMEC, 2003) set out guidelines for informing State based processes for the accreditation of prevocational training positions consistent with the broad aims of the prevocational years and to ensure that hospitals provide JMOs with sufficient experience, education, training and supervision to enable them to meet training program objectives. The state-based accreditation processes should:

- involve periodic on-site assessment by trained peer-reviewers,
- have the provision for monitoring standards between formal site visits,
- include criteria that are sufficiently detailed to identify non-compliance, and

- include opportunities for a hospital to address deficiencies and be re-evaluated for accreditation (CPMEC, 2003, pp 8-9).

Accreditation standards and criteria for prevocational training positions should include consideration of:

- organisation and administration of the training and education program,
- structure and content of the training and education program,
- supervision of junior medical officers,
- assessment of junior medical officers,
- feedback from junior medical officers about their programs and supervisors, and
- procedures for ongoing evaluation of the training program (CPMEC, 2003, p.8).

Key professional standards that outline best-practice in the accreditation of medical training include those of the United Kingdom Postgraduate Medical Education and Training Board (relevant because it relates specifically to the training of prevocational junior doctors) and the Australian Medical Council (relevant because it is the peak body with responsibility for determining appropriate standards for medical education, training and assessment for undergraduate and vocational training programs).

In July 2008 the UK Postgraduate Medical Education and Training Board released updated 'Generic Standards for Training' (PMETB, 2008). Standards were developed in each of the following domains:

- Patient safety,
- Quality management, review and evaluation,
- Equality, diversity and opportunity,
- Recruitment, selection and appointment,
- Delivery of approved curriculum including assessment,
- Support and development of trainees, trainers and local faculty,
- Management of education and training,
- Educational resources and capacity, and
- Outcomes.

These domains emphasise both the delivery of a high quality health service for patients, and the delivery of a high quality educational experience for junior doctors.

The Australian Medical Council has developed accreditation standards that address the requirements for delivery of high quality specialist medical education and training that cover:

- The context of education and training,
- Training program outcomes,
- Educational programs: curriculum content, teaching and learning, assessment of learning, and monitoring and evaluation of programs,
- Implementing the curriculum for trainees,
- Delivery and resource requirements for implementing the training program, and
- Continuing Professional Development (AMC, 2008).

The first draft of the Prevocational Medical Accreditation Framework (PMAF) released for comment in November 2008, is informed by, and consistent with, best practice and current developments in the accreditation of medical training. When applied to the accreditation of prevocational training posts the PMAF should, therefore, provide mechanism for monitoring and improving the quality of clinical education for junior doctors. For this reason it is recommended:

Recommendation 1:
That CPMEC ensures all prevocational general practice and community rotations are consistent with the principles of the Prevocational Medical Accreditation Framework.

3.2.2 Comparison of tools and methodologies used to accredit prevocational general practice rotations in the different states.

In order to ascertain how general practice rotations are accredited by the different states a survey was circulated requesting information and copies of accreditation tools. A copy of the survey and a summary of the responses are attached in Appendix 2.

While the various state-based standards differ in regard to the format, structure and specific criteria used, it is clear there is a significant degree of similarity between them (CPMEC, 2007, pp 18-26). Where differences exist they are largely attributable to the fact that each state is responsible for the development, revision and ongoing governance of their accreditation processes and standards. PMC accreditation committees are responsive to their local environments, including legislative and administrative requirements, the availability of supervisors, and the types of facilities, with the result that there is a degree of state-based variation. Notwithstanding this, there are close working relationships between the PMCs (which is also fostered through CPMEC), providing an ongoing forum for dialogue about prevocational medical education and training, including accreditation standards and processes. Consequently there is a high degree of consistency in the states' coverage of key issues identified in the *National Training and Assessment Guidelines for Junior Medical Doctors PGY1 and 2* (CPMEC, 2003, see above).

Where PMCs are involved with accrediting general practice/community settings, similar processes and standards are used by the different States, and, with a few exceptions, within the hospital sector.

The PMCs in Western Australia, New South Wales, and Queensland accredit all prevocational general practice training rotations. The Postgraduate Medical Council of Victoria (PMCV) has delegated authority from the Medical Practitioners Board of Victoria for intern accreditation functions; all general practice rotations offered at a PGY1 level are thus required to be accredited. The PMCV accredits PGY2 positions if such positions fall due by virtue of accreditation of the feeder hospital or if new GP practices gain accreditation and funding through the Prevocational General Practice Placements Program (PGPPP).

In South Australia the RACGP accredits' all resident medical officer placements in general practice when they are established and, together with ACRRM, are responsible for ongoing accreditation of PGY2 and PGY2+ positions. The Postgraduate Medical

Council of South Australia (PMCSA) is responsible for accrediting all PGY1 placements, including those offered through the PGPPP.

In Tasmania only PGY2 and 2+ positions are available through the PGPPP and practices that offer positions must be accredited to provide vocational training by the RACGP (for urban practices) or ACRRM (for rural and remote practices). No additional processes are used to accredit prevocational general practice rotations in Tasmania.

The Northern Territory PMC was in the process of being re-established during this project and was not formally surveyed; however, PMCNT have recently used the accreditation tools developed by IMET to accredit hospital based PGY1 positions.

In summary, where a prevocational general practice rotation is offered at a PGY1 level the state postgraduate medical council is the delegated authority responsible for accrediting the position. The responsibility for accrediting positions offered at PGY2 and above is less clear, with 3 state PMCs (W.A., N.S.W., and Qld) systematically accrediting all prevocational general practice rotations, two states (S.A. and Tasmania), not accrediting them, and one state (Victoria) moving towards assessment of all GP rotations from feeder hospitals that are being accredited. As the number of prevocational training posts in general practice and other community settings increase (as is anticipated with the pending increase in medical graduates) it is likely that the mix of PGY1 / 2 /2+ positions and the educational and vocational opportunities they afford will also change. The accreditation processes in each state are well established and (as discussed above) are subject to regular review through routine operational processes.

While a number of differences between the state accreditation tools and processes were noted, the project did not seek to determine the practical effects of those differences. It should be acknowledged, however, that accreditation of prevocational training posts is a dynamic process which is responsive to a range of local contingencies. Changes in health education (such as the expected increase in the number of graduates) and public health sector more generally (such as the national registration of health professionals) will need to be reflected in the accreditation process. The national PMAF is expected to provide a benchmark in relation to accreditation which should result in better articulation of intern training requirements and improvements in consistency between the states, thus allowing for national recognition of internships.

Because of their special expertise in developing and supporting the education and training requirements for prevocational doctors' and the need to explore opportunities to better integrate and coordinate training programs, the Postgraduate Medical Councils should continue to be involved with accreditation of prevocational positions, including general practice and community rotations. This involvement should be managed in a way that maximises cooperation of the CPMEC with the RACGP, ACRRM and other educational Fund Holder Organisations in order to reduce to burden of accreditation processes for general practitioners and accrediting organisations.

Recommendation 2:
That CPMEC continue to advocate that PMCs be nationally recognised as the organizations with the expertise and responsibility for the accreditation of all prevocational training positions including general practice and community rotations.

3.2.3 The different State accreditation processes and tools

Accreditation for general practice positions typically involves preliminary self-reporting by the general practice against an accreditation survey tool, presentation of subsidiary information (such as data on the demographic profile and cases-mix of the general practice, position description, outline of education and orientation program, etc), and a site visit by accreditation surveyors. There are normally two or three people on the survey team, including at least one clinician. While the time spent at a general practice is usually 1-2 hours, time is also required for preparation and completion of paperwork and for travel to the (often rural and remote) general practices. The survey team members will usually spend ½ to one day conducting the visit, and may require an overnight stay. A similar time commitment is involved with conducting accreditation visits for hospital-based training positions, however it should be noted that training hospitals usually support multiple training positions whereas a general practice will have only one or two prevocational positions, making the cost of accrediting general practice training positions relatively more expensive than hospital positions.

Following the site visit a survey report is submitted for consideration by the relevant PMC committee (such as an Accreditation Committee) and is sent to the training practice for response. The report will make recommendations on the accreditation status, the length of each term/rotation and may identify actions relating to planning, implementation or quality improvement measures which the practice is asked to address. A final report is sent to the relevant state medical board for endorsement. Positions can be accredited for a maximum of three years.

The project required that the tools used by each state to accredit general practice rotations be reviewed. The Postgraduate Medical Council of Victoria, and the Institute of Medical Education and Training (IMET) have modified their accreditation tools to better suit the needs of general practice. In Victoria this has involved removing criteria that is specifically relevant to hospital services and collection of hospital-specific data.

The Postgraduate Medical Council of South Australia (PMCSA) has developed a template to be used during general practice accreditation visits which addresses key areas that have the potential to differ between hospital and community settings. These are the provision of supervision, the experience of the JMO, the formulation of learning goals that are consistent with the ACFJD and mechanisms for pastoral care.

Although Western Australia and Queensland have not adapted their tools specifically for general practice rotations, surveyors are reported to be conscious of the differences between accrediting hospital and general practice/community training posts. General practice staff are advised not to complete sections of the accreditation surveys that they believe are not relevant to them, and surveyors modify the questions asked during a visit and will tailor the written report, to suit the nature of the practice. A key assumption in this process is the belief that core accreditation standards for prevocational doctors are applicable across a range of training contexts. This assumption is also reflected by states PMCs that have developed accreditation tools specifically for general practice training rotations. These tools are based on the core accreditation standards but also include specific criteria relevant to general practice (such as the collection of information relating to the practice profile and relation to feeder hospitals), or the challenges of

delivering training outside a hospital setting (such as the integration of training experience within the overall prevocational training program).

Because the role of ACRRM and the RACGP in accrediting and otherwise supporting the provision of prevocational training in general practice, the PMCs were asked about the nature of their collaboration with these Colleges. None of the PMCs have formal processes in place for sharing accreditation documentation or visits with RACGP or ACRRM. The standard General Practice training program is three years; the first year of this program is the hospital based year. The PGY2/3 posts accredited by the PMCV can be counted towards the first 12 months of the General Practice training program. For this reason the PMCV provides a list of PGY2/3 accredited posts that it has reviewed to the RACGP each year.

3.2.4 Challenges of accrediting general practice rotations

When the state PMCs were asked whether there were any particular or unexpected challenges associated with accrediting prevocational general practice rotations, three issues were identified. These were:

1) determining appropriate standards for supervision,
2) aligning expectations of different stakeholder organisations, and
3) persuading general practices' of the value of accreditation by a prevocational education and training body.

Both the NSW Institute of Medical Education and the Postgraduate Medical Council of Victoria have identified instances where their own expectations of the appropriate level of supervision for prevocational doctors who provide on-call services differed from the GP supervisors, and the RACGP. The RACGP guidelines for the supervision of prevocational doctors, state that supervisors must be present while PGY1 doctors attend home visits, including services provided while on-call. RACGP requires that when PGY2 doctors conduct home visits or provide on-call services the assessment and management of all patients are later discussed with the supervisor (RACGP, 2007, pp 8-9, standards 5d and 6d). ACRRM standards state that 'the supervisor, or delegated supervisor, must be physically present *or available within 10 minutes* to be able to provide physical review at any place where the PGPPP doctor provides care' (ACRRM, 2008, p.3, standard 4.1, italics added). This allows for a PGY1 doctor to undertake a consultation without direct supervision. IMET noted that their usual supervision requirement for junior doctors working at the PGY2 level at a hospital is that they should have on site supervision at all times. In a hospital setting this can mean that the supervisor is present, but may be asleep. Clarifying appropriate supervisory requirements has been a challenge for general practice rotations where PGY2 doctors may be asked to work independently to provide on-call services.

The PMCV has also identified an instance where the principal supervisor assumed the PGY1 doctor would be able to provide on call services with phone back-up. This resulted in the development of a policy for interns undertaking a general practice placement in relation to the expected requirements of supervision when an intern is on-call or working outside of normal hours. This indicates the need for ongoing education of GP supervisors about the differing requirements of prevocational doctors compared

with vocational trainees. Establishing the appropriate level of supervision for prevocational doctors, and determining whether expectations are consistent between the PMCs, the Colleges, hospital and community based supervisors and junior doctors is a key issue in the provision of prevocational general practice training (see section 3.4).

The model of supervision used within the PGPPP program is different from that used within the hospital sector. The 'Wave' or 'Confluence' model of consulting used in the program requires that every patient assessed by the intern is also seen and assessed jointly by the supervisor. This allows the junior doctor responsibility for all aspects of the consultation (such as history taking, examination, diagnosis and management plan) with back-up and immediate feed back available from the supervisor. This model of supervision specifically suits the consultation style and funding requirements of general practice (with the Medicare fee-for-service, being paid only when they supervisor signs off on the interns' patients).

The fact that supervision standards for prevocational doctors have only recently been developed by the RACGP and ACRRM and that there are inconsistencies between the Colleges and the PMCs, is a clear indication of the need for ongoing dialogue about and clarification of the issues. The development of the PMAF will help determine the extent to which there is national consistency in the supervision requirements for junior doctors working in different training situations, and will provide an opportunity for identifying where further work and consultation is needed. Given their role as key stakeholders in the provision of general practice and community training, working with ACRRM and the RACGP to identify and ensure appropriate levels of supervision for prevocational trainees will be important (see Recommendations 3 and 4, below). Ensuring that appropriate supervisory guidelines are developed which meet the expectations of the range of stakeholders (e.g. professional bodies, educational providers, supervisors, trainees and health consumers) and funding organisations, will remain, an ongoing process. Accreditation provides an opportunity for reviewing, evaluating, gathering feedback on, and encouraging innovation in, the provision of intern training. In so doing it provides one mechanism through which different expectations of appropriate supervision can be negotiated and more closely aligned.

The Postgraduate Medical Council of South Australia stresses the importance of clarifying the role, and aligning the expectations of, the different organisations involved with the prevocational general practice training. In the past, ambiguities have arisen over the role of hospital staff responsible for coordinating and supporting the prevocational general practice rotations, and the role of the regional training providers.

Finally, the Postgraduate Medical Council of Western Australia has reported some difficulty explaining the importance of their own processes for accrediting prevocational general practice rotations, given that training practices and supervisors have already been accredited by RACGP or ACRRM, and by their regional training provider.

In each of the above instances, developing a nationally consistent prevocational accreditation framework may help clarify expectations, resolve ambiguities, and minimise the work required to accredit general practices training posts. Working with ACRRM, the RACGP and other key stakeholders will be important for achieving these ends.

Information from state postgraduate medical councils indicates that there is little formal exchange of information between them and the RACGP and ACRRM in relation to the accreditation of prevocational general practice rotations. This project has provided an opportunity to explore how such an exchange might benefit the different organisations, and might minimise the requirements of different accreditation processes for general practices. Both the Colleges have expressed an interest in such an exchange.

There is potential to strengthen relationships between the stakeholder organisations, and to reduce the need for duplication of administrative requirements for accreditation. Further opportunities exist through an exploration of the involvement of College and PMC staff with each others accreditation processes and future discussions could address:

- a process for informing the Colleges of the outcomes of the PMC general practice accreditation visits,
- what data is needed by different organisations and could be shared following an accreditation visit,
- coordinating the timing of accreditation by the different organisations so as to minimise the disruption to the practice,
- training a common pool of accreditation assessors who can work across organisations and across the educational continuum; this would have the potential to increase the overall number of available assessors, and to make the most efficient use of their time,
- formalising inter-organisational involvement in areas such as accreditation of prevocational training positions; this may increase an understanding of, and consistency between, policy development and implementation within the different organisations.

Privacy considerations, the implications for staff workloads, and the benefits to each organisation would need to be investigated prior to undertaking any such changes.

Recommendation 3:
To minimise the accreditation burden, CPMEC work with the Royal Australian College of General Practitioners, the Australian College for Rural and Remote Medicine, and other relevant Fund Holder organisations to:
- exchange information relevant to the accreditation of GP training practices with respect to prevocational training positions,
- explore the possibility of sharing accreditation visits,
- articulate similarities and differences between the PMCV and other accreditation processes, and
- explore possibilities for the recognition of prior accreditation status granted by the respective accreditation bodies.

Recommendation 4:
That CPMEC explore with the relevant Colleges the possible development of a process to deliver a common pool of accreditation assessors who can work across the training continuum. These assessors should be:
- familiar with requirements of the different organisations, able to
- participate in accreditation visits as the representative of more that one organisation, and
- able to facilitate effective communication between relevant organisations.

A key component of the provision of General Practice education that was not included in the brief for the *National Accreditation Framework for General Practice and Community Settings Project*, is the role of the Regional Training Providers (RTPs). Several members of the National Advisory Committee have proposed that consideration should be given to the role of the RTPs in the above process given that they conduct routine site visits and provide support for supervisors and training practices. Opportunities may also exist to coordinate accreditation visits in order to minimise the disruption to general practices', reduce the human resources required to conduct site visits, and to share the collection of standard documentation and data. For these reasons it is recommended that:

Recommendation 5:
That CPMEC explore with the National PGPPP Advisory Committee the development of processes that enhance the involvement of Fund Holder organizations (such as Regional Training providers, Divisions, Rural Clinical Schools) in partnering general practices through the accreditation process.

3.3 Development of an Accreditation survey tool for general practice and community settings

3.3.1 Initial development and review of the accreditation tool.

The initial version of the general practice accreditation tool was developed in late 2007 by a working group, drawn from members of the PMCV Accreditation Subcommittee. The working group was comprised of Ms Carol Jordon (Executive Officer, PMCV), Ms Penelope Watson (Accreditation Manager, PMCV) Dr Rod Fawcett (Chair, Accreditation Subcommittee) and Dr Gretel Heitbaum. In addition to being a member of the Accreditation Subcommittee and an accreditation survey team leader, Dr Heitbaum is a general practitioner and the Chair of RACGPs' Victorian Faculty Vocational Training Accreditation Committee. Her expertise and experience greatly contributed to the initial development of the survey tool, and a belief that it identified key issues for the accreditation of general practice rotations. The general practice accreditation tool was based on the existing survey tool used to accredit hospital-based training positions and was reviewed prior to use by the PMCV Accreditation Subcommittee and by the Medical Practitioners Board of Victoria, in particular the President of the Board, Dr Joanna Flynn, herself a GP. Before the commencement of this project the tool had been

used to accredit four general practice intern positions in Victoria. This project has enabled the opportunity to formally review and evaluate the Victorian accreditation tool.

3.3.2 The Accreditation tool

The accreditation tool is comprised of two parts, both of which must be completed by the general practice prior to an accreditation visit. Supporting documentation must also be provided detailing the position description, orientation program, education program, supervision, rosters, and mechanisms for feedback and appraisal which the practice has in place to support the general practice rotation.

Initially, the language used throughout the survey tools was changed to be inclusive of general practice (rather than refer exclusively to 'Hospital' or hospital-based positions, etc). Part 1 - *General Practice Information & Overview* (Appendix 3), collects demographic information and general information about the medical practice hosting the training positions. It was amended to more closely align with the PGPPP application form and now includes the RRMA Classification, Regional Training Provider Details, type of Practice (i.e. Aboriginal medical service, community health care setting, general practice) and the clinical privileges of the supervisors at the practice.

Part 2 - *Assessment Against Functions and Standards for 2008 – General Practice* (Appendix 4), is based on the PMCV accreditation standards. It allows for the general practice to rate itself against the PMCV standards and criteria prior to the practice visit, and for the accreditation survey team to do the same (without knowing in advance the self-rating by the general practice).

The general practice survey tool contains all the criteria used to accredit hospital posts, but was expanded to include the following four additional criteria:

Function 1: Environment and culture in relation to HMO support

1.9 The practice must offer the full range of ongoing primary care.
1.10 The practice should be accredited under the RACGP minimum practice standards by a recognised accreditation body.
1.11 The hospital, practice and principal trainer must ensure that the HMO has adequate insurance coverage and is registered with the state or territory medical council for the clinical work to be undertaken.

Function 7: Facilities and Amenities
7.5 The practice provides adequate consulting space for the JMO.

The third part of the accreditation tool (Part 3 – *Hospital Assessment of Intern/PGY2 posts*) is used when accrediting hospital training posts. This tool is not required for accrediting General Practice and Community training posts as it collects data specific to the hospital sector (such as separations per year, WIES, number of beds, number of ward rounds per week, rostered hours, pre-admission clinics, and operating sessions).

3.4 Comparison of the accreditation standards of the RACGP, ACRRM and the PMCV, including implications for developing the prevocational accreditation standards for general practice rotations.

The guidelines for the PGPPP, and the standards of the RACGP and ACRRM were mapped against the standards used by the PMCV to accredit prevocational training posts. This process enabled the documentation of consistencies and inconsistencies between general practice and hospital accreditation standards, and consideration of how they impacted on the requirements for education and supervision. The documents reviewed included the:

- PGPPP *Program Guidelines for Training Collaborations,*
- PMCV/Medical Practitioners Board of Victoria *Standards for the accreditation of intern posts and the standards for the assessment of PGY2 posts,*
- RACGP, *Standards for General Practice Education and Training: Trainers and Training posts 2005 (RACGP 1), Standards for General Practice Education and Training; Programs and Providers 2005 (RACGP 2),* and *Standards for the Supervision of Prevocational Doctors in General Practice, December 2007 (RACGP 3),* and
- ACRRM *Standards Required of ACRRM Teaching Posts and Teachers In Rural and Remote Medicine (ACRRM 1),* and *Standards for Regional Training Providers (RTP) Recognition (ACRRM 2).*

As part of the mapping process each of the PMCV accreditation standards were detailed against the PGPPP *Program Guidelines for Training Collaborations,* and the RACGP and ACRRM standards that most closely approximate them (see Appendix 5). Following this, specific PMCV accreditation criteria were tabulated against RACGP and ACRRM standards and criteria.

This produced a comprehensive analysis demonstrating an extensive overlap between the various standards documents, despite slight differences in the wording and intent of the different standards. None-the-less a number of gaps were revealed that warrant attention. These include how best to ensure the needs of prevocational doctors are adequately addressed while on GP rotations, and how to ensure the integration of general practice terms within the overall JMO program. The implications of these gaps for prevocational education and supervision are discussed below.

An extensive report of the standards mapping exercise (exceeding 50 pages) was circulated to members of the National Advisory Committee and they were asked to comment on issues raised and the extent to which the mapped standards reflected the accreditation standards used within their own organisations or state PMCs. National Advisory Committee members (including representatives of ACRRM and the RACGP) endorsed the results of the mapping exercise. Committee members representing other state PMCs did not identify any significant differences between their own accreditation standards and the PMCV standards that were mapped.

ACRRM and the RACGP both have multilayered accreditation processes. Supervisors, training posts, training providers and educational programs are covered by different standards and guidelines, and their accreditation may be conducted by different organisations (i.e. General Practice Education and Training and Regional Training

Providers). As a consequence practices that offer prevocational training posts have already met the requirements of a range of accreditation processes, including multiple practice visits. The accreditation of training practices and supervisors predominantly assumes that training is to be provided for registrars working towards vocational registration by the different Colleges. Despite recent work (i.e. *The RACGP Standards for Supervision of Prevocational Doctors*) the question of how best to manage the training needs of prevocational doctors or to accredit training positions for them is less clearly articulated.

This suggests that attention needs to be paid to identifying how different levels of prevocational doctors' needs vary from doctors enrolled in the vocational training program of ACRRM or the RACGP, and ensuring these needs are met. This includes identifying appropriate curricula and learning opportunities, mix of service provision and dedicated educational time, and an appropriate level of responsibility for patient care and requirements for supervision. In order to achieve this end Regional Training Providers and Supervisors will need a clear understanding of the Australian Curriculum Framework for Junior Doctors (ACFJD) and how it relates to the curriculum or other training requirements of ACRRM and the RACGP. As discussed in section 3.2.4, determining an appropriate level of supervision for prevocational doctors and ensuring that level is met, is a key issue for the provision of general practice training rotations.

The standards mapping exercise also identified the need to ensure an appropriate integration of the general practice term within the overall prevocational training program. The current PMCV accreditation standards include criteria which enable identification of the mechanisms to assess transition between the hospital-based rotations and general practice rotation, and back again. Notwithstanding this, there is a disjunction between the standards and what happens in practice relating specifically to:

- coordination of the management of prevocational doctors by the feeder hospital, general practice and rural training provider,
- the integration of JMOs learning plan / objectives in the general practice rotation into their overall experience as a junior doctor,
- the feedback process for JMOs about their experiences while on their general practice placement, and
- mechanisms for ensuring the continuity of support for prevocational doctors while in the general practice rotation and away from their parent hospital.

Good communication and clear planning between the coordinator of prevocational training within the rotating hospital, the RTP and the practice supervisor, as well as mechanisms for ensuring continuity of support for the junior doctor by the rotating hospital, is essential. Consequently communication and support of trainees need to be addressed through appropriately worded accreditation criteria. Accreditation standards which recognise these issues, both within the general practice and within the rotating hospital, should be addressed by the national prevocational accreditation framework for general practice and community settings.

Recommendation 6:
Ensure that accreditation standards for prevocational practice rotations assess:
- coordination of the management of prevocational doctors by the feeder hospital, general practice and Fund Holder organisations (eg. Regional Training Provider),
- the integration of JMOs learning plan / objectives in the general practice rotation into their overall experience as a junior doctor
- the feedback process for JMOs about their experiences while on their general practice placement, and
- mechanisms for ensuring the continuity of support for prevocational doctors while in the general practice rotation and away from their parent hospital

3.5 Piloting of the accreditation tools

It had initially been hoped that the accreditation tools would be piloted in up to four general practices, including some practices outside Victoria. Unfortunately scheduling pilot accreditation visits proved to be very challenging. There are a limited number of practices that support prevocational general practice training and these are normally accredited once every three years. Very few were due for accreditation within the short time frame afforded by the project (June-August 2008). Queensland was in the midst of a major review of their accreditation process and were piloting their new accreditation tools; they were not in a position to offer a general practice for piloting. In addition, funding cuts to the PGPPP program announced while the project was underway, created uncertainty over the ongoing viability of training rotations, with the consequence that several practices in which the tool might have been piloted, opted to delay their accreditation until the implications of the new funding arrangements could be fully understood. National Advisory Committee members from each state tried to identify practices for accreditation visits and to obtain feedback on the draft accreditation tools; however, no practices outside Victoria could be identified to assist in this aspect of the project.

Pilot accreditation visits took place in three general practices in regional Victoria. General Practices in Trafalgar and Mildura had been approved for PGPPP funding for new intern positions and required accreditation. A PGY2 post was surveyed at a practice in Warrnambool that had been operating for two years. The purpose of conducting the accreditation visits was to:

1. gauge the suitability of the accreditation tools for general practice supervisors and administrative staff,
2. validate that information collected using the accreditation tool corresponded to expectations underpinning its design, and
3. identify any unexpected outcomes or challenges relating to the transposition of PMCV accreditation process into a general practice context.

3.5.1 Pilot Method

Practices at Trafalgar and Warrnambool were provided with information about the project, and asked whether the project manager could observe the practice accreditation visit. Once consent was given the project manager contacted members of the accreditation survey team seeking their permission to attend the visit, providing information about the project and outlining what was hoped to be achieved by attending the visit. Permission to attend was granted by both practices and the survey team leaders. In addition to time spent with the General Practice Supervisors, the project manager also spent time with members of the survey teams, and was able to discuss the process of accreditation and the survey tools with them.

The project manager received a copy of the accreditation tools completed by each general practice, along with all supporting documentation. Documentation included:

- a copy of the position description developed for the prevocational rotation,
- an outline of the orientation program,
- an outline of the education program,
- details of the supervision available to the junior doctor,
- work rosters, and
- details of the mechanisms used to provide feedback to and appraisal of the junior doctor.

This documentation was used to assess whether data collected by the accreditation tools corresponded to expectations. In each case the completed accreditation surveys met the expectations of the survey teams. In particular, the self-assessment rating against the accreditation criteria completed by the general practices, provided a structure for discussion, an opportunity to explore and expand on the practices own perceived strengths and weaknesses, and highlighted additional resources that the survey team could easily provide.

The project manager was present during all components of the practice visits, and (although present as an observer) was encouraged to take an active part, asking questions and seeking clarification as required. When the survey teams had completed their discussions the project manager conducted a short, semi-structured interview with the principal supervisors. Accreditation survey team members remained present during these interviews. Given the dynamic nature of the discussion and the fact that many questions had already been addressed during the visit, these items provided a guide only for the interview.

The GP supervisors were asked:

1. What was involved with becoming an accredited teaching practice by ACRRM, the RACGP and their RTP and how this differed from the PMCV accreditation process?
2. Could they identify duplication between the processes or opportunities for streamlining them?
3. Would they be willing for the PMCV to share information about the accreditation visit with the RACGP or ACRRM, or to access information on their accreditation with the Colleges?

4. Could they describe the differences between supervising and training prevocational doctors and vocational registrars?
5. What was their level of familiarity with the Australian Curriculum Framework for Junior Doctors and whether they had been able to use it to develop learning plans/objectives with their junior doctors?

Although one of the practices was accredited as a training practice by ACRRM, both focused their discussions on accreditation with their Regional Training Provider and the RACGP.

3.5.2 Results of the pilot accreditation visits

Question: *What was involved with becoming accredited as teaching practices by ACRRM, the RACGP and their RTP and how this differed from the PMCV accreditation process?*

Practices apply through their Regional Training Provider for status as a training practice and for accreditation of supervisors, and the RTP makes recommendations to the RACGP. There was an initial RACGP site visit, but once a practice was accredited subsequent accreditation was a 'paper-based' process, co-ordinated through the RTP, with RACGP only revisiting the GP site every 6 years. The RTPs conduct their own accreditation process every three years which includes a site visit.

When discussing what was involved in meeting different accreditation requirements both Principal Supervisors acknowledged that all required a reasonable degree of work and consequent disruption to their clinical duties. Notwithstanding this, their role as educators was essential to their role as general practitioners, and they both described accreditation as important for maintaining and enhancing their skills and the quality of experience they could provide for their junior doctors and registrars.

One commented:

> *"The first few times you're involved in an accreditation it can be a bit overwhelming, but then you work out that it's really beneficial. It helps you accumulate skills, tidy your program up, and helps you share information in a positive way."*

It was clear that both practices considered accreditation by the PMCV to be quite different from the other accreditation processes they had experienced. The accreditation survey tool, the supplementary documentation required, and the nature of the discussion that took place during the practice visit, all had a different focus from the requirements of the Colleges and rural training providers. Because of its focus on prevocational doctors the PMCV accreditation process required the GP Supervisors to re-examine the supervision and training they provide and adapt them to the needs of junior doctors.

> *"The [PMCV] process made me think through how the [prevocational] position might work. We do a lot of training and we have a lot of materials already that are used by registrars and undergrads, but this made me work through how they need to be adapted. And that was good."*

The PMCV process requires details relating to the practical management of the position, as well as an understanding of issues relating to the educational and professional development of junior doctors. Reflecting on this one of the GP Supervisor commented that the PMCV process:

> *"was well balanced. It provided both an eye for detail and a sense of the big picture."*

Question: *Could they identify duplication between the processes [of the RACGP, ACRRM and the PMCV] or opportunities for streamlining them?* And: *Would they be willing for the PMCV to share information about the accreditation visit with the RACGP or ACRRM, or to access information on their accreditation with the Colleges?*

As noted above, both GP Supervisors thought the PMCV accreditation process was substantially different for the process of the Colleges, and for this reason could not identify significant overlap or duplication between the processes. One GP Supervisor noted that there were undoubtedly elements that were repetitive, in terms of the collection of basic data. The other commented that the process was different enough and he not did think there was much overlap, so while he was sympathetic to the concept that the Colleges and the PMCV could share information about his role as a trainer, he could not see how that might work. The other GP Supervisor also supported the idea of the PMCV and the College sharing information about his accreditation as a supervisor and as a teaching practice.

Question: *Could they describe the differences between supervising and training prevocational doctors and vocational registrars?*

Both GP Supervisors talked at length about the different supervision and training requirement of prevocational doctors and vocational registrars, stressing the importance of providing a higher level of support and direct supervision to prevocational doctors, than to vocational registrars, especially in the early weeks of their rotation.

One of the practices was seeking to establish a PGY1 position. This supervisor described using a 'wave model' of supervision, whereby every patient seen by the junior doctor would also be seen by a supervisor. It was also noted that the clinic could not claim the Medicare rebate for patients seen by the junior doctor unless they were signed off by a supervisor. This practice also had policies governing which patients were not to be seen by the junior doctor, and categories of drugs they could not prescribe. Orientation was seen as being particularly important. This practice had planned to ask the junior doctor to work on-call, with phone back-up to the supervisor, however following discussions with the PMCV survey team leader this plan was revised.
The second practice was supporting a PGY2 position that had been established for over two years. The GP Supervisor stated that as the junior doctors who filled this post had a year of postgraduate experience, they were usually able to practice with a reasonable degree of independence by the end of the rotation. Notwithstanding this, care was taken to ensure the junior doctor was eased into the practice slowly, given ample opportunity observe consultations with supervisors and to learn how the practice operates. Junior doctors were encouraged to seek advice from the supervisors whenever needed. Because of the constraints of the PGPPP program funding, this practice did not ask junior doctors to work on-call or after-hours.

Question: *What was their level of familiarity with the ACFJD and whether they had been able to use it to develop learning plans/objectives with their junior doctors?*

One GP Supervisor knew about the Australian Curriculum Framework for Junior Doctors, but was not familiar with its content, while the other did not know of its existence. Neither, therefore, had used it in the development of learning plans for their prevocational doctors.

The GP Supervisors' lack of familiarity with the ACFJD suggests the need to review the way in which the curriculum framework is publicised to GPs involved with training prevocational doctors. In so doing, the importance should be stressed of establishing how the learning opportunities available in GP rotations contribute to, and can be documented within, the over-all junior doctor program.

Recommendation 7:
That CPMEC promote the Australian Curriculum Framework for Junior Doctors and the Prevocational Medical Accreditation Framework to general practitioners who provide training to prevocational doctors.

In summary, both GP supervisors interviewed were supportive of the PMCV accreditation process and accreditation tool. The GP supervisors in the two practices visited felt the tool and documentation required were sufficiently different from accreditation through the RACGP, ACRRM and RTPs as to prompt beneficial review of their supervisory and educational programs. Both were willing for information about their accreditation status to be shared between the Colleges and the PMCV.

It is unfortunate that the pilot was only conducted in one state (Victoria) and only involved a small number of practices. Despite the consistency of responses between participating GP supervisors, caution must be urged in generalising these findings. None-the-less, the strength of the support expressed for the PMCV accreditation process, combined with the supervisors' willingness for personal information to be shared between accrediting organisations, and lack of knowledge of the ACFJD, all provide data that suggests and warrants further investigation. Because of the paucity of empirical data assessing accreditation in health (ACSQHC, 2003, p 11-12 and 2006 p 14, Greenfield & Braithwaite, 2007b p 13) the introduction of the PMAF provides CPMEC with the opportunity to conduct ground-breaking research during the initial implementation and evaluation of the framework. In particular, the results of this pilot suggest particular issues that should be followed up through an expanded and carefully constructed study.

Recommendation 8:
That CPMEC continue to evaluate the accreditation of prevocational general practice training posts through the implementation of the project recommendations.

Recommendation 9:
That CPMEC be provided with resources to undertake this work in conjunction with the Postgraduate Medical Councils and the relevant Colleges.

3.6 Peer review and modification of the accreditation tool

In addition to determining the performance of the tool and its acceptability to general practitioners it was important to establish whether it sufficiently addressed the standards and criteria required to satisfy the needs of the accrediting organisations. This was achieved through peer review, as carried out by the PMCV Accreditation Subcommittee (see section 3.3.1), and the project's National Advisory Committee. Following the pilot accreditation visits the accreditation tool was reviewed by the National Advisory Committee and a number of minor amendments were suggested. These changes included:

Function 1: Environment and culture in relation to HMO support

1. Criterion 1.9 - Removing the requirement that a general practice must offer the 'full range of primary care', and inserting a requirement that the practice 'must offer an educationally diverse experience of primary care'. This change was suggested to accommodate placements in community health services which may target particular groups or health issues, but can none-the-less provide a robust training opportunity for prevocational doctors (such as drug and alcohol, youth, Aboriginal or women's health services).

Function 5: Feedback and Appraisal

2. Criterion 5.5 – This criterion referred to the provision of feedback on the junior doctors' performance throughout their prevocational training. The criterion was altered to read: "The Practice provides feedback on HMOs performance to the Supervisor of Intern Training/Director of Clinical Training or equivalent." This change was intended to emphasise the importance of coordinating with the feeder hospital in order to ensure appropriate management of junior doctor training.

Function 7: Facilities and Amenities

3. Criterion 7.1 – This criterion referred to the provision of accommodation for junior doctors while on a rural placement. The criterion was altered so as to align with the ACRRM and RACGP standard on accommodation.[1]

Rating scales:

4. Rating scales for the standards and functions – Although the assessment criteria for the different standards and functions had been amended to suit general practice and community settings, the rating scales had not. Language was changed to be inclusive of general practice, and modifications made to emphasise the significance of working with feeder hospitals to ensure high quality prevocational general practice rotations.

It was suggested that the accreditation tool developed by the project be aligned with that of Queensland as it was thought that PMCQ might provide the format for the Prevocational Medical Accreditation Framework (PMAF). As the PMAF was still in

[1] It should be noted that the ACRRM/RACGP requirements specify a higher standard of accommodation than is currently required for junior doctors undertaking rotations at rural hospitals. Some members of the National Advisory Committee identified the provision of unsatisfactory accommodation for rural hospital-based rotations as contributing to junior doctors' dissatisfaction with the positions. It was noted that identifying criteria for appropriate accommodation within the national accreditation framework, may improve the situation.

development at the time this suggestion was not acted upon. Notwithstanding this, the tool is consistent with the principles of the current draft PMAF (as released at the National Forum, Hobart, in November 2008).

4. Documentation of learning opportunities available to prevocational doctors within General Practice and development of a position description for prevocational General Practice rotations.

4.1 Documentation of learning opportunities available to prevocational doctors within General Practice.

In order to identify consistencies between the training curricula of the RACGP, ACRRM and the ACFJD and to document the learning opportunities available to prevocational doctors while they are working in general practice, an analysis was begun that mapped the different curricula. The tool chosen to facilitate the mapping was developed by the PMCV Medical Director and Primary Consultant with SED Health Consulting, Dr Ian Graham. Since being developed on behalf of the Postgraduate Medical Council of Queensland, the tool has been used to map learning objectives and opportunities available to junior doctors during Emergency, General Surgical and General Medical intern rotations. The tool was revised for use in this project, and is currently being used to map the undergraduate curriculum of all Victorian medical schools, to the ACFJD.

The tool works by allowing the user to build up individual spread-sheets matching items from the curriculum being mapped, to the ACFJD. This enables the generation of data describing the best match between the items being coded and the areas, categories, topics and capabilities listed in the ACFJD. If multiple spread sheets are developed (as has been the case with mapping the general practice curriculum) two summary spreadsheet are generated, which provide both a consolidated contents list of all spreadsheets, and a graphical display that highlights the gaps and duplications across the different spreadsheets.

Elements of the curricula of the RACGP and ACRRM were reviewed. Both Colleges have comprehensive curricula documentation, including a number of related discussion documents, easily available for downloading from their websites.[2] In each case, the curricula operate at a range of levels, containing discussions of the principles underpinning the disciplines (general practice and rural and remote medicine), the domains which govern their practice, and a series of curriculum statements that address specific topic areas and clinical skills. As the learning objective and outcomes are detailed at the level of both the domains governing practice, and the topic-specific curriculum statements, the decision was made to use these learning objectives and outcomes to begin mapping the general practice curriculum documents to the ACFJD.

[2] RACGP: http://www.racgp.org.au/curriculum#pagetop, and ACRRM: http://www.acrrm.org.au/main.asp?NodeID=90

Given the extent of the RACGP and ACRRM curricula it was not possible to comprehensively map it. Instead, a start has been made, by identifying and collecting relevant curriculum documents, and by identifying a mapping tool and defining a mapping strategy. It is anticipated that by using an increasingly standardised mapping tool and by clearly articulating the mapping strategy, it will be possible for staff within the PMCV and other postgraduate medical councils, to continue the systematic mapping of different components of general practice curricula after the completion of the project.

The RACGP identify five domains of general practice that provide a framework around which thirty individual curriculum statements are organised. ACRRM nominates seven domains to support twenty two specific curricula statements. Initially the learning objectives identified in each of the specified domains were mapped. This demonstrated that at a broad level much of the ACFJD can be met within the learning environment of general practice and rural general medicine.

Following this, the decision was made for focus on the RACGP curriculum. The reason for this decision is that the RACGP curriculum specifies the importance of ongoing learning throughout a GPs professional life. To this end their curricula statements highlight expected knowledge and learning objectives for medical students, prevocational and vocational trainees, and for continuing professional development. This structure allows for easy identification of the RACGP's expectations for prevocational general practice trainees, and comparison with the ACFJD. ACRRM curriculum does not provide as clear a specification of the level at which different curricula are targeted.

To date the following Curriculum Statements have been mapped:

- *RACGP Common Learning Objectives,*
- *RACGP Aged Care,*
- *RACGP Children's and young people's health,* and
- *ACRRM Primary Curriculum Learning Outcomes.*

The mapping was undertaken by the project manager (who is not medically trained), and review was provided by Dr Rodney Fawcett, Chair of the National Advisory Committee and Director of Medical Education and Training, Barwon Health. Results of the mapping exercise can be found in an Excel document submitted with the report, and are summarised in Appendix 6a and b (*General Practice Curricula mapped to the ACFJD).*

Preliminary review of the RACGP and ACRRM curriculum demonstrate they overlap significantly with the ACFJD. There are specific elements of the ACFJD that are particularly suited for delivery in general practice, however it is also the case that working in general practice expands on the professional skills and knowledge junior doctors acquire during their hospital-based rotations. In contrast to publicly funded hospitals, which often employ a large number and diverse range of health professionals and administrators, general practice operates on a small business model, requiring the junior doctor develop a different knowledge of and relationship to other practice staff and primary health care providers. The patients who attend a general practice will present with different health problems than do hospital patients, or may present at the initial stage of conditions that eventually require hospitalisation and post-discharge follow up. Junior doctors working within public hospitals do not have exposure to the full continuum upon which many common problems and conditions present. For these

reasons, the administrative, clinical and other professional skills required to work in general practice are slightly different from those required to work within the hospital sector. Working in general practice exposes junior doctors to different aspects of each area, category and topic identified within the ACFJD. It should also be noted that there is a large degree of variation between general practices: their demographic and staff profile will significantly impact on the training opportunities that are available to junior doctors. A key purpose of providing different training rotations for junior doctors is to ensure they develop a broad range of knowledge and skills, and that they are encouraged to take on responsibility for patient care in a supported structured and well supervised environment. General practice provides a rich learning environment in which junior doctors can acquire the skills to manage situations they are unlikely to face while working within the hospital sector. It also affords them an opportunity for individual patient care which is not always possible in the hospital environment where service delivery can take precedence over training, with the result that interns are often at the bottom of the decision making hierarchy (Cantiloon & MacDermott, 2008, p.256).

Area: Clinical Management

Category: Safe Patient Care

Topic: Systems - general practice operates on different funding and business models than public hospitals. For this reason the organisational systems and protocols in place in general practice will differ from those with the hospital sector, as will specific opportunities for participation in continuous quality improvement activities.

Topics: Risk & Prevention, Adverse Events & Near Misses, Infection Control, Radiation Safety, Medication Safety - the case-mix of patients seen by general practitioners is different from those seen by hospital clinicians. For this reason the clinical skills and protocols most commonly exercised in general practice will differ from those with the hospital sector. These differences include the main sources of medical error and risk, likely adverse events, near misses and systems failures, and issues relating to the safe prescriptions and administration of medications, and issues relating to the management of infection control and radiation safety. In each case the processes for documentation and other management protocols will be different within general practice and the hospital sector.

Topic: Public Health – working in general practice provides an excellent opportunity for junior doctors to develop their knowledge of public health issues. General practice requires that doctors understand the health profile of their community, along with reporting requirements for notifiable diseases and outbreak management.

Category: Patient Assessment

Topics: History & Examination, and Problem formulation – General practice is a particularly good setting for developing skills in history taking, examination and problem formulation. General practice consultations tend to be less fragmented than episodes of hospital-based care, and are generally provided to patients who are less critically ill than hospital patients. This allows prevocational GPs to assume responsibility for patients in an environment where there is likely to be more time available for them to develop diagnostic and clinical management skills.

Topics: Investigations, and Referrals & Consultations – because of the type of patients seen in general practice and it's position within the primary health sector, the range of investigations available to general practitioners and the opportunities and processes for referring patients to specialist care are different from those available to hospital practitioners.

Category: Emergencies

When presented with a medical emergency prevocational GPs are required to manage the situation differently than their hospital colleagues. In particular, there will be less back-up during the execution of life support skills. There will also be a need to identify acute patients and organise their transfer to tertiary care.

Category: Patient Management and Common Problems and Conditions

Patients seen by general practitioners typically have different problems or are at different stages of an illness or other condition, than patients seen by hospital practitioners. For this reason prevocational general practitioners will be required to employ different management options, including use of medications and strategies for pain management, than their hospital colleagues. In particular, working in general practice allows junior doctors the opportunity to develop knowledge of the subacute care options available for patients, including options for ambulatory and other community care.

Category: Skills and Procedures

The types of assessment and procedural skills required of prevocational general practitioners (and the manner in which they are executed) differ from those required of junior doctors working within the hospital sector. For example, prevocational general practitioners involved with the care of patients following hospital treatment will need to employ a different set of management and rehabilitation strategies than their hospital based colleagues.

Area: Communication

Category: Patient Interaction

General practice provides a rich environment in which junior doctors can develop their communication skills. Hospital treatment is usually a fragmented process, with patients often being attended by multiple health professionals. In contrast, junior doctors working in general practice are responsible for the entire episode of care for their patients, with oversight usually being provided at the end of the consultation, after assessment, diagnosis, and treatment have all been formulated. Within general practice junior doctors may also see patients on multiple visits, or attend multiple members of the same family. This affords them opportunities for communicating and building on their relationships with patients that are seldom available within the hospital sector.

Category: Managing Information

Working within general practice exposes junior doctors to a range of information management systems, and will expand their understanding of how different systems work within different contexts. Expectations of and processes for documenting consultations, making referrals and prescribing vary between primary and tertiary sectors and between different service providers. In addition, guidelines for patient management within primary care often vary from guidelines applicable for hospital patients. Exposure to such differences will enhance junior doctors understanding of why they exist, and will help reinforce flexibility within the junior medical workforce.

Category: Working in Teams

Primary health care teams differ from the teams that junior doctors work with in hospitals. For example, they may have immediate access to a small number of general practitioners, and possibly a range of other allied health professionals such as a practice nurse and community health workers. Understanding the difference in team structure, dynamics, roles and responsibilities broadens junior doctors' skills and knowledge.

Area: Professionalism

Category: Doctor & Society

Working in general practice is likely to provide junior doctors with a different (or enhanced) perspective on each of the topics listed in this category, than they would be exposed to working solely within the hospital sector. Primary health care provides particularly good opportunities for understanding health promotion, the relationship between culture society and healthcare, and issues relating to access to healthcare. Some primary health care services provide the opportunity for junior doctors to work closely with indigenous patients and health workers. Primary care also exposes junior doctors to medico-legal issues and an understanding of the use of particular healthcare resources that may not apply within the hospital sector.

Categories: Professional Behaviour and Teaching & Learning

Working in general practice will broaden the exposure of junior doctors to different aspects of professional behaviour and responsibility. For example, slightly different pressures are associated with time-management for prevocational general practitioners working in a small business, with sole responsibility for patient care, than for junior doctors working within hospitals, who need to manage their time according to the requirements of the members of a broader health care team and access to hospital infrastructure and resources (such as consultants and investigative facilities). Teaching and learning opportunities available within general practice, including significantly the opportunity to explore career opportunities within primary care, also vary from those available within the hospital sector.

Given that a large proportion of medical graduates will ultimately work in primary health care it is important to provide training within general practices as part of prevocational training. The challenge for ensuring that such rotations are of a high educational quality will be in further determining which elements of the ACFJD are best

delivered in general practice, in ensuring JMOs are well supported as they acquire these skills, and in ensuring the rotations compliments the learning experience they have during the rest of their JMO training.

In summary, general practice is an environment that is rich in learning opportunities, provides occasions for practicing a range of clinical skills with increasing responsibility for patient care, and is well suited for the delivery of most aspects of the ACFJD. Patients experiencing many of the 'Common Problems and Conditions' identified by the curricula will first present at general practice, prior to requiring hospitalisation, and will also receive follow-up care from their general practitioner. Consequently, working in primary health care exposes junior doctors to aspects of health which they do not normally experience while working in the hospital sector (except perhaps in Emergency Medicine departments). In doing so it not only strengthens their diagnostic and procedural skills, but also reinforces the importance of achieving effective integration of and communication between the primary and tertiary health sectors. The topics and capabilities listed in the curricula category 'Doctor & Society' are also best acquired in general practice. In general practice junior doctors can directly witness the effects of social and cultural forces on an individual's ability to access healthcare resources and achieve positive outcomes, in a way that they are seldom able to while working in the hospital sector. For these reasons it is recommended:

Recommendation 10:
That CPMEC affirm the benefits of providing junior doctors with training rotations in general practice and extended primary health care, and work towards enhancing prevocational training opportunities in the primary health care sector.

4.2 Development of a Position Description for prevocational general practice rotations.

A rotation description has been developed for intern prevocational general practice positions (Appendix 7) which is included in "*A Guide for Interns in Victoria*" provided to all commencing interns. This description has been developed so as to be consistent with the rotation descriptions for medical, surgical, emergency medicine and non-core intern rotations in Victoria. Learning objectives are listed under the category headings used within the ACFJD; 'Clinical Management', 'Communication' and 'Professionalism'. This effectively establishes a structure for aligning learning opportunities and objectives within general practice with those outlined in the ACFJD.

The rotation description was developed in consultation with getGP, and with input from Dr Peter Stevens, Practice Principal, Heyfield Medical Practice and Ms Colleen Oakley Browne, Project Manager, getGP.

5. Dissemination of project findings through a conference presentation and peer reviewed publication.

A paper was presented at the 13th National Prevocational Medical Education Forum in Hobart, 9-12 November 2008. A copy of the conference abstract is found at Appendix 8.

Appropriate journals in which to publish are still being explored. Because of the need to publicise the ACFJD and the PMAF to general practitioners who supervise prevocational doctors, the *Australian Journal of Rural Health* and *Australian Family Physician*, are likely forums for publication. *Medical Teacher* would also be an appropriate journal through which to disseminate the results of the project.

6. Conclusions

This project set out to identify the similarities and gaps between training for prevocational doctors working in the hospital and community sectors, and to enhance their alignment and improve the integration of non-hospital based training within an overall prevocational program. It was shown that there is a large degree of consistency between the different accreditation standards of the state PMCs (or equivalent) and the Colleges responsible for the delivery of prevocational general practice trainings. The curriculum of the RACGP and ACRRM were also shown to be compatible with the ACFJD. Where differences exist, they largely result from the particular needs of prevocational as compared with vocational general practice trainees. The accreditation tool developed during this project identifies these needs and provides a mechanism through which they can be monitored.

Best practice in the accreditation of health services requires the involvement of a range of interested parties in ongoing evaluation and continuous quality improvement. The project outcomes highlight the need for CPMEC to continue to provide leadership in relation to the standards for prevocational medical education and training, including those for general practice and community terms, but with the involvement of other stakeholders. Because of the impending increase in the number of medical graduates expanding opportunities for delivering clinical training and improving the efficiency with which it is delivered are of paramount importance. The development of the PMAF will facilitate the articulation of principles and processes for the good governance of prevocational education and training, and of the particular needs of prevocational doctors. The project recommendations identify several mechanisms for encouraging discussion between relevant stakeholders which may bring about national consistency and remove unnecessary duplication. It is now important to carefully monitor how the recommendations of this project are acted upon, and to determine their effect on the development and implementation of the PMAF and the delivery of prevocational general practice training.

7. Recommen dations

It is recommended that Confederation of Postgraduate Medical Education Councils act on the following:

1) Ensure that all prevocational general practice and community rotations are consistent with the principles of the Prevocational Medical Accreditation Framework.

2) That CPMEC continue to advocate that PMCs be nationally recognised as the organizations with the expertise and responsibility for the accreditation of all prevocational training positions including general practice and community rotations.

3) To minimise the accreditation burden, CPMEC work with the Royal Australian College of General Practitioners, the Australian College for Rural and Remote Medicine, and other relevant Fund Holder organisations to:

- exchange information relevant to the accreditation of GP training practices with respect to prevocational training positions,
- explore the possibility of sharing accreditation visits,
- articulate similarities and differences between the PMC and other accreditation processes, and
- explore possibilities for recognition of prior accreditation status granted by the respective accreditation bodies.

4) That CPMEC explore with the relevant Colleges the possible development of a process to deliver a common pool of accreditation assessors who can work across the training continuum. These assessors should be

- familiar with the requirements of the different organizations,
- able to participate in accreditation visits as the representative of more than one organization, and
- able to facilitate effective communication between relevant organisations.

5) That CPMEC explore with the National PGPPP Advisory Committee the development of processes that enhance the involvement of Fund Holder organizations (such as Regional Training Providers, Divisions, Rural Clinical Schools) in partnering general practices through the accreditation process.

6) Ensure that accreditation standards for prevocational general practice rotations assess:

- coordination of the management of prevocational doctors by the feeder hospital, general practice and Fund Holder organisation (e.g. regional training provider),
- the integration of JMOs learning plan / objectives in the general practice rotation into their overall experience as a junior doctor,
- the feedback process for JMOs about their experiences while on their general practice placement, and
- mechanisms for ensuring the continuity of support for prevocational doctors while in the general practice rotation and away from their parent hospital.

7) That CPMEC promote the Australian Curriculum Framework for Junior Doctors and the Prevocational Medical Accreditation Framework to general practitioners who provide training to prevocational doctors.

8) That CPMEC continue to evaluate the accreditation of prevocational general practice training posts through the implementation of the project recommendations.

9) That CPMEC be provided with resources to undertake this work in conjunction with the Postgraduate Medical Councils and the relevant Colleges.

10) That CPMEC affirm the benefits of providing junior doctors with training rotations in general practice and extended primary care, and work towards enhancing prevocational training opportunities in the primary health care sector.

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Appendix 1 Membership of National Advisory Committee

Name	Organisation
Dr Rod Fawcett	Chair, PMCV Accreditation subcommittee/Director of Education and Training, Barwon Health (Chair)
Ms Carol Jordon	Executive Officer, PMCV
Dr Peter Stevens	Principal, Heyfield Medical Centre
Dr Clare Murtagh	JMO (Intern), Barwon Health
Ms Penelope Watson	Accreditation Manager, PMCV
Mr Joe Anthony Rotella	Chair, General Practice Students Network
Dr Jagdishwar (Jag) Singh	CPMEC, General Manager
Prof Dick Ruffin	Chair, PMCSA
Prof Lou Landau	Chair, PMCWA
Ms Sheree Keech	Coordinator, PMCWA
Ms Deb LeBhers	Executive Officer, PMCQ
Dr Morton Rawlins	Director of Educational Services, RACGP
Ms Marita Cowie	Chief Executive Officer, ACRRM
Ms Trish Johnson Smith*	ACRRM, Acting PGPPP Coordinator
Dr Nick Cooling	PMIT nominee; Director of Training, General Practice Training Tasmania
Dr Susan Paul	IMET representative, IMET Accreditation Committee, member IMET PGPPP Working Group
Dr Emily Mauldon	Project Manager

*Replaced Ms Leanne Renfree, former ACRRM PGPPP Coordinator.

POSTGRADUATE MEDICAL COUNCILS

Accreditation of General Practice/PGPPP placements

As part of a Medical Training Review Panel (MTRP) funded project, *National Accreditation Framework for General Practice and Community Settings,* the Postgraduate Medical Council of Victoria (PMCV) undertook to compare the way state Postgraduate Medical Councils (PMCs) accredit prevocational general practice placements. In addition to comparing accreditation standards and instruments, a survey was developed and circulated to PMC staff involved with the accreditation of general practice training posts.

The responses of the different state PMCs to the survey have been tabulated below, along with summaries for each question and some recommendations, which may feed into the final project report. Responses have not been collated for Tasmania or the Northern Territory. In Tasmania the PGPPP has only PGY2 and 2+ positions in practices that are accredited to provide vocational training by the RACGP (urban practices) and ACRRM (rural and remote practices). No additional processes are used to accredit prevocational general practice positions. The Northern Territory has been using accreditation tools developed by Institute of Medical Education and Training (IMET) for intern posts. At the time of this survey the Northern Territory was in the process of setting up its new Postgraduate Medical Council.

1. *Is your organisation responsible for accrediting GP rotations and/or community rotations for prevocational doctors? If not, what organisation(s) do you understand to be responsible?*

WA	SA	NSW	QUEENSLAND	VICTORIA
Yes, PMCWA is required to accredit all PGY1, PGY2 and PGY2+ places in WA. In WA PGPPP and Community Residency positions are only offered to PGY2 and PGY2+. Normally a pre-accreditation visit is required prior to junior doctors commencing in the practice and a follow-up accreditation visit once junior doctors are rotating through the practice.	PMCSA accredits all PGY1 positions in SA, but not PGY2 and above. PGPPP is offered at intern through PGY3/4, with PMCSA accrediting PGY1 and RACGP or ACRRM accrediting PGY2 and 2+ positions. RACGP accredits all PGPPP Resident Medical Officer (RMO) placements on a one-off basis when a placement is first approved and set up.	IMET do accreditation of GP practices.	PMCQ accredits PGPPP placements.	PMCV has delegated authority from the Medical Practitioners Board of Victoria (MPBV) for accrediting all PGY1, including intern GP (PGPPP) placements. Accreditation of PGY2 and 2+ is not mandatory but these positions are accredited by PMCV on a voluntary basis as accreditation of the parent hospital is due. Practices and GP supervisors in Victoria that have appropriate accreditation by RACGP and ACRRM can offer PGY2 and PGY2+ PGPPP positions without PMCV accreditation.

In order to be eligible for PGPPP funding, training practices and supervisors much be accredited with either the RACGP or ACRRM, and where positions are offered at PGY1 level, must also be accredited with their state PMC.[*] Beyond this, there is variation in the role different state Postgraduate Medical Councils assume in relation to accrediting PGPPP training posts. The PMCs in WA, NSW, and Qld accredit all general practice training rotations. The PMC in Victoria is required to accredit all GP rotations offered at a PGY1 level, and accredits some PGY2 and 2+ at the request of the training practice or if such positions fall due by virtue of accreditation of the parent hospital. In SA the RACGP accredits all PGPPP resident medical officer placements when they are established, PMCSA accredits all PGY1 placements, and RACGP or ACRRM are responsible for ongoing accreditation of PGY2 and 2+ positions. As mentioned above, in Tasmania PGPPP positions are only offered at PGY2 and 2+, and are accredited by RACGP and ACRRM.

In summary, where PGPPP positions are offered at a PGY1 level the state PMC is responsible for accrediting the position. The responsibility for accrediting positions offered at PGY2 and above is less clear, with 3 state PMCs (W.A., N.S.W., and Qld) systematically accrediting all PGPPP rotations, 2 states (SA and Tasmania), not accrediting them, and 1 state (Victoria) accrediting them on a voluntary basis. As the PGPPP program evolves it is likely that the mix of PGY1 / 2 /2+ positions and the educational and vocational opportunities they afford will also change.

[*] Prevocational General Practice Placement Program Guidelines for Training Collaboration, http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/Prevocational/Prevoc/200704pgppp_guidelines.doc. (accessed 6/8/08).

2. *Can you please give a brief description of your organisations' process for accrediting prevocational GP placements? (i.e. survey forms used, site visit or purely by documentation, how many people involved, how long the process takes, etc.).*

WA	SA	NSW	QUEENSLAND	VICTORIA
The process to accredit a GP placement is the same as that used for any accreditation visit. PMCWA will contact the GP Practice requesting a suitable date for the visit (normally 6-8 weeks notice) and asks for the following documentation from the clinic: • Job descriptions • JMO Duty Rosters • Formal education programs • Practice statistics • Orientation Material It is worth noting that the Western Australian General Practice Education and Training (WAGPET), the provider of the community residency program have developed manuals for their practices, which includes the following for the junior doctors: • Education Log • Mid-term assessment form • End of term assessment form • Learning Plan, and • Log of knowledge, skills and behaviours.	The accreditation process includes: • JMO survey • A site visit (by a team of 2 usually the Chair of PMCSA and a JMO). Visits are usually around 1.5 hours in duration. Practices are required to provide their relevant term description prior to the visit.	The process is outlined below, however as PGPPP is relatively new to NSW the process is still being refined: • Self-Assessment conducted by the GP using a modified subset of the standards • Onsite survey conducted by an IMET appointed survey team of two surveyors (visit usually takes one day) • Survey results assessed by the Prevocational Accreditation Committee and one year provisional accreditation can be awarded • After one year a self-assessment is conducted by the GP using the full set of standards • Onsite one day survey conducted using the full set of standards. Survey team consists of 2 to 3 surveyors. Survey results assessed by the Prevocational Accreditation Committee and dependent of compliance to the standards full accreditation awarded for 6 months, 1 year or 3 years.	PMCQ uses survey forms and a site visit is undertaken by a PMCQ team of surveyors including a GP, a junior doctor, and a senior clinician. Accreditation visits take approximately 2 hours per practice.	Accreditation is based on a 3 yearly cycle and is conducted in the same way as for hospital-based positions. When new positions are established or reaccreditation is due practices are contacted by PMCV, a date is set for the accreditation visit and appropriate documentation sent to the practice. The general practice is required to complete the PMCV accreditation survey, and provide details on: position description, orientation program, education program, supervision, duty rosters and processes for feedback and appraisal. This process may involve collaboration of several doctors at the practice, and HMO Manager (or other appropriate person) from parent hospital. Usually there are a minimum of two people on the survey team, with visits at practice taking 1-2 hours. If it's a rural practice this may mean a full day of is required for survey team members.

2. *Can you please give a brief description of your organisations' process for accrediting prevocational GP placements? (i.e. survey forms used, site visit or purely by documentation, how many people involved, how long the process takes, etc.). (cont)*

WA	SA	NSW	QUEENSLAND	VICTORIA
Accreditation questionnaires are requested from: • Trainees (where applicable), • Consultants, Supervisors and other Teachers, • Feeder Hospital PMCWA is currently reviewing their accreditation documents for PGPPP and Community Residency visits. At present when PMCWA sends documents to a GP clinic, it requests the GP to complete what they think is relevant. A visit normally lasts for one to two hours and is conducted by a team of up to three surveyors: • Lead Surveyor (a Medical Practitioner who has participated in six accreditation visits as a support surveyor), • Support Surveyor • Observer/Trainee (optional). The draft report is emailed to the practice for accuracy of factual detail and is then considered by the Accreditation and Standards Committee. The entire process can take approximately two to three months.		Accreditation may also be dependent on the GP meeting certain provisos. In some cases a further focus visit may be conducted to ensure provisos are met.		The Report of the accreditation survey team is sent to General Practice to be checked for accuracy of detail, then to the Accreditation Subcommittee. Provisional accreditation may be recommended to the Medical Board subject to periodic review or receipt of further documentation regarding for example, training infrastructure or the education program. The Medical Practitioners Board of Victoria is invited to endorse all recommendation from the Accreditation subcommittee relating to intern accreditation. The process from the start of organising the visit to when the accreditation reports are endorsed can take approximately two to three months.

Because of the close working relationships of the PMCs and their ongoing collaboration under the auspices of the Confederation of Postgraduate Medical Education Councils (CPMEC), processes and standards for accrediting prevocational training posts are very similar and, with a few exceptions, are applicable to training in both the hospital and community sectors. Accreditation for PGPPP positions involves preliminary self-reporting against accreditation survey instruments, presentation of subsidiary information (such as data on the demographic profile and case-mix of the general practice, position description, outline of education and orientation program, etc), and a site visit by accreditation surveyors. There are consistently two or three people on the survey team, including one clinician. While the time spent at a general practice is usually 1-2 hours, time is also required for preparation and completion of paperwork. Because of the distances involved with travelling to the (often rural and remote) general practices survey visitors will usually spend ½ to one day conducting the visits. A similar time commitment is involved with conducting accreditation visits for hospital-based training positions, however it should be noted that training hospitals typically support multiple training positions where as a general practice will typically have only one or two prevocational positions, making the cost of accrediting general practice training positions relatively more expensive than hospital positions.

Following the site visit a report is developed for consideration by the relevant council accreditation body and the training practice. The PMCs can recommend from a number of accreditation options regarding duration, including requirements for provisional accreditation and periodic reviews.

3. *Do you have accreditation standards or survey instruments that are tailored for GP rotations? If "yes" in what ways are these different from accreditation standards or survey instruments used to accredit other prevocational training posts in your state/territory? Please explain (Can you please provide a copy?).*

WA	SA	NSW	QUEENSLAND	VICTORIA
PMCWA currently does not conduct their accreditation visits any differently for the community residency or the PGPPP sites. However, the surveyors will modify their questions and reports to suit the nature of the practice. The PMCWA uses a combined full hospital and unit report for each community residency and PGPPP site. The surveyor will also adapt the report to suit the nature of a GP practice; usually the surveyor will note the following standards as not applying: • 1.2 Prevocational Training Committee; and • 2.2 Support for Supervisors, Team Supervisors and Directors of Clinical Training. However this may vary according to the practice.	Broad instrument used to guide visit. Focus is on supervision, experience, goals in terms of ACFJD and mechanisms for pastoral care.	IMET tool and the standards are tailored for the GP service. As the hospital supplying the prevocational trainees still takes primary responsibility for the trainee, many of the standards are not applicable to the GP service, e.g. standards around providing a balance and mix of terms and prevocational trainee management.	PMCQ survey instruments not especially tailored for GPs. Old and new standards cover the requirements. PMCQ addressed both RACGP and ACRRM standards when developing accreditation materials. *Believe the standards are applicable to all training contexts. During survey visits experienced surveys are able to identify specific criteria that are not relevant to GP.*	Yes. The language in the accreditation tool was changed to be inclusive of general practice (rather than refer exclusively to 'Hospital' or hospital-based positions, etc). Four additional criteria were added: 1.9 The practice must offer the full range of ongoing primary care. 1.10 The practice should be accredited under the RACGP minimum practice standards by a recognised accreditation body. 1.11 The hospital, practice and principal trainer must ensure that the HMO has adequate insurance coverage and is registered with the state or territory medical council for the clinical work to be undertaken. 7.5 The practice provides adequate consulting space for the JMO.

3. Do you have accreditation standards or survey instruments that are tailored for GP rotations? If "yes" in what ways are these different from accreditation standards or survey instruments used to accredit other prevocational training posts in your state/territory? Please explain. (cont)

WA	SA	NSW	QUEENSLAND	VICTORIA
It is also worth noting, the PMCWA Accreditation and Standards Committee last year recognised a need to have GP representation on its committee, and a representative of the Royal Australian College of General Practitioners has since joined. Also, the Committee is beginning to investigate if there is a need to produce a more community based/GP accreditation tool.				*Part 1 – Health Service Information & Overview* was amended to include the following: RRMA Classification, Regional Training Provider Details, Type of Practice and the clinical skills of the supervisors at the practice. *Part 3 – Hospital Assessment of Intern/PGY2 posts* is not used. This instrument collects data on hospital separations per year, WIES, no. of beds, no. of ward rounds per week, rostered hours, pre admission clinics and operating sessions. The Accreditation subcommittee includes a nominee of the RACGP and in 2008 was expanded to include a nominee of ACRRM.

NSW and Victoria have both modified their accreditation tools to better suit the needs of general practice by removing criteria that was specifically relevant to a hospital setting, including the collection of hospital data. SA has developed a template to be used during GP accreditation visits which focuses on supervision, the experience of the JMO, learning goals in terms of Australian Curriculum Framework for Junior Doctors and mechanisms for pastoral care. These were identified as key issues that have the potential to differ between hospital and community settings. Although WA and Queensland have not adapted their tools specifically for general practice placements, surveyors are conscious of the differences between accrediting hospital and community training posts. General practices staff will typically be advised not to complete sections of the accreditation survey that they do not feel is relevant to them, and surveyors will adapt their visit and report to suit the nature of the practice. A key assumption in this process is the belief that core accreditation standards for prevocational doctors are applicable to all training contexts.

4. *Do you work with ACRRM / RACGP to accredit prevocational GP placements? If so, what is the nature of your relationship? (i.e. shared documentation, shared accreditation visits, shared surveyors, representation at Accreditation committee level).*

WA	SA	NSW	Queensland	VICTORIA
PMCWA is currently having discussions with the providers of the PGPPP program and Community Residency Program regarding accreditation requirements and the possibility of being notified of the outcome of the ACRRM and RACGP accreditation surveys.	No, but could do so.	Not at this stage, however this may change in the future as there are obvious advantages in working together such as reducing duplication.	PMCQ accredits own positions and will continue to do this. They use shared surveyors recommended by RACGP.	The PMCV does not currently work with RACGP or ACRRM to accredit positions although this possibility has been discussed with ACRRM. There is an RACGP nominee on the Accreditation and Education subcommittees and an ACRRM nominee on the Accreditation subcommittee. Some shared surveyors, although they do not work in a 'shared' capacity.

None of the postgraduate medical councils (PMCs) have formal processes in place for sharing accreditation documentation or visits with RACGP or ACRRM. Not withstanding this, members of the Colleges' routinely work with the PMCs, both at a committee level, and in the capacity of accreditation surveyors. It is recommended that in further developing a National Accreditation Framework for General Practice and Community Settings opportunities be explored for sharing information and human resources between the PMCs and the RACGP and ACCRM. This should involve identifying what information collected during accreditation is relevant to each organisation and developing processes for sharing that information. As RACGP and ACCRM do not conduct sites visits as frequently as the PMCs, the Colleges may wish to consider how to best link with the PMC accreditation process and identify what supplementary information would benefit the Colleges process.

5. *Have you identified any particular challenges or problems accrediting GP placements or supporting JMOs who undertake them? If "yes" please explain.*

WA	SA	NSW	QUEENSLAND	VICTORIA
At times, there are difficulties in explaining the importance of PMC accreditation process for prevocational GP sites (as the majority have been accredited by ACCRM /RACGP). This will require a cultural change.	There is come competition between GPET providers and feeder hospitals re forms and evaluation. For example, feeder hospitals have GP Coordinators, the GPET scheme has education coordinators, and both have evaluation forms and certain requirements for the JMOs.	The only problem/challenge we have identified is around supervision. The usual supervision for PGY2s at a hospital is that they should have on site supervision at all times. The supervisors can however be asleep. This has been a challenge for GP placements as a PGY2 working at a GP clinic may at times be on-call for the local hospital, but the local hospital may not always have a more senior doctor on-site. To resolve the issue the Prevocational Accreditation Committee decided that for all out of hours calls the supervisor is to be present for the first five weeks of a term or until such time as the junior doctor is re-evaluated and the supervisor is confident that the JMO has the skills to work independently. The Committee also noted that a PGY2 placed at any GP clinic would continue to require supervision for all triage 1 consultations and that all patients, being treated by the PGY2, whose condition deteriorates, must be flagged to the PGY2's supervisor.	No problems identified to date.	A recent visit raised the issue of supervision for JMOs on call; which will be discussed and clarified by the Accreditation subcommittee in the coming months.

Both NSW and Victoria have experienced problems in relation to GP expectations of supervision for prevocational doctors while on-call. RACGP guidelines for supervision of prevocational doctors states that supervisors must be present while a PGY1 doctor attends home visits, including services provided while on-call, however there is no requirement for the GP to attend home visits by PGY 2 doctors.[*] There is clearly a discrepancy between the IMET policy stated above and the RACGP policy.

SA has noted that the competing expectations and requirements of different organisations (hospital GP coordinators and GPET) have created ambiguity and tension in the past.

WA has reported some difficulty explaining the importance of their accreditation processes for prevocational general practice positions, given that training practices and supervisors have already been accredited by RACGP or ACRRM. This resistance may reflect different expectations regarding the role of the PGPPP as either a gateway to general and rural practice or as a component of an overall postgraduate training program designed to offer junior doctors a broad experience before specialisation.

In each of the above instances, developing a set of nationally consistent accreditation standards and a framework in which they can be applied may help clarify expectations and resolve ambiguities. In particular, such a framework should consider appropriate levels of supervision for prevocational doctors, and how that might differ between the hospital and community, and public and private sectors and between urban and rural settings. Working with ACRRM and the RACGP to achieve this end will be important.

[*] RACGP, Standards for the Supervision of Prevocational Doctors in General Practice, December 2007, pp 9-10. http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/Prevocational/SupervisionStandards/200801supervision_of_prevocational_doctors.pdf . (accessed 7/8/08).

6. *Do you have any suggestions on what should be included in an accreditation framework for prevocational GP placements?*

WA	SA	NSW	QUEENSLAND	VICTORIA
No.	Must include learning goals for the GP rotation, expected experience, full details of supervision and a process for handling conflict.	Clarity around supervision for both PGY1 and PGY2 doctors.	No.	No.

In response to a previous question Queensland noted that core accreditation standards are applicable to all training settings. SA has identified four aspects of training (i.e. learning goals, overall experience, supervision and conflict management) which may operate differently in the community and hospital sectors. NSW has stressed the need for clear expectations regarding the supervision of prevocational doctors.

7. Are there any aspects of the accreditation of prevocational GP rotations in your state, which you believe could be improved?

WA	SA	NSW	QUEENSLAND	VICTORIA
An accreditation tool, standards and information package specifically for prevocational GP rotations.	N/A.	None at this point	Unsure.	Note at this point.

While WA suggests that the development of an accreditation process tailored specifically for general practice rotations may be beneficial, no other state identified any aspects of their accreditation process for prevocational GP rotations that could be improved.

Appendix 3 Accreditation Tool Part 1

Part 1: GENERAL PRACTICE INFORMATION & OVERVIEW

PART A – HEALTH SERVICE INFORMATION

1. General Practice Details

Please complete the following table

Training Practice Name:		
Postal Address:		
	Town:	Postcode:
Street Address:		
	Town:	Postcode:
Practice Principal Contact Details (or equivalent)		
Name:		
Position:		
Phone:		
Email:		
Practice Manager Contact Details (for details concerning visits, documentation, etc.)		
Name:		
Position:		
Phone:		
Email:		
RRMA Classification (please circle)	**1 2 3 4 5 6 7**	
Type of Post (please tick)		
☐ Aboriginal Medical Service ☐ Clinic ☐ Community Health Care Setting ☐ General Practice	☐ Health Care Centre ☐ Primary Health Care Setting ☐ RFD Service	
Is the practice accredited as a training practice by		
RACGP Yes ☐	Date of accreditation:	No ☐
ACRRM Yes ☐	Date of accreditation:	No ☐
Regional Training Provider (RTP) Details		
Rural Training Provider Name:		
Principal Contact Name:		
Phone Number:		

Health Service Details

Feeder Hospital Details	
Hospital Name:	
Principal Contact Name:	
Position:	
Phone Number:	

Part 1: GENERAL PRACTICE INFORMATION & OVERVIEW

2. General Practice overview

Please comment on the following:

a) Describe the practice type and size (e.g. number of doctors, practice staff, services offered, typical workload, range of procedures, resident and visiting specialists, and equipment.)

b) Outline public health/demographic data that may impact on the type of experience provided.

c) Outline particular benefits for interns, PGY2s and any other pre-vocational trainees working in the practice.

3. Feeder hospital relationship and interaction with the practice

a) Describe the recruitment and selection process used to identify the intern/PGY2 doctor(s) coming to the practice.

b) Describe the nature of the interaction(s) between the feeder hospital and the practice. (e.g. level of contact about HMO staffing and management support provided by feeder hospital, nature of any administrative arrangements between the feeder hospital and health service, visits between services by senior staff.)

c) Describe the proposed orientation and any other sessions/written materials which will be provided by the following:

The Training Practice

_____

_____

_____

The Feeder Hospital

_____

_____

4. Educational resources

Describe the proposed educational resources which will be made available. (e.g. access to online medical journals, access to 'GP Learning', shared educational programs with feeder hospital.)

_____

_____

_____

5. Facilities

Please provide a list of facilities available to the intern/PGY2 working at the practice. (e.g. car parking, computer/internet access, child care, recreational facilities and accommodation).

_____

_____

6. Supervision

a) Describe staff at the practice who will be involved the training and education of the intern/PGY2 by completing the table below:

Supervisor/Mentor Information	
Name	
RACGP Accredited Trainer	☐ Level 1 ☐ Level 2
Level Supervising	☐ Intern ☐ PGY2
Clinical Privileges	☐ Anaesthetics ☐ O&G ☐ Surgery ☐ Emergency Medicine ☐ Other
Time allocated per week to supervision	Undergraduate/s: . Intern/s: ..... PGY2/s: ..... Registrar/s: .....
Name	
RACGP Accredited Trainer	☐ Level 1 ☐ Level 2
Level Supervising	☐ Intern ☐ PGY2
Clinical Privileges	☐ Anaesthetics ☐ O&G ☐ Surgery ☐ Emergency Medicine ☐ Other
Time allocated per week to supervision	Undergraduate/s: . Intern/s: ..... PGY2/s: ..... Registrar/s: .....

Part 1: GENERAL PRACTICE INFORMATION & OVERVIEW

Name	
RACGP Accredited Trainer	☐ Level 1 ☐ Level 2
Level Supervising	☐ Intern ☐ PGY2
Clinical Privileges	☐ Anaesthetics ☐ O&G ☐ Surgery ☐ Emergency Medicine ☐ Other
Time allocated per week to supervision	Undergraduate/s:. Intern/s: ..... PGY2/s: ..... Registrar/s: .....

b) Supervision program in detail.

Describe the supervision arrangements for the intern/PGY2 doctor whilst at the practice.

_____

_____

_____

7. Evaluation and Reporting

Outline how you intend to internally evaluate the program offered to the intern/PGY2 doctor. How will the outcomes of this evaluation be used?

_____

_____

_____

Appendix 4 Accreditation Tool Part 2

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Function 1: Environment and culture in relation to HMO support

Standard 1: The Health Service demonstrates a commitment to the development of HMOs.

Rating Scale for Function 1: Environment and culture

Little Compliance - The practice has an awareness or knowledge of what systems and process need to be implemented but have only basic systems currently in place to support HMOs.
Some Compliance - There are systems and processes in place to support HMOs, but there is little or no monitoring of outcomes or efforts at continuous improvement.
Moderate compliance - This requires coordination with parent hospital regarding the collection of relevant outcome data,, evaluating and improving systems and outcomes enabling well developed systems to be in place and operational.
Extensive compliance - This requires that data is being utilised and fed back for the purposes of benchmarking and comparing systems internally and/or externally. The practice has/is networking to identify better ways of doing things.
Outstanding compliance – Such practices are considered leaders in the field relevant to this criterion. In addition to fully integrated systems and processes to support HMOs, there is evidence of innovation and continuous improvement through internal and external evaluation and benchmarking and monitoring of HMO welfare.

This function will be demonstrated when/by:

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
1.1 The hospital, practice and fundholder supports' the professional development of HMOs through appropriate training and professional development programs, including the appointment of a suitably trained Supervisor of Intern Training/ Director of Clinical Training and Principal trainer within the practice. *RACGP Standard T.1 – T.10 ACRRM Criterion 1.1 ACRRM Criterion 2.4*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
1.2 The practice and hospital provides effective organisational structures for the management of HMOs. *RACGP Standard T.34, T.37 ACRRM Criterion 2.7*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
1.3 HMOs are encouraged to assume responsibility commensurate with their skills and experience and supervision.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Rating Scale for Function 1: Environment and culture (cont)

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
1.4 The practice reviews its rostering and work practices to ensure HMOs have a balance between education, service and lifestyle. *RACGP Standard T.30, T38, T.39, T.40 RACGP Quality T.36,*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
1.5 The practice and hospital has established processes to enable access to confidential career counselling and advice which is known to the HMO and their supervisors and other team members.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
1.6 The overall management of the HMO year is coordinated between the parent hospital and rotation practice.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
1.7 The practice and hospital have in place processes for identifying HMOs experiencing difficulties who can be assisted promptly and confidentially.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
1.8 The practice has a process in place to enable supervisors and managers of HMOs to identify "at risk" behaviour and take appropriate action.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
1.9 The practice must offer the HMO an educationally diverse experience of primary care. *RACGP Standard T.27*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
1.10 The practice should be accredited under the RACGP minimum practice standards by a recognised accreditation body. *RACGP Quality T.35 ACRRM Criterion 2.4*	☐ ACRRM ☐ RACGP	☐ ACRRM ☐ RACGP	☐ ACRRM ☐ RACGP	☐ ACRRM ☐ RACGP

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Rating Scale for Function 1: Environment and culture (cont)

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team Rating
1.11 The hospital, practice and principal trainer must ensure that the HMO has adequate insurance coverage and is registered with the state or territory medical council for the clinical work to be undertaken. *RACGP Standard T.20*	☐ Hospital - Vicarious Liability Insurance cover ☐ Relevant registration with Board	☐ Hospital - Vicarious Liability Insurance cover ☐ Relevant registration with Board	☐ Hospital - Vicarious Liability Insurance cover ☐ Relevant registration with Board	☐ Hospital - Vicarious Liability Insurance cover ☐ Relevant registration with Board

Overall Rating for Function 1: Environment and culture

Instructions: Please indicate (tick) an overall rating for this function.

INTERN ASSESSMENT		PGY2 ASSESSMENT	
Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Health Service Comments/Evidence

Survey Team Comments
Please tick the appropriate box
Does the practice or hospital employ:
Principal trainer ☐Yes ☐No
Supervisor of Intern Training ☐Yes ☐No
Director of Clinical Training ☐Yes ☐No

Further Comments

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008

Function 2: Orientation

Standard 2: HMOs participate in formal orientation programs which are designed and evaluated to ensure sound learning occurs.

Rating Scale for Function 2: Orientation

Little compliance – The orientation program is non-existent or not relevant.
Some compliance – The orientation program is of limited relevance to HMOs, or is didactic and/or paper based. There is no or only paper based orientation for new rotations during the year.
Moderate compliance - There is an orientation program for the general practice or community rotation, which is interactive and has appropriate paper support.
Extensive compliance - There is, in addition to a comprehensive initial program, an orientation program for the general practice or community rotation which is interactive and has appropriate paper support. All HMOs are expected to attend. The orientation programs are coordinated between the parent and rotation hospitals and are evaluated annually.
Outstanding compliance – There is an orientation program for the general practice or community rotation which is interactive and has appropriate paper support. The orientation program is mandatory for all HMOs, is evaluated annually and incorporates feedback from HMOs. The orientation programs are co-ordinated with programs at the parent/rotation hospitals and are modified in light of the evaluation.

This function will be demonstrated when/by:

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
2.1 The practice and hospital provide a formal orientation program at the beginning of the year, and at the beginning of the general practice rotation. *RACGP Standard T.19*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
2.2 Orientation material is sent to the HMO prior to their commencing the general practice rotation.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
2.3 Orientation programs are interactive and not lecture based. *RACGP Standard T.19*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding ☐
2.4 Orientation programs are evaluated to ensure they meet the needs of HMOs. *RACGP Feedback T.44*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Rating Scale for Function 2: Orientation (cont)

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
2.5 HMOs receive written material and/or handbooks which supplements the content of the formal orientation program(s). *RACGP Standard T.19*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
2.6 During orientation HMOs are made aware of and introduced to local health care networks.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
2.7 The orientation programs are co-ordinated between the practice and the parent hospital if applicable. *RACGP Standard T.19*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Overall Rating for Function 2: Orientation

Instructions: Please indicate (tick) an overall rating for this standard

INTERN ASSESSMENT		PGY2 ASSESSMENT	
Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Health Service Comments/Evidence

Survey Team Comments

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Function 3: Education Program

Standard 3: HMOs are provided with appropriate formal educational opportunities

Rating Scale for Function 3: Education Program

Little compliance – There is no program for HMOs and little expectation that they will attend other education programs.
Some compliance – There is either a program designed for HMOs or other educational programs which they may attend. HMOs are encouraged to attend other relevant programs.
Moderate compliance – There is a program designed for HMOs and all are expected to attend. HMOs are encouraged to attend other relevant programs.
Extensive compliance – There is a program designed for HMOS which they are expected to attend. The program is evaluated annually and the feedback from HMOs is acted upon to modify existing programs and/or design of new programs.
Outstanding compliance – The HMOs specific program is mandatory for all, is evaluated annually and incorporates feedback from HMOs. It is also coordinated with programs at parent/rotation hospitals and is modified in the light of evaluation.

This function will be demonstrated when/by:

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
3.1 The principal trainer assesses the educational needs of HMOs and develops appropriate programs and commits resources to meet these identified needs. *RACGP Standard T.14* *ACRRM Criterion 1.2*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
3.2 There is a formal and structured education program specifically for HMOs, which involves practice-based teaching. Time allocation dependant on level of HMO training. *RACGP Standard T.9, T.16, T.32* *ACRRM Criterion 2.6*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
3.3 Education programs are accessible. *ACRRM Criterion 2.2* *ACRRM Criterion 2.5*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Rating Scale for Function 3: Education Program (cont)

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team Rating	Health Service self assessment rating	Survey team rating
3.4 Attendance at education programs is supported by the practice and principal trainer. RACGP Standard T.15 *ACRRM Criterion 2.6* *ACRRM Criterion 2.7*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
3.5 Education programs are coordinated between the parent hospital and rotation practices. Including ALS and paediatric experience (assessment of sick child) *ACRRM Criterion 2.6*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
3.6 There are learning objectives for the general practice rotation which are consistent with the Australian Curriculum Framework for Junior Doctors and the PMCV *Learning Framework for PGY2/3.* RACGP Standard T17 ACRRM Criterion 2.5	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
3.7 Education programs are evaluated to ensure they meet the needs of HMOs. *RACGP Feedback T.42, T.43* *ACRRM Criterion 2.8*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
3.8 The hospital, fundholder and regional training provider trains and supports registrars and clinicians in their role as teachers and supervisors of HMOs. *RACGP Standard T.5*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Overall Rating for Function 3: Education Program

INTERN ASSESSMENT		PGY2 ASSESSMENT	
Health Service self assessment rating	**Survey team rating**	**Health Service self assessment rating**	**Survey team rating**
☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Health Service Comments/Evidence

Survey Team Comments

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Function 4: Supervision

Standard 4: HMOs are supervised at a level appropriate to their experience and responsibilities

Rating Scale for Function 4: Supervision

Limited compliance – HMOs do not always have an appropriately qualified supervisor available.
Some compliance – HMOs always have appropriately qualified supervisors available but the supervisors' understanding of their role is limited.
Moderate compliance – HMOs supervisors are available, are aware of their role and are known to the HMOs.
Extensive compliance – Supervisors actively supervise and discuss/define the HMOs expectations of the rotation at the commencement of the rotation and check whether these have been met at the completion of the rotation.
Outstanding compliance – Supervisors actively supervise, discuss/define the HMOs expectations of the rotation at the commencement and end of rotations and set aside time to help them meet their agreed expectations during the rotation.

This function will be demonstrated when/by:

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	**Survey Team Rating**	**Health Service self assessment rating**	**Survey Team Rating**
4.1 HMOs have a designated Practice Supervisor who are known to them and who actively supervise. *RACGP Standard T8-10* *ACRRM Criterion 1.1*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
4.2 The practice supervisor(s) have a clear understanding of their role and responsibility in assisting HMOs to meet their learning objectives and demonstrate a commitment to their training. *RACGP Standard T.5, T.6, T.9, T.10, T.14, T.21, T.22, T.24, T.25* *ACRRM Criterion 1.2, 1.3, 1.4*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Rating Scale for Function 4: Supervision (cont)

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
4.3 Appropriate supervision is provided at all times by suitably qualified and experienced medical practitioners. *RACGP Standard T.1-5, T8-10, T.26 ACRRM Criterion 1.1*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
4.4 The practice has a process in place which enables an evaluation of the adequacy and effectiveness of supervision of HMO's annually. *RACGP Feedback T.42, T.43, T.44*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
4.5 Supervisors encourage HMOs to reflect on, and critically appraise their clinical experience, and to draw links between their knowledge base and their clinical experience. *RACGP Standard T.14, T.17*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Overall Rating for Function 4: Supervision

INTERN ASSESSMENT		PGY2 ASSESSMENT	
Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Health Service Comments/Evidence

Survey Team Comments

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Function 5: Feedback and Assessment

Standard 5: HMOs receive continuous and constructive feedback on their performance

Instructions: Please tick an appropriate response for each assessment criteria using the rating scale below.
Rating Scale for Function 5: Feedback and Assessment

Little compliance –HMOs receive no summative feedback and minimal or no formative feedback.
Some compliance – Supervisors complete assessment forms but do not involve HMOs in the process. HMOs receive minimal or no formative feedback.
Moderate compliance – HMOs are involved in the completion of summative assessment forms and receive formative feedback.
Extensive compliance – HMOs are assessed on the agreed objectives for their term in their summative feedback and receive mid term formative feedback according to the same objectives.
Outstanding compliance – HMOs are encouraged to develop their own specific learning objectives for their term, in addition to those outlined, and are assessed against these at both summative and formative feedback sessions.

This function will be demonstrated when/by:

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
5.1 The practice clearly explains the criteria, process and timing of assessment and feedback to HMOs.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
5.2 Assessment of HMOs is based on the achievement of objectives, expectations and standards, clearly understood by supervisors and HMOs. *RACGP Standard T.14, T.17*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
5.3 HMOs receive progressive and informal feedback throughout the rotation from supervisors and other clinic staff. *RACGP Standard T.14, T.15, T.17*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Rating Scale for Function 5: Feedback and assessment (cont)

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	**Survey team rating**	**Health Service self assessment rating**	**Survey team rating**
5.4 HMOs receive formal feedback on the rotation as a whole from clinical supervisors, including registrars, at the end of every rotation. *RACGP Standard T.14, T.17* *RACGP Feedback T.43, T.45, T.47*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
5.5 Performance feedback on the year as a whole is received from the Supervisor of Intern Training/Director of Clinical Training or equivalent.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
5.6 HMOs are encouraged to take responsibility for their own performance, and to seek feedback from their supervisors in relation to their performance. *RACGP Standard T.14, T.17* *RACGP Feedback T.42, T.46*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Overall Rating for Function 5: Feedback and Assessment

INTERN ASSESSMENT		PGY2 ASSESSMENT	
Health Service self assessment rating	**Survey team rating**	**Health Service self assessment rating**	**Survey team rating**
☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Health Service Comments/Evidence

Survey Team Comments

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Function 6: Program evaluation

Standard 6: The Health Service formally evaluates the HMOs program in a continuous improvement framework

Rating Scale for Function 6: Program Evaluation
In all cases, the HMO program and the rotations made available by the hospital must meet the requirements of the Medical Practitioners Board of Victoria.

Little compliance - There is no formal evaluation of the HMO program. Informal comments may be directed to the Supervisor of Intern Training or equivalent; or the HMO Manager.
Some compliance – HMOs are asked to provide feedback on the program and the rotations but the information is not collated or fed back to the practice supervisors or parent hospital.
Moderate compliance – HMOs and senior practice staff are asked to provide feedback on the program and the general practice rotation. Feedback is reviewed within the practice and forwarded to the parent hospital.
Extensive compliance – HMOs and senior practice staff are expected to provide feedback on the program and the general practice rotation. Information is forwarded to the parent hospital and reviewed annually by senior practice staff
Outstanding compliance – HMOs and senior practice staff are expected to provide feedback on the program and the rotation and the information is used in feedback sessions to senior staff and HMOs at the end of each year. The evaluation is coordinated between the parent hospital and general practice and is used to modify the rotation in light of the evaluation.

This function will be demonstrated when/by:

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
6.1 The HMO program is evaluated. *ACRRM Criterion 2.8*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
6.2 A process is available for supervisors and senior staff, as appropriate, to provide feedback on the HMO program. *RACGP Feedback T.43, T.45, T.47* *ACRRM Criterion 2.8*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
6.3 A confidential process is available for HMOs to provide feedback on their experience. *RACGP Feedback T.42, T.44, T.46* *ACRRM Criterion 2.8*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding ☐	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Rating for Function 6- Program Evaluation (cont)

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
6.4 Feedback is acted upon to improve the HMO experience for HMOs, supervisors and practice and hospital administrators and the program is modified as necessary.	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Overall Rating for Function 6: Program Evaluation
Instructions: Please indicate (tick) an overall rating for this function

INTERN ASSESSMENT		PGY2 ASSESSMENT	
Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Health Service Comments/Evidence

Survey Team Comments

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Function 7: Facilities and Amenities

Standard 7: The Health Service provides a safe physical environment and amenities that support the HMO.

Rating Scale for Function 7: Facilities and Amenities

Little compliance -There is no evidence of suitable overnight accommodation and/or facilities specifically for HMOs.
Some compliance - There is evidence of basic accommodation and/or facilities for HMOs.
Moderate compliance - There is evidence of suitable accommodation and facilities for HMOs.
Extensive compliance - There is evidence of high quality and accessible accommodation and facilities for HMOs.
Outstanding compliance - In addition to high quality and accessible accommodation and facilities for HMOs, there is evidence of ongoing monitoring and opportunity for improvement of facilities.

This function will be demonstrated when/by:

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
7.1 The practice provides safe, clean and accessible overnight accommodation for HMOs, if in a rural location. *RACGP Quality T.35* *ACRRM Criterion 2.4*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
7.2 The practice provides appropriate on site recreational areas with access to on-line information systems for HMOs. *RACGP Quality T.35*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
7.3 The practice provides a secure place for storage of personal belongings for HMOs during work hours. *RACGP Standard T.29* *ACRRM Criterion 2.4*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding
7.4 The practice provides HMOs with access to facilities and educational resources, including clinical skills teaching facilities, appropriate to their educational needs and clinical needs of the practice. *RACGP Standard T.31*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Part 2: ASSESSMENT AGAINST FUNCTIONS AND STANDARDS FOR 2008 - GENERAL PRACTICE

Facilities and Amenities continued

Assessment criteria	INTERN ASSESSMENT		PGY2 ASSESSMENT	
	Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
7.5 The practice provides adequate consulting space for the HMO. *RACGP Standard T.29* *ACRRM Criterion 2.4*	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Overall Rating for Function 7: Facilities and Amenities

INTERN ASSESSMENT		PGY2 ASSESSMENT	
Health Service self assessment rating	Survey team rating	Health Service self assessment rating	Survey team rating
☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding	☐ Little ☐ Some ☐ Moderate ☐ Extensive ☐ Outstanding

Health Service Comments/Evidence

Survey Team Comments

Appendix 5 Comparison of RACGP, ACRRM and PMCV standards

POSTGRADUATE MEDICAL COUNCIL OF VICTORIA

COMPARISON OF ACCREDITATION STANDARDS

Background:

In 2007 the Postgraduate Medical Council of Victoria (PMCV) began placing junior doctors into general practice through the Prevocational General Practice Placements Program (PGPPP). Although prevocational doctors have had the opportunity to work in general practice for a number of years, placements have previously been coordinated through the RACGP and ACRRM, and have tended to involve doctors at a more advanced stage of their prevocational training. While these Colleges have extensive processes for quality assurance and improvement, and the accreditation of training, they differ from those of the PMCV which were originally designed to accredit training positions within public hospitals. It is necessary, therefore, to examine the relevant accreditation standards in order to determine how closely they are aligned.

This document maps the guidelines for the PGPPP, and the standards of the RACGP and ACRRM against the standards used by the PMCV to accredit prevocational training posts. An attempt has been made to create a 'best-fit' between the different organisations' standards. This exercise has revealed many instances where the standards overlap or provide comprehensive coverage of relevant issues, despite slight differences in their wording and intention, but has also revealed a number of gaps which warrant attention. The standards reviewed include the:

- PGPPP *Program Guidelines for Training Collaborations,*
- PMCV/Medical Practitioners Board of Victoria standards for the accreditation of intern posts and the standards for the assessment of PGY2 posts
- RACGP, *Standards for General Practice Education and Training: Trainers and Training posts 2005 (RACGP 1), Standards for General Practice Education and Training; Programs and Providers 2005 (RACGP 2),* and *Standards for the Supervision of Prevocational Doctors in General Practice, December 2007 (RACGP 3), and*
- ACRRM *Standards Required of ACRRM Teaching Posts and Teachers In Rural and Remote Medicine (ACRRM 1), and Standards for Regional Training Providers (RTP) Recognition (ACRRM 2).*

Preliminary Conclusions:

ACRRM and the RACGP both have a multilayered accreditation process whereby supervisors, training posts, training providers and educational programs all require accreditation and are covered by different accreditation standards and guidelines. This process predominantly assumes that training is to be provided for registrars working towards vocational registration by the different Colleges. Despite recent work (i.e. the RACGP Standards for Supervision of Prevocational Doctors) the question of how best to manage the training needs of prevocational doctors or to accredit training positions for them is less clearly articulated.

Two major components of the PMCV accreditation standards which appear not to be adequately covered by the RACGP and ACRRM standards are:
1) ensuring the needs of prevocational doctors are adequately addressed while on GP rotations, and
2) ensuring a thorough integration of GP terms within the JMO program.

Attention should be paid by the PMCV to articulating how different levels of prevocational doctors' needs' vary from doctors enrolled in vocational training with ACRRM or the RACGP, and ensuring these needs are met. This will require that Regional Training Providers and Supervisors have a clear understanding of, and map clinical and other training opportunities to, the Australian Curriculum Framework for Junior Doctors (ACFJD) (rather than the respective Colleges' curriculum or other training requirements). Little attention is paid in the current standards to the transition between the parent hospital and GP term, and back again, including;

- the integration of the JMOs' learning plan / objectives in the GP term into their overall experience as a junior doctor,
- adequately documenting and feeding back information about JMOs' experiences while on their GP placement,
- continuity of support for the prevocational doctor in the GP term by their parent hospital, and
- overall coordination of the management of the prevocational doctor by the parent hospital, general practice and rural training provider.

Accreditation standards which recognise these issues, both within the general practice and within the rotating hospital, should be incorporated into the overall PMCV accreditation framework.

Given the thorough process of ACRRM and the RACGP, the PMCV should have confidence that training practices and supervisors that have received appropriate accreditation will deliver a high-quality educational experience to prevocational doctors. The opportunity therefore exists for the PMCV to alter its requirements and to work with RACGP and ACRRM to explore possibilities for streamlining accreditation of PGPPP placements through sharing documentation or other elements of the accreditation process. The PMCV should give consideration to a revised accreditation survey process in relation to General Practice terms that addresses the issues identified above, but still continues to provide an appropriate mechanism for the PMCV to monitor how well that educational experience meets the needs of prevocational doctors undertaking a GP term.

If a revised accreditation process is to be developed a risks/benefits analysis should be undertake that addresses the following issues:

- acceptability of proposal to RACGP, ACRRM and Medical Board
- issues relating to sharing of documentation (i.e., privacy, security)
- resource implications for participating organisations (including general practices, accreditation surveyors, etc),
- periodic monitoring of changes to accreditation standards/requirements of participating organisations.

The Mapping Exercise:

Each of the PMCV accreditation standards is outlined below, along with the PGPPP *Program Guidelines for Training Collaborations,* and the RACGP and ACRRM standards that most closely approximates them. Following this, specific PMCV accreditation criteria are tabulated against RACGP and ACRRM standards and criteria, with each standard being represented in a different column.

It should be noted that an initial mapping analysis was carried out focusing on the PGPPP *Program Guidelines for Training Collaborations,* the RACGP *Standards for General Practice Education and Training: Trainers and Training posts (2005)* and*, Standards for the Supervision of Prevocational Doctors in General Practice, (December 2007),* and the ACRRM *Standards Required of ACRRM Teaching Posts and Teachers In Rural and Remote Medicine.* As this resulted in significant gaps, additional standards for training providers were identified and added to the analysis (ACRRM *Standards for Regional Training Providers (RTP) Recognition,* and RACGP *Standards for General Practice Education and Training; Programs and Providers*). These standards were used to complement the initial analysis, demonstrating coverage by ACRRM and RACGP of the majority of the PMCV accreditation criteria that were not addressed in the earlier standards. For this reason the standards for training providers and programs have not been comprehensively mapped against all PMCV accreditation criteria. Where the PMCV standards and criteria are adequately cover by the RACGP and ACRRM standards for training posts and supervisors, the standards for training providers and programs may not appear in tabular form.

1. ENVIRONMENT AND CULTURE

PMCV Standards
Function 1: Hospital environment and culture in relation to HMO support
Standard 1: The hospital demonstrates a commitment to the development of HMOs

RACGP

Standards for the General Practice or Primary Care Facility
The general practice or primary care facility involved in training must provide excellent learning opportunities for the registrar. The primary care team should be aware of the experience and role of the prevocational doctor, and the need to ensure that they have adequate time for learning as well as clinical experience. Computers are required for many aspects of primary care and are certain to be an important tool in the future. It is important that prevocational doctors understand to role of computers during their supervised post.

PGPPP program Guidelines
Hospital
The hospital supplying junior doctors must:
- recruit an additional doctor to ensure the hospital remains adequately resourced;
- participate in the selection process for the junior doctor to undertake a general practice placement;
- be actively involved in the Training Collaboration; and
- remain the employer of the junior doctor and provide appropriate indemnity cover (where alternative arrangements are preferred by all members of the Training Collaboration, these should be detailed with appropriate justification).

Training Collaboration
The organisation providing a general practice experience should:
- have a genuine interest in prevocational doctors' education and training;
- be located in an eligible area (refer to Section 6 of the Guidelines);
- have a general practice supervisor that is accredited by ACRRM and/or RACGP;
- have more than one general practitioner (GP) in practice (however, if a practice has only one GP, capacity to provide adequate supervision needs to be demonstrated in the application);
- be accredited for general practice training purposes by ACRRM and/or RACGP;
- be accredited by the relevant Postgraduate Medical Education Council if the junior doctor is an intern;
- demonstrate a willingness to provide a level of support for the junior doctor greater than that provided for a basic term registrar undertaking training in the Australian General Practice Training Program;
- expect patient numbers to be lower than a basic term registrar (i.e. less than four standard consultations per hour);
- demonstrate a program of activity for the junior doctor; and
- demonstrate a program of supervision for the junior doctor.

ACRRM

2. Practice Training posts
This standard on rural and remote training posts is concerned with issues surrounding the level of organisation, facilities, policies and resources provided to learners in the ACRRM Vocational Training Pathway and the range of clinical learning opportunities provided by the post to meet educational outcomes.

This includes those posts that enable rural and remote doctors to develop the necessary knowledge and skills to be innovative, flexible and resourceful practitioners of the future. Therefore these experiences should occur in the full range and diversity of rural and remote settings of practices and hospitals and may include, Royal Flying Doctor Services, branch surgeries, Aboriginal Community Controlled Health Organisations etc.

ENVIRONMENT AND CULTURE

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1
1.1 The hospital, practice and fundholder supports the professional development of HMOs through appropriate training and professional development programs, including the appointment of a suitably trained Supervisor of Intern Training/ Director of Clinical Training and /Principal trainer or Supervisor within the Practice RACGP Standards T.1 – T.10 (Standards for General Practice Supervisors p. 6) ACRRM Criterion 1.1, 2.2, 2.3, 2.4	Standards T.1 – T.10; see below		*Standards for General Practice Supervisors* These detail standards for GP trainers including registration status, qualifications, commitment to education of junior doctors, time available, commitment to continuing professional development and quality improvement.	Criterion 1.1 The rural and remote doctor teacher must have sufficient qualifications and experience to act as an appropriate Supervisor or Mentor. Criterion 2.2 The training post provides appropriate training resources. Criterion 2.3 The training practice has a documented teaching plan. Criterion 2.4 The training practice is suitably equipped with clinical and office equipment sufficient to allow the registrar to practise well and to learn new skills. *Relevant Indicator*: Provides access to professional development for all staff, this includes training specifically orientated to supporting learners in the practice setting and in the community together with their families when this applies.

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1
1.2 The hospital and practice provides effective organisational structures for the management of HMOs. RACGP Standard T.34, T.37 Standards for the GP or Primary Care Facility (p.11) ACRRM Criterion 2.7	Standard T.34 Practice staff members must be informed of the function and needs of the registrar, provide feedback to the GP on how the registrar interacts with them, and encourage the registrar to take an interest in aspects of practice administration. Standard T.37 There should be adequate administrative staff to support all the clinical staff in the Facility.		7. Practice staff members should be informed of the function and needs of the prevocational doctor, and provide feedback to the GP on how the prevocational doctor interacts with them, and encourage the prevocational doctor to take an interest in aspects of practice administration.	Criterion 2.7 The training post must have clear and adequate organisational management arrangements. *Relevant Indicator*: • It is a requirement that training posts and learners enter into an appropriate arrangement of employment and learning/training opportunities according to the learner's professional ability and professional recognition in Australia, and in line with any employer/employee relationship required by the over-arching training organisation – e.g. for Registrars with teaching practices in accordance with GPET National Terms and Conditions for Registrar Employment
1 .3 HMOs are encouraged to assume responsibility commensurate with their skills and experience and supervision. RACGP Standards for Training Programs P. 4		Standard P.4 The program must be underpinned by educational concepts and principles appropriate to professional postgraduate vocational training, including: • emphasising experiential	4. The supervisor should provide supervision to the prevocational doctor to the level appropriate to their level of training as indicated below. 5. Level 1 PGY 1 doctor: 6. Level 2 PGY 2 doctor:	Not Mentioned.

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1
Standards of support required for the Prevocational Doctor (pp.9-10)		learning through practical clinical experience. This involves consulting with patients who present with common and significant conditions that exemplify general practice.	7. Level 3 PGY 3 doctor: 8. Level 4 PGY 4+ doctor: [each level specifies responsibilities for supervisor. Emphasis on supervisor not the JMO].	
1.4 The hospital and practice reviews its rostering and work practices to ensure HMOs have a balance between education, service and lifestyle. RACGP Standard T.30, T.36, T.38, T.39, T.40 Standards relating to the workload of the Prevocational Doctor (p.13) ACRRM Criteria 2.5, 2.6	Standard T.30 The service demands of the training post must not be excessive and the structuring of duty hours and on call schedules consider the needs of patients, continuity of care and the educational needs of the registrar. Quality T.36 The practice should be able to function adequately. Standard T.38 The registrar must average at least eight patients per session in usual general practice… Standard T.39 The registrar must not book more than four patients per hour in the first year in general practice.		There should be an adequate patient load for the prevocational doctor. Consideration should be given to the doctor's experience, the quality of patient care, the time taken in teaching and the type of services rendered. However, the clinical load should mean that the doctor is occupied most of the day, allowing for the above factors and normal daily and seasonal fluctuations. 1. The prevocational doctor should see an average of at least eight patients per session, whenever possible. 2. The prevocational doctor should not have more than four patients booked per hour. 3. The workload of the prevocational doctor should be monitored and managed to ensure they do not see a	Criterion 2.5 The training practice provides a range of clinical learning opportunities. *Relevant Indicator.* • The training post at a minimum: Provides the learner with an adequate but not excessive patient workload. It is not possible to set parameters in this regard, as consideration has to be given to the learner's experience and the types of services rendered. However, the clinical load should mean that the learner is occupied most of the working day, allowing for the above factors and normal daily and seasonal fluctuations. The key is to ensure a balance for the learner between gaining adequate clinical experience and having the opportunity to undertake other learning activities.

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1
	Standard T.40 The workload of the registrar must be monitored and managed to ensure they do not see a particular group (age or gender) or presentation in an excessive proportion.		particular group (age or gender) or presentation in an excessive proportion, on order to experience the wide variety of presentations in general practice.	Criterion 2.6 There are structured dedicated teaching times for training and study negotiated between the learner and overseen by regional consortium boards and/or other education providers. *Relevant Indicators:* • Time release for learners to undertake educational activities including structured external activities, self-directed learning etc, according to the requirements for their stage of learning as outlined by relevant education providers and as approved by ACRRM • Time for opportunistic and structured teaching especially of procedural skills training. • Time to attend compulsory training courses e.g. EMST, APLS.
1.5 The hospital has established processes to enable access to confidential career counselling and advice which is known to the HMO and their supervisors and other team members.	N/A	N/A	A doctor taking responsibility for the supervision of prevocational doctors at all stages of their term should display the following attributes:	Criterion 1.4 The supervisor and/or mentor is committed to supporting registrars. *Relevant indicator*: The supervisor and/or mentor:

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1
RACGP Standards for general practice supervisors (P. 6) ACRRM Criterion 1.4			• be able to adopt a counselling role with the prevocational doctor in relation to career or vocational planning and dealing with work pressures.	• Undertakes responsibility for providing professional and personal support and guidance to a learner as required. • Is able to assist the learner with the development of an overall learning plan and assist the learner to review that plan regularly during each 12-month period. • Maintains confidentiality with the learner.
1.6 The overall management of the HMO year is coordinated between the parent hospital and rotation practice.	Not Mentioned	Not Mentioned	Not Mentioned	Not Mentioned
1.7 The hospital has in place a process for identifying HMOs experiencing difficulties who can be assisted promptly and confidentially. RACGP Standards of Support for Registrars P.31 Standards for general practice supervisors (P. 6) ACRRM Criterion 1.4		Standard P.31 There are mechanisms for pastoral support, counselling and monitoring of registrar wellbeing that include: • a documented 'registrar in difficulty' process • identified procedures for remediation • a process for identifying problems that might lead to difficulties in special training situations, such as remote placements or practising alone for a period of time.	A doctor taking responsibility for the supervision of prevocational doctors at all stages of their term should display the following attributes: • be able to adopt a counselling role with the prevocational doctor in relation to career or vocational planning and dealing with work pressures (p. 6)	Criterion 1.4 The supervisor and/or mentor is committed to supporting registrars. *Relevant indicator*: The supervisor and/or mentor: • Undertakes responsibility for providing professional and personal support and guidance to a learner as required. • Maintains confidentiality with the learner. • Demonstrates well developed communication

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1
				and interpersonal skills. • Possesses personal attributes suitable to undertaking a mentorship role including: • Empathy, • Active listening skills, • Self awareness, • Open-mindedness, • Reliability, • Being innovative, resourceful and flexible.
1.8 The hospital has a process in place to enable supervisors and managers of HMOs to identify "at risk" behaviour and take appropriate action. RACGP Standards for Training Programs P.10 ACRRM Criterion 1.3		Standard P.10 An integral and critical part of the education and training in the program must be high quality regular formative assessment with constructive feedback to registrars on their performance. This assessment must be supported by: • documented remediation processes to assist registrars whose progress is assessed as unsatisfactory • a documented process for dealing with registrars whose progress remains unsatisfactory after remediation.	Not Mentioned	Criterion 1.3 The supervisor and/or mentor has demonstrated abilities as a teacher. *Relevant indicator:* The supervisor and/or mentor: • Is skilled in observing patient consultations and other learner activities; in appraising performance and helping learners to analyse their performance; in identifying learning opportunities; in providing feedback in a constructive and supportive manner; and remediation. • In collaboration with the education provider/training broker, is able to assist the learner with the development of a learning plan, and

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1
1.8 (cont)				identifying specific learning goals that are realistic. … This will include frank discussions on progress to date and possible variation of training to meet new needs as they arise.

Additional Standards for GP terms - PMCV	**RACGP1**	**RACGP2**	**RACGP3**	**ACRRM**
1.9 The practice must offer the full range of ongoing primary care. RACGP Standard T.27 Standards for the General Practice or Primary Care Facility (p.11) ACRRM Criterion 2.5	Standard T.27 The facility must offer the full range of ongoing primary care to all patients who attend.		1. The facility must offer the full range of ongoing primary care to all patients who attend.	Criterion 2.5 The training practice provides a range of clinical learning opportunities. *Relevant Indicators:* The training post at a minimum: • Provides the learner with a range of clinical experiences and responsibilities that cover the spectrum of illness, conditions and situations usually encountered in rural and remote medical practice, including the opportunity to gain experience in emergency medicine and after hours work. Posts will offer opportunities for special/procedural skills training as appropriate and depending upon availability either locally or off-site. This will depend upon the range

Additional Standards for GP terms - PMCV	**RACGP1**	**RACGP2**	**RACGP3**	**ACRRM**
1.9 (cont)				of skills and level of experience of the supervisor and other members of the health care team and the morbidity and mortality profile of the local community. ▪ Provide opportunities for the learner to take on extended continuity of care responsibilities such as home visits, nursing home visits, hospital visits and other visits outside the practice premises. • Provides the learner with opportunities to be part of and learn through being a member of a rural and/or remote health care team with adequate access to nursing, allied health, radiology, pathology and other diagnostic services. There should be adequate access to hospitals and to consult with allied health professionals, Aboriginal Health Services and other community services should be encouraged.

ENVIRONMENT AND CULTURE (cont)

Additional Standards for GP terms – PMCV	**RACGP1**	**RACGP2**	**RACGP3**	**ACRRM**
1.10 The practice should be accredited under the RACGP minimum practice standards by a recognised accreditation body. RACGP (1) Quality T.35 ACRRM (1) Criterion 2.4	Quality T.35 The facility should be accredited under the RACGP minimum practice standards by a recognised accreditation body.			Criterion 2.4 The training practice is suitably equipped with clinical and office equipment sufficient to allow the registrar to practise well and to learn new skills. *Relevant Indicator*: Has achieved Practice Accreditation or can demonstrate that the practice: - possesses the necessary equipment required for Practice Accreditation; - has a patient record system including health summary, health screening and recall systems suitable for Practice Accreditation. Electronic records system would be desirable or is otherwise recognised by the ACRRM Board as a suitable teaching posts.

ENVIRONMENT AND CULTURE (cont)

Additional Standards for GP terms – PMCV	**RACGP1**	**RACGP2**	**RACGP3**	**ACRRM**
1.11 The hospital, practice and principal trainer must ensure that the HMO has adequate insurance coverage and is registered with the state or territory medical board for the clinical work to be undertaken. RACGP (1) Standard T.20 (3) Standards of support required for the Prevocational Doctor (p.9)	Standard T.20: The trainer must ensure that the registrar has adequate insurance coverage and is registered with the state or territory medical council for the clinical work to be undertaken.		2. The supervisor should be satisfied and/or have verified with the fundholder that the prevocational doctor is registered with the state or territory medical council for the clinical work to be undertaken. 3. The supervisor should be satisfied and/or have verified with the fundholder that the prevocational doctor holds medical indemnity insurance for the clinical work to be undertaken.	Criterion 2.7 The practice must have clear and adequate organisational management arrangements. *Relevant Indicator:* The learner, rural doctor teacher and training post are covered by appropriate insurance.

2. ORIENTATION

PMCV Standards

Function 2: Orientation
Standard 2: HMOs participate in formal orientation programs which are designed and evaluated to ensure sound learning occurs.

RACGP
Standards of support required for registrar training
The trainer will be required to offer support to the registrar.

Standards of support required for the prevocational doctor.
The supervisor will be required to offer support to the prevocational doctor.

ACRRM

Standards for RTP Recognition: Education and Training
Criterion 5.1
The provider is able to demonstrate effective management processes for the design, delivery, monitoring, assessment, review and improvement of vocational training for FACRRM candidates, including compliance with ACRRM vocational training standards.

ORIENTATION

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
2.1 The hospital provides a formal orientation program at the beginning of the year, on commencing at a new hospital and at the beginning of each rotation. RACGP Standard T.19 Standards of support required for the Prevocational Doctor (p.9) ACRRM (2) Criterion 5.1	Standard T.19 The trainer must provide orientation to the practice ensuring that the registrar is: • introduced to all members of staff and the stage of training and responsibilities of the registrar is known by all • trained to use any systems in use such as computer systems and recall systems • aware of all procedures in the practice for referral, admission to hospital, after hours arrangements, follow up of patients, sterilisation, S8 medications and disposal of waste • aware of the location of all resources, including reference materials, medications and equipment.		1. The supervisor should provide orientation to the practice ensuring that the prevocational doctor is: • introduced to all members of staff and the stage of training and responsibilities of the registrar is known by all • trained to use any systems in use such as computer systems and recall systems • be aware of the location of educational resources, including reference materials.	Not Mentioned	Criterion 5.1 *Relevant indicators; Orientation* 1. Evidence of a FACRRM candidate access to an Orientation to Rural and Remote Medicine. 3. Evidence of teaching practice orientation which must include management, staffing bi8lling, appointments, hospital work, VMO arrangements, nursing home visits, rosters, change over, back up for VMO, after-hours work, facilities, involvement in the community and other health providers.
2.2 Orientation programs are interactive and not lecture based. RACGP Standard T.19	Refer Standard T.19 above		As above, 1.	Not Mentioned	

ORIENTATION (cont)

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
2.3 Orientation programs to both the hospital and the unit rotation are evaluated to ensure they meet the needs of HMOs. RACGP Feedback T.44	Feedback T.44 Registrars will be asked to provide feedback on the adequacy of: • the orientation and induction process *(Standard T.19)* • on site support and supervision arrangements *(Standards T.21–T.24)*.		Not Mentioned	Not Mentioned	Criterion 5.1 *Relevant indicators; Orientation* 9. Evidence of evaluation of orientation processes.
2.4 HMOs receive written material and/or handbooks which supplement the content of the formal orientation program(s).	Refer Standard T.19 above.		Not Mentioned	Not Mentioned	
2.5 The orientation programs are co-ordinated between the parent and rotation hospitals if applicable.	Refer Standard T. 19 above		Not Mentioned	Not Mentioned	

3. EDUCATION PROGRAM

PMCV Standards

Function 3: Education Program

Standard 3: HMOs are provided with appropriate formal educational opportunities.

PGPPP
Organisation providing general practice services
Relevant indicators: The organisation should:

- have a genuine interest in prevocational doctors' education and training;
- be accredited for general practice training purposes by ACRRM and/or RACGP;
- demonstrate a willingness to provide a level of support for the junior doctor greater than that provided for a basic term registrar undertaking training in the Australian General Practice Training Program;
- demonstrate a program of activity for the junior doctor.

Hospital
Relevant indicator: The hospital supplying junior doctors must:

- be actively involved in the Training Collaboration.

RACGP
Standards for the education of registrars

The college curriculum provides the framework for the education of registrars. Teaching should be based on the registrar's learning plan and other perceived needs that arise during training. Teaching should include a range of methods such as direct observation, discussions on clinical problems and interesting cases, joint consultations, formal teaching on specific topics, review of taped consultations, demonstrations, participation in clinical procedures and selected or random case analysis. Sometimes small group discussions with other members of the practice might be employed.

The trainer must assist the registrar in the development of a learning plan, with input from the medical educators where appropriate. It is essential for registrars to discuss their experience and attitudes to general practice with trainers before and during the attachment. The registrar's overall training should be discussed as well as perceptions of clinical strengths and weaknesses and consulting, counselling and communication skills. The registrar needs to understand the practice protocols, administration and other important features. In this way an individualised learning plan and training program can be developed that is tailored to the needs of the registrar and the opportunities provided in the placement, keeping in mind all the curriculum domains.

Discussions with the registrar must be based on the principles of constructive feedback. This will include frank discussion on progress to date and possible variation of the program to meet new needs as they arise. The registrar's learning plan should be reviewed in consultation with the trainer upon completion of the attachment.

Standards for the education of Prevocational Doctors

Teaching should be based on the ACRRM and/or RACGP and/or CPMED curricula, the national JMO curriculum and the relevant medical registration board/council requirements, and also the intern training programs of the parent hospital plus other perceived needs that arise during training. Teaching should include a range of methods such as direct observation, discussion on clinical problems and interesting cases, joint consultations, formal teaching on specific topics, review of taped consultations, demonstrations, participation in clinical

procedures and selected or random case analysis. Sometimes small group discussions with other members of the practice might be employed.

The prevocational doctor's overall education should be discussed as well as perceptions of clinical strengths and weaknesses and consulting, counselling and communication skills.

The prevocational doctor needs to understand the practice protocols, administration and other important features. Discussions with the prevocational doctor should be based on the principles of constructive feedback. This will include frank discussions on progress to date and possible variation of the program to meet new needs as they arise.

This will include frank discussions on progress to date and possible variation of the program to meet new needs as they arise:

ACRRM

1. Teaching, supervision and mentoring
This standard describes the criteria to be used for the selection and accreditation of Supervisors for trainees participating in the ACRRM Vocational Training Pathway. It focuses on the capacity of individuals to provide quality teaching, feedback and support.

2. Practice training posts
This standard on rural and remote training posts is concerned with issues surrounding the level of organisation, facilities, policies and resources provided to learners in the ACRRM Vocational Training Pathway and the range of clinical learning opportunities provided by the post to meet educational outcomes.

This includes those posts that enable rural and remote doctors to develop the necessary knowledge and skills to be innovative, flexible and resourceful practitioners of the future. Therefore these experiences should occur in the full range and diversity of rural and remote settings of practices and hospitals and may include, Royal Flying Doctor Services, branch surgeries, Aboriginal Community Controlled Health Organisations etc.

EDUCATION PROGRAM

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1
3.1 The principal trainer assesses the educational needs of HMOs and develops appropriate programs and commits resources to meet these identified needs. RACGP Standard T.14 Standards for the education of Prevocational Doctors (p.8) ACRRM Criterion 1.2, 2.2	Standard T.14 The trainer must assist the registrar in the development of a learning plan by week 4 of each 6 months of training – this will be submitted as part of the training portfolio for completion of training. The registrar should discuss this with the training advisor and submit a copy to the general practice training provider to be lodged in the training providers' record system.		3. The supervisor should provide planned education as outlined by the curriculum. These sessions should be at an appropriate level considering the prevocational doctor's knowledge and experience. The prevocational doctor may prepare them. 4. The planned education should amount to a session of general practice time a week.	Criterion 1.2 The Supervisor has demonstrated commitment as a teacher. *Relevant Indicators:* Provides an appraisal and an assessment of the learner in accordance with their stage of learning along the ACRRM Vocational Training Pathway, the current post and the education providers' requirements. For example, in the first 12 months of training the Supervisor undertakes direct observation or review of learner's taped consultations or web cam (at least once every 3 months) to provide the learner with feedback on performance and to guide the learner in self-evaluation of performance. Criterion 2.2 The training post provides appropriate training resources.

EDUCATION PROGRAM (cont)

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1
3.2 There is a formal and structured education program specifically for HMOs, which involves practice-based teaching. Time allocation dependant on level of HMO training. RACGP Standard T.9, T.16, T.32 Standards for the education of Prevocational Doctors (p 8) ACRRM Criterion 2.3, 2.6	Standard T.9 The trainer must be available for teaching, support and discussion for 3 hours per week for the registrar's first 6 months of general practice training and 2 hours per week for the second 6 months Standard T.16 The trainer must provide a planned education session each week in the 1 hour face to face session (please note that this is part of the availability requirement *Standard T.9*). These sessions must be consistent with the registrar's learning plan and at an appropriate level considering the registrar's knowledge and experience. They may be prepared by the registrar. Standard T.32 The facility must ensure that a private space is provided for teaching purposes and that systems are in place to protect teaching time from interruptions.		2. The supervisor should provide direct observational sessions (which could be by video review). 3. The supervisor should provide planned education as outlined by the curriculum. These sessions should be at an appropriate level considering the prevocational doctor's knowledge and experience. The prevocational doctor may prepare them. 4. The planned education should amount to a session of general practice time a week.	Criterion 2.3 The training practice has a documented teaching plan. Criterion 2.6 There are structured dedicated teaching times for training and study negotiated between the learner and overseen by regional consortium boards and/or other education providers.

PMCV	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
3.3 Education programs are accessible. RACGP (2) Standards for Training Programs P.1 ACRMM (1) Criterion 2.2, 2.5		Standard P.1 The aims and goals of the program must be clearly documented and readily accessible by all participants.		Criterion 2.2 The training post provides appropriate training resources. Criterion 2.5 The training practice provides a range of clinical learning opportunities.	
3.4 Attendance at education programs is supported by practice and principal trainer. RACGP (1) Standard T.15, Quality T.36 ACRRM (1) Criterion 2.6	Standard T.15 The trainer must support access for a medical educator to undertake direct observation sessions (which could be by video review) as prescribed by the general practice training provider. A copy of the required written report can be kept at the practice if the trainer and registrar wish. Quality T.36 The practice should be able to function adequately without the registrar present when they attend educational activities.		Not Mentioned	Criterion 2.6 There are structured dedicated teaching times for training and study negotiated between the learner and overseen by regional consortium boards and/or other education providers. *Indicators.* The training post at a minimum: • Time release is provided for learners to undertake educational activities including structured external activities, self-directed learning etc according to the requirements for their stage of learning as outlined by relevant education providers and as approved by ACRRM	

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
				Time for opportunistic and structured teaching especially of procedural skills training • Time to attend compulsory training courses e.g. EMST, APLS	
3.5 Education programs are coordinated between the parent and rotation practices, including ALS and paediatric experience (assessment of sick child)			Not Mentioned	Refer Criterion 2.6 above	
3.6 There are learning objectives for each individual rotation which are consistent with the requirements of MPBV and the PMCV *Learning Framework for PGY2/3*. RACGP (1) Standard T.17 (2) Standards for Training Programs, Standard P.3 (3) Standards for general practice supervisors (p.6) ACRRM (1) Criterion 2.5	Standard T.17 The trainer must assess the registrar's competence through consideration of training and experience or if necessary, by observation in areas that have an increased risk of adverse outcomes and litigation. Currently these include:	Standard P.3 The program must address the learning needs of participants prescribed in all five domains described in the RACGP curriculum.	The supervisor will also be the clinical educator for this prevocational doctor, ensuring that the prevocational doctor gains confidence and competence through education and experience. The experience offered should be commensurate with the prevocational doctor's stage of training, competence and confidence. It should also reflect the prevocational doctor's	Criterion 2.5 The training practice provides a range of clinical learning opportunities	

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
	• assessment of trauma, particularly fractures, nerve and tendon injuries, etc…		and postgraduate medical council's defined learning outcomes. (p. 6) Teaching should be based on the ACRRM and/or RACGP and/or CPMEC curricula, the national JMO curriculum and the relevant medical registration board/council requirements, and also the intern training programs of the parent hospital plus other perceived needs that arise during training. (p. 8)		
3.7 Education programs are evaluated to ensure they meet the needs of HMOs. RACGP (1) Feedback T.42, T.43 (2) Monitoring and Feedback (p.13) ACRRM Criterion 2.8	Feedback T.42 Registrars will be asked to provide feedback on: • the number of direct observation sessions and an assessment of the quality of feedback *(Standard T.15)*		1. The prevocational doctor will be asked to provide feedback on: • frequency and range of primary care patients seen • scheduling of their consultations and education activities	Criterion 2.8 The training post conducts a structured process to evaluate the training within the post that demonstrates how information is gathered, analysed and acted upon to improve the quality of training.	

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
	• the number of one hour face to face sessions in each 3 month period and the quality of these sessions, including their relevance to the learning plan *(Standard T.16)* • the quality of teaching and clinical support provided *(Standard T.9)* • the quality and timeliness of the assistance they received with the development and review of their learning plan *(Standard T.14)*. Feedback T.43 Trainers will be asked to provide feedback on: • registrar learning plan(s) undertaken in the practice, including comments on the strength and weaknesses of the plan, particularly in relation to achieving the learning outcomes		2. The supervisor should be in a position to provide feedback in relation to the following parameters • the number of patients seen each week •the number of patients booked per week •type of patients and problems encountered each week • on-call arrangements where applicable		

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
	in their practice *(Standard T.14)* • visits undertaken by external clinical educators and comments on any interaction with the visitor *(Standard T.15)* • assessed educational outcomes of the (uninterrupted) 1 hour teaching sessions provided for each six month period *(Standard T.16)* • professional development as a trainer and a clinical educator and the support received from the general practice training provider to undertake this *(Standard T.5)*.				

EDUCATION PROGRAM (cont)

PMCV Standards	RACGP1	RACGP2	RACGP3	ACRRM1	ACRRM2
3.8 The hospital, fundholder and regional training provider trains and supports registrars and clinicians in their role as teachers and supervisors of HMOs. RACGP(1) Standard T.5 (2) Standards of support for trainers. (3) Standards for general practice supervisors (p. 6) ACRRM (2) 6. Supervisor and Medical Educator Involvement	Standard T.5 The trainer must participate in continuing professional development aimed at improving performance as a general practice educator.	Standards of support for trainers *Relevant indicators:* The general practice training provider must ensure that: P.36 General practitioners are supported in seeking accreditation and prepared adequately for taking up the role of trainer. P.37 Trainers have at least 3 days of meetings (or pro rata equivalent) annually to enable trainers to come together and develop teaching skills. P.40 Trainers are supported in undertaking a higher degree in general practice or medical education.	5. The supervisor should participate in documented continuing professional development aimed at improving performance as a general practice educator.		Criterion 6.1 The provider is able to demonstrate effective quality monitoring and assurance systems for trainers (RM Supervisors, Mentors, Medical Educators). *Relevant indicators:* 6. Evidence of access to RRMEO training for supervisors of FACRRM candidates, FACRRM training advisors and medical educators (provided initially by ACRRM). 7. Evidence of supervisor and medical educator access to relevant educational resources and professional development opportunities. 8. Evidence of RTP facilitation of supervisor and medical educator attendance (or distance participation) at least one ACRRM education workshop per accreditation period.

4. SUPERVISION

PMCV Standards

Function 4: Supervision

Standard 4: HMOs are supervised at a level appropriate to their experience and responsibilities.

PGPPP

Organisation providing general practice services

Relevant indicators: The organisation should:

- have a general practice supervisor that is accredited by ACRRM and/or RACGP;
- have more than one general practitioner (GP) in practice (however, if a practice has only one GP, capacity to provide adequate supervision needs to be demonstrated in the application);
- be accredited for general practice training purposes by ACRRM and/or RACGP;
- be accredited by the relevant Postgraduate Medical Education Council if the junior doctor is an intern;
- demonstrate a program of supervision for the junior doctor.

RACGP

Additional standards for trainers: first year in general practice

Trainers involved in vocational training of registrars in their first year in general practice (formerly known as general practice supervisors) require more knowledge and skills and will have more demands made on them.

Standards relating to the workload of registrars

There must be an adequate patient load for the registrar. Consideration has to be given to the registrar's experience, the quality of patient care, time taken in teaching and the type of services rendered. However, the clinical load should mean the registrar is occupied most of the day, allowing for the above factors and normal daily and seasonal fluctuations.

*Standards for general practice supervisors (*p.6).

The supervisor will also be the clinical educator for this prevocational doctor, ensuring that the prevocational doctor gains confidence and competence through education and experience. The experience offered should be commensurate with the prevocational doctor's stage of training, competence and confidence. It should also reflect the prevocational doctor's and postgraduate medical council's defined learning outcomes. The supervisor should ensure that the prevocational doctor has a balanced case mix that encourages learning and a breadth of experience to ensure an understanding of the breadth of skills and knowledge required for a career in general practice throughout Australia (p.6)

ACRRM

Standard 1- Teaching supervision and mentoring

This standard describes the criteria to be used for the selection and accreditation of Supervisors for trainees participating in the ACRRM Vocational Training Pathway. It focuses on the capacity of individuals to provide quality teaching, feedback and support.

SUPERVSION

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
4.1 HMOs have designated Term Supervisors for each rotation, who are known to them and who actively supervise. RACGP Standard T.8-T.10 Standards for general practice supervisors (p.6) ACRRM Criterion 1.1	Standard T.8 The trainer must have at least 4 years full time equivalent experience in general practice. This may include postgraduate training experience in general practice. Standard T.9 The trainer must be available for teaching, support and discussion for 3 hours per week for the registrar's first 6 months of general practice training and 2 hours per week for the second 6 months. (This is inclusive of the 1 hour of face to face for all trainers described in *Standard T.6*). Standard T.10 The trainer must demonstrate preparation for and ability as a general practice trainer. This requirement could be satisfied by: • 12 months experience as a trainer and having attended general practice educator professional development sessions, or….	A doctor taking responsibility for the supervision of prevocational doctors at all stages of their term should display the following attributes: • be known, approachable and easily accessible to the prevocational doctor and have established a rapport with them early in their placement… (p. 6) 6. The supervisor should provide ongoing supervision of the prevocational doctor and provide teaching on a case basis and by formal regular tutorials. (p. 7).	Criterion 1.1 The rural and remote doctor teacher must have sufficient qualifications and experience to act as an appropriate Supervisor or Mentor.

SUPERVSION (cont)

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
4.2 HMO supervisors have a clear understanding of their role and responsibility in assisting HMOs to meet their learning objectives and demonstrate a commitment to their training. RACGP - Standard T5, T6, T9, T10, T14, T21, T22, T24, T25 Standards for general practice supervisors (p.6-7) Standards for the education of prevocational doctors (p.8) ACRRM Criterion 1.2, 1.3, 1.4	Standard T.5 The trainer must participate in continuing professional development aimed at improving performance as a general practice educator. Standard T.6 The trainer must be available for 1 hour per week of protected contiguous time for face to face* teaching and discussion with the registrar for all general practice attachments. Standard T.9 The trainer must be available for teaching, support and discussion for 3 hours per week for the registrar's first 6 months of general practice training and 2 hours per week for the second 6 months. (This is inclusive of the one hour of face to face for all trainers described in *Standard T.6*). Standard T.10 The trainer must demonstrate preparation for and ability as a general practice trainer...	5. The supervisor should participate in documented continuing professional development aimed at improving performance as a general practice educator. (p.7) 1. The supervisor should assist the prevocational doctor to understand the requirements for the term. 2. The supervisor should provide direct observation sessions (which could be by video review). 3. The supervisor should provide planned education as outlined by the curriculum. These sessions should be at an appropriate level considering the prevocational doctor's knowledge and experience. The prevocational doctor may prepare them. 4. planned education should amount to a session of general practice time a week. (p.8)	Criterion 1.2 The Supervisor has demonstrated a commitment as a teacher. Criterion 1.3 The Supervisor has demonstrated abilities as a teacher. Criterion 1.4 The Mentor is committed to supporting registrars.

SUPERVSION (cont)

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
4.2 (cont)	Standard T.14 The trainer must assist the registrar in the development of a learning plan by week 4 of each 6 months of training – this will be submitted as part of the training portfolio for completion of training. The registrar should discuss this with the training advisor and submit a copy to the general practice training provider to be lodged in the training provider's record system. Standard T.21 The trainer must be located in the same practice as the registrar unless training is part of a specific program approved by the college that involves distance education. If the registrar is undertaking training in more than one practice, the registrar must have on site supervision in each practice and both practices must be approved for training. … Standard T.22 Trainers or their delegates must be on site during office hours: • 80% in months 1–6 • 50% in months 7–12 • 25% from month 13.		

SUPERVSION (cont)

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
4.2 (cont)	Standard T.24 When off site the trainer must be available by phone or make arrangements for another recognised general practice teacher to be available, including after hours. The trainer or GP must be able to attend a situation that requires backup unless alternative arrangements have been made prior to the event with the registrar's consent.		
4.3 Appropriate supervision is provided at all times by suitably qualified and appropriately experienced medical practitioners. RACGP Standard T1-5, T8-10, T26 Standards of support required for the prevocational doctor (p.9) ACRRM – Criterion 1.1	Standard T.1 The trainer must have full and unrestricted registration by the State Medical Board and no prior history of removal from the register for disciplinary reasons under any jurisdiction. Standard T.2 The trainer must be an excellent clinician. This may be demonstrated by: • holding Fellowship of the RACGP, or • being accepted by peers as an excellent clinician and providing a written recommendation from a local medical educator to whom the clinician is known.	4. The supervisor should provide supervision to the prevocational doctor to the level appropriate to their level of training as indicated below. 5. Level 1 The PGY1 doctor: The supervisor takes direct and principal responsibility for individual patients: a. The supervisor should be physically present at the workplace at all times whilst the prevocational doctor is providing clinical care. b. If the supervisor is absent from the medical practice, medical practitioners with general or full unconditional registration should oversee the graduate's practice. c. The prevocational doctor should consult the supervisor about the management of all patients.	*Indicators for Criterion 1.1* The Supervisor and/or Mentor has as a minimum: • Current registration with the relevant State medical board • Fellowship of ACRRM; or equivalent experience or expertise in other specialties recognised by the ACRRM Board • Not less than five years full time equivalent experience in Rural and Remote Medicine or General Practice or other approved specialist practice. If experience was gained in General Practice four years of this full time equivalent experience must have been acquired in rural or remote medical practice • The ability to act as an appropriate role model, exhibiting a high standard of clinical competence, communication skills and professional values in relation to patient care.

SUPERVSION (cont)

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
4.3 (cont)	Standard T.3 The trainer must be a good role model and demonstrate commitment to the development of the profession by: • current membership of the RACGP, • current membership of the Australian College of Rural and Remote Medicine (ACRRM), or • demonstrable active involvement in a primary care professional organisation. Standard T.4 The trainer must hold vocational recognition as a GP by the Health Insurance Commission. Standard T.5 The trainer must participate in continuing professional development aimed at improving performance as a general practice educator. Refer to Standard T.8 – T.10 above	d. The prevocational doctor is to carry out home visits only as an observer to the supervisor. The provision of on-call services is only to be undertaken in circumstances where the supervisor is physically present. The Student may elicit histories and examine patients in their homes only under direct supervision. 6. Level 2 The PGY2 doctor: The supervisor shares responsibility for individual patients: a. The supervisor should be physically present at the workplace or in readily accessible contact at all times whilst the prevocational doctor is providing clinical care. b. If the supervisor is absent from the medical practice, medical practitioners with general or full unconditional registration should oversee the graduate's practice. c. The prevocational doctor should review the management of all patients with the supervisor at a reasonable frequency, such as the end of every consulting session or day. d. Where there is a recurrent presentation without improvement, the patient should be reviewed by the supervisor.	▪ A demonstrated commitment to ongoing professional development and participates in *ACRRM's Professional Development Program* or equivalent. Criterion 1.2 The supervisor and/or mentor has demonstrated commitment as a teacher. *Relevant indicators:* The supervisor and/or mentor at a minimum: •Is accessible and available to the learner, either on site or delegated, or by telephone or radio, in accordance with the requirements outlined by the education provider. •Organises an accredited deputy supervisor for times when the learner cannot access the supervisor or when the post is split between two practices. If the trainee is undertaking experience in more than one practice, the learner must have access to a supervisor in each practice and both practices must be approved by ACRRM.

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
4.3 (cont)	Quality T.26 Trainers should work towards developing a deeper understanding of the complexity and challenges of general practice through such activities as: • participating in peer groups of trainers • developing a continuing professional development (CPD) learning plan to develop educational skills, etc…	e. The supervisor should ensure that if the prevocational doctor is to carry out home-visits or provide on-call services that the assessment and management of the patients are discussed with the supervisor for all patients. 7. Level 3 The PGY 3 doctor: The supervisor shares responsibility for individual patients: a. At a frequency determined by the supervisor, the prevocational doctor should inform the supervisor about the management of individual patients. b. If the supervisor is absent from the medical practice, medical practitioners with general or full unconditional registration should oversee the prevocational doctor's practice. c. The supervisor should ensure that if the prevocational doctor is to carry out home visits and provide on-call services, that the assessment and management of individual patients is discussed with the supervisor at a frequency determined by both the supervisor and the prevocational doctor. 8. Level 4 The PGY 4+ doctor: The registrant takes primary responsibility for individual patients: a. The supervisor should ensure that there are mechanisms in place for monitoring whether the prevocational doctor is practising safely.	

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
		b. The prevocational doctor is permitted to work alone provided that the supervisor is contactable by telephone at all times. c. The prevocational doctor can carry out home visits and provide on-call and after hours services providing adequate phone support is available at all times. (p. 9-10)	
4.4 The hospital has a process in place which enables an evaluation of the adequacy and effectiveness of supervision of HMO's annually. RACGP Feedback T.42, T.43, T.44 Monitoring and Feedback (p.13) ACRRM Criterion 1.2	Feedback T.42 Registrars will be asked to provide feedback on: • the number of direct observation sessions and an assessment of the quality of feedback *(Standard T.15)* • the number of 1 hour face to face sessions in each 3 month period and the quality of these sessions, including their relevance to the learning plan *(Standard T.16)* • the quality of teaching and clinical support provided *(Standard T.9)* • the quality and timeliness of the assistance they received with the development and review of their learning plan *(Standard T.14)*.	1. The prevocational doctor will be asked to provide feedback on: • frequency and range of primary care patients seen • scheduling of their consultations and education activities 2. The supervisor should be in a position to provide feedback in relation to the following parameters • the number of patients seen each week •the number of patients booked per week •type of patients and problems encountered each week • on-call arrangements where applicable	Criterion 1.2 The supervisor and/or mentor has demonstrated commitment as a teacher. *Relevant indicators:* The supervisor and/or mentor at a minimum: • Accepts the importance of developing their own teaching skills and agrees to participate in initial and appropriate ongoing supervisor teacher training and assessor training activities – minimum attendance of 3 days per year at supervisor or teacher-training workshops or participation as a specialist facilitator in ACRRM accredited workshops, online clinical forums or conferences. • Participates in teaching and supervision evaluation activities.

SUPERVSION (cont)

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
	Feedback T.43 Trainers will be asked to provide feedback on: • registrar learning plan(s) undertaken in the practice, including comments on the strength and weaknesses of the plan, particularly in relation to achieving the learning outcomes in their practice *(Standard T.14)* • visits undertaken by external clinical educators and comments on any interaction with the visitor *(Standard T.15)* • assessed educational outcomes of the (uninterrupted) 1 hour teaching sessions provided for each six month period *(Standard T.16)* • professional development as a trainer and a clinical educator and the support received from the general practice training provider to undertake this *(Standard T.5)*. Feedback T.44 Registrars will be asked to provide feedback on the adequacy of: • the orientation and induction process		

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
4.4 (cont)	*(Standard T.19)* • on site support and supervision arrangements *(Standards T.21–T.24)*.		
4.5 Supervisors encourage HMOs to reflect on, and critically appraise their clinical experience, and to draw links between their knowledge base and their clinical experience. RACGP Standard T.14, T.17 Standards for general practice supervisors (p. 6). ACRRM Criterion 1.2	Standard T.14 The trainer must assist the registrar in the development of a learning plan by week 4 of each 6 months of training – this will be submitted as part of the training portfolio for completion of training. The registrar should discuss this with the training advisor and submit a copy to the general practice training provider to be lodged in the training provider's record system. Standard T.17 The trainer must assess the registrar's competence through consideration of training and experience or if necessary, by observation in areas that have an increased risk of adverse outcomes and litigation. Currently these include: • assessment of trauma, particularly fractures, nerve and tendon injuries • diagnosis of serious medical problems: myocardial infarction, etc...	The supervisor will also be the clinical educator for this prevocational doctor, ensuring that the prevocational doctor gains confidence and competence through education and experience. The experience offered should be commensurate with the prevocational doctor's stage of training, competence and confidence. It should also reflect the prevocational doctor's and postgraduate medical council's defined learning outcomes. The supervisor should ensure that the prevocational doctor has a balanced case mix that encourages learning and a breadth of experience to ensure an understanding of the breadth of skills and knowledge required for a career in general practice throughout Australia. The supervisor will be responsible for assisting the student with the completion of any required training records, such as logbooks. (p.6)	Criterion 1.2 The supervisor and/or mentor has demonstrated commitment as a teacher. *Relevant indicators:* The supervisor and/or mentor at a minimum: • Provides an appraisal and an assessment of the learner in accordance with their stage of learning • provides the learner with feedback on performance and to guide the learner in self evaluation of performance.

5. FEEDBACK AND ASSESSMENT

PMCV Standards

Function 5: Feedback and Assessment

Standard 5: HMOs receive continuous and constructive feedback on their performance

RACGP

Monitoring and feedback
The RACGP will require evidence of quality education and training in order to ensure the ongoing standing of general practice training in Australia. For this purpose, and to maintain contact with trainers and registrars, the college will seek the information in relation to education, support and workload. (Refer Standards T.42 –T.46)

ACRRM

Standard 1- Teaching supervision and mentoring

This standard describes the criteria to be used for the selection and accreditation of Supervisors for trainees participating in the ACRRM Vocational Training Pathway. It focuses on the capacity of individuals to provide quality teaching, feedback and support.

FEEDBACK AND ASSESSMENT

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
5.1 The hospital clearly explains the criteria, process and timing of assessment and feedback to HMOs. RACGP Standards for Training Programs, Standard P.10 ACRRM (1) Criterion 2.3 ACRRM (2) Criterion 5.1		Standard P.10 (see above)	Not Mentioned	Criterion 2.3 The training practice has a documented teaching plan. *Relevant indicator:* This teaching plan includes as a minimum: •How practice-based assessment, feedback and summative assessments will be conducted.	Criterion 5.1 The provider is able to demonstrate effective management processes for the design, delivery, monitoring assessment, review and improvement of vocational training for FACRRM candidates, including compliance with ACRRM vocational training standards. *Relevant indicators: Learning Plans / In Practice Assessment* 6. Evidence that RTP ensures in practice assessment conducted to ACRRM standards.

FEEDBACK AND ASSESSMENT (cont)

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
5.2 Assessment of HMOs is based on the achievement of objectives, expectations and standards, clearly understood by supervisors and HMOs. RACGP Standard T14, T17 Standards for general practice supervisors (p. 6) Standards for the education of prevocational doctors (p. 8) ACRRM (1) Criterion 1.2, 1.3	Standard T.14 The trainer must assist the registrar in the development of a learning plan by week 4 of each 6 months of training – this will be submitted as part of the training portfolio for completion of training. The registrar should discuss this with the training advisor and submit a copy to the general practice training provider to be lodged in the training provider's record system. Standard T.17 The trainer must assess the registrar's competence through consideration of training and experience or if necessary, by observation in areas that have an increased risk of adverse outcomes and litigation. Currently these include assessment of trauma,		[The experience] should also reflect the prevocational doctor's and postgraduate medical council's defined learning outcomes. (p. 6) The prevocational doctor's overall education should be discussed as well as perceptions of clinical strengths and weaknesses and consulting, counselling and communication skills. The prevocational doctor needs to understand the practice protocols, administration and other important features. Discussions with the prevocational doctor should be based on the principles of constructive feedback. This will include frank discussion on progress to date and possible variation of the program to meet new needs as they arise:	Criterion 1.2 The supervisor and/or mentor has demonstrated commitment as a teacher. *Relevant indicators:* The supervisor and/or mentor at a minimum: • Meets with the learner early in training to discuss and appraise the learner's previous experience, attitudes to practice, clinical strengths and weaknesses, and consulting, counselling and communication skills, in order to assist the learner to develop a learning plan in accordance with the ACRRM Vocational training Pathway. Criterion 1.3 The supervisor and/or mentor has demonstrated abilities as a teacher.	

FEEDBACK AND ASSESSMENT (cont)

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
5.2 (cont)	particularly fractures, nerve and tendon injuries, etc……		1. The supervisor should assist the prevocational doctor to understand the requirements for the term. 2. The supervisor should provide direct observational sessions (which could be by video review). 3. The supervisor should provide planned education as outlined by the curriculum. These sessions should be at an appropriate level considering the prevocational doctor's knowledge and experience. The prevocational doctor may prepare them. 4. The planned education should amount to a session of general practice time a week. (p. 8)	*Relevant indicators:* The supervisor and/or mentor: • In collaboration with the education provider/training broker, is able to assist the learner with the development of a learning plan, and identifying specific learning goals that are realistic. The supervisor should use the learning plan to guide the provision of structured educational activities. The supervisor should assist the learner to review the learning plan regularly during each 12-month period or on completion of hospital posts. This will include frank discussion on progress to date and possible variation of training to meet new needs as they arise.	

FEEDBACK AND ASSESSMENT (cont)

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
5.3 HMOs receive progressive and informal feedback throughout every rotation from clinical supervisors, including registrars. RACGP Standard T.14, T.15, T.17 ACRRM (1) Criterion 1.2 ACRRM (2) Criterion 10.1	Standard T.14 and Standard T.17 refer above. Standard T.15 The trainer must support access for a medical educator to undertake direct observation sessions (which could be by video review) as prescribed by the general practice training provider. A copy of the required written report can be kept at the practice if the trainer and registrar wish.		As above.	Criterion 1.2 The supervisor and/or mentor has demonstrated commitment as a teacher. *Relevant indicators:* The supervisor and/or mentor at a minimum: ▪ Provides an appraisal and an assessment of the learner in accordance with their stage of learning ▪ Provides the learner with feedback on performance and ▪ Guides the learner in self evaluation of performance.	Criterion 10.1 The provider is able to demonstrate processes for monitoring, reviewing and improving the quality and performance of its operations. *Relevant indicator:* 1. Evidence of trainer and registrar feedback (formal and informal).

FEEDBACK AND ASSESSMENT (cont)

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
5.4 HMOs receive formal feedback on the rotation as a whole from clinical supervisors, including registrars, at the end of every rotation. RACGP Standard T14, T17 RACGP Feedback T43, T45, T47 Monitoring and Feedback (p.13)	Standard 14 and Standard 17 refer above Feedback T.43 Trainers will be asked to provide feedback on: • registrar learning plan(s) undertaken in the practice, including comments on the strength and weaknesses of the plan, particularly in relation to achieving the learning outcomes in their practice *(Standard T.14)* • visits undertaken by external clinical educators and comments on any interaction with the visitor *(Standard T.15)* • assessed educational outcomes of the (uninterrupted) 1 hour teaching sessions provided for each six month period		1. The prevocational doctor will be asked to provide feedback on: • frequency and range of primary care patients seen • scheduling of their consultations and education activities. 2. The supervisor should be in a position to provide feedback in relation to the following parameters • the number of patients seen each week •the number of patients booked per week •type of patients and problems encountered each week • on-call arrangements where applicable (p.13)		As above.

FEEDBACK AND ASSESSMENT (cont)

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
5.4 (cont)	*(Standard T.16)* • professional development as a trainer and a clinical educator and the support received from the general practice training provider to undertake this. *(Standard T.5)*. Feedback T.45 Trainers must provide registrars with feedback on: • skills requiring special training including Pap tests, assessment of a sick child or minor surgery, certifying in their log book the achievement of competency if appropriate *(Standard T.17)* • the reaction of staff and patients to their work in the practice *(Standard T.34)*.				

FEEDBACK AND ASSESMENT (cont)

PMCV Standards	RACGP 1	RACGP 2	RACGP 3	ACRRM 1	ACRRM 2
5.4 (cont)	Feedback T.47 Trainers must be in a position to provide feedback in relation to the following parameters: • the number of patients seen each week *(Standard T.38)* • the number of patients booked per hour *(Standard T.39)* • if requested by the registrar, any groups of patients (age, gender or reason for encounter) that are seen in excess relative to other doctors in the practice or relative to other general practices *(Standard T.40)*.				

FEEDBACK AND ASSESSMENT (cont)

PMCV Standards	RACGP1	RACGP2	RACGP3	ACRRM1	ACRRM2
5.5 Performance feedback on the year as a whole is received from the Supervisor of Intern Training/Director of Clinical Training or equivalent			Not Mentioned.	Not Mentioned.	
5.6 HMOs are encouraged to take responsibility for their own performance, and to seek feedback from their supervisors in relation to their performance. RACGP Standard T.14, T.17 RACGP Feedback T.42, T.46 Standards for general practice supervisors (p. 6) ACRRM Criterion 1.2	See above for standards		The supervisor will also be the clinical educator for this prevocational doctor, ensuring that the prevocational doctor gains confidence and competence through education and experience. The experience offered should be commensurate with the prevocational doctor's stage of training, competence and confidence. (p. 6)	Criterion 1.2 The supervisor and/or mentor has demonstrated commitment as a teacher. *Relevant indicators:* The supervisor and/or mentor at a minimum: • Provides an appraisal and an assessment of the learner in accordance with their stage of learning … to provide the learner with feedback on performance and to guide the learner in self evaluation of performance.	Criterion 5.1 (as above) 12. Evidence of increasing opportunities for FACRRM candidates in independent practice and decision making.

6. PROGRAM EVALUATION

PMCV Standards

Function 6: Program evaluation

Standard 6: The hospital formally evaluates the HMO program in a continuous improvement framework.

RACGP

Monitoring and feedback
The RACGP will require evidence of quality education and training in order to ensure the ongoing standing of general practice training in Australia. For this purpose, and to maintain contact with trainers and registrars, the college will seek the information relating to education, support and workload.

ACRRM

Criterion 2.8
The training post conducts a structured process to evaluate the training within the post that demonstrates how information is gathered, analysed and acted upon to improve the quality of training.

PROGRAM EVALUATION

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1	ACRRM 2
6.1 The HMO program is evaluated. ACRRM (1) Criterion 2.8 ACRRM (2) Criterion 5.1			Criterion 2.8 The training post conducts a structured process to evaluate the training within the post that demonstrates how information is gathered, analysed and acted upon to improve the quality of training. *Indicators:* The training post at a minimum: • Provides formal feedback on the progress of the learner to regional consortia/universities/education providers and ACRRM on request. •Consents to the learner in the ACRRM Vocational Training pathway, providing feedback to the education provider and ACRRM on the training environment provided by the post and the rural or remote doctor teachers. • Regularly seeks learner's views on the quality and suitability of the training environment provided by the post.	Criterion 5.1 The provider is able to demonstrate effective management processes for the design, delivery, monitoring assessment, review and improvement of vocational training for FACRRM candidates, including compliance with ACRRM vocational training standards. *Relevant indicators:* 7. Evidence of an evaluation framework for monitoring outcomes – covered by GPET 6(h) and (i). 8. Evidence of formal evaluation processes including registrar and supervisor survey and evidence of incorporation of informal feedback sessions at education release workshops.

PROGRAM EVALUATION (cont)

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1	ACRRM 2
6.2 A process is available for supervisors and senior staff, as appropriate, to provide feedback on the HMO program. RACGP Feedback T.43, T.45, T.47 ACRMM Criterion 2.8	Refer Feedback and Monitoring section for Standards.	Refer Monitoring and Feedback (p. 13)	Refer Criterion 2.8 above	As above.
6.3 A confidential process is available for HMOs to provide feedback on their experiences. RACGP Feedback T.42, T.44, T.46 ACRRM – Criterion 2.8	Refer Supervision section for standards	Refer Monitoring and Feedback (p. 13)	Refer Criterion 2.8 above	
6.4 Feedback is acted upon to improve the HMO experience for HMOs, supervisors and hospital administrators and the program is modified as necessary.			Refer Criterion 2.8 above	

7. FACILITIES AND AMENITIES

PMCV Standards

Function 7: Facilities and Amenities

Standard 7: The hospital provides a safe physical environment and amenities that support the HMO.

RACGP

ACRRM

2. Practice training posts

This standard on rural and remote training posts is concerned with issues surrounding the level of organisation, facilities, policies and resources provided to learners in the ACRRM Vocational Training Pathway and the range of clinical learning opportunities provided by the post to meet educational outcomes.

This includes those posts that enable rural and remote doctors to develop the necessary knowledge and skills to be innovative, flexible and resourceful practitioners of the future. Therefore these experiences should occur in the full range and diversity of rural and remote settings of practices and hospitals and may include, Royal Flying Doctor Services, branch surgeries, Aboriginal Community Controlled Health Organisations etc.

FACILITIES AND AMENITIES

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
7.1 The practice provides safe, clean and accessible overnight accommodation for HMOs if rural location. RACGP Quality T.35 ACRRM Criterion 2.4	Quality T.35 The facility should be accredited under the RACGP minimum practice standards by a recognised accreditation body.	Not Mentioned	Criterion 2.4 The training practice is suitably equipped with clinical and office equipment sufficient to allow the registrar to practise well and to learn new skills. *Relevant Indicator:* That the training practice facilities contain as a minimum: • Adequate physical facilities for all staff including the learner.
7.2 The practice provides appropriate on site recreational areas with access to on-line information systems for HMOs. RACGP Quality T.35	Refer Quality T.35 above	Not Mentioned	Refer Criterion 2.4 above
7.3 The practice provides a secure place for storage of personal belongings for HMOs during work hours. RACGP Standard T.29 ACRRM Criterion 2.4	Standard T.29 The facility must provide adequate consulting space for the registrar. This means a suitably equipped room available for the registrar's work. Ideally this room should be easily accessible to the GP who is taking responsibility for training to facilitate informal discussion of clinical problems and areas of interest as they arise.		Refer Criterion 2.4 above

FACILTIES AND AMENITIES (cont)

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
7.4 The practice provides HMOs with access to facilities and educational resources, including clinical skills teaching facilities, appropriate to their educational needs and clinical needs of the hospital. RACGP Standard T.31	Standard T.31 There must be a set of reference materials and patient information materials available in the facility that can be accessed by the registrar whenever consulting and without interrupting another clinician who is working. The practice must have up to date copies of: • a general practice textbook, such as *General Practice* by John Murtagh • the *Therapeutic Guidelines* series • access to the Pharmaceutical Benefits Scheme (PBS) and a current medication reference, e.g. MediMedia Australia Annual (MIMS)		Criterion 2.4 The training practice is suitably equipped with clinical and office equipment sufficient to allow the registrar to practise well and to learn new skills. *Relevant indicators:* That the training practice facilities contain as a minimum: • A dedicated patient consultation room for the learner that is suitably equipped. • Onsite or immediate access to the equipment listed in Table 1 (excluding hospital posts) • Has achieved Practice Accreditation or can demonstrate that the practice: - possesses the necessary equipment required for Practice Accreditation; - has a patient record system including health summary, health screening and recall systems suitable for Practice Accreditation. Electronic records system would be desirable or is otherwise recognised by the ACRRM Board as a suitable teaching post • Provides adequate physical facilities for all staff including the learner • Provides access to professional development for all staff, this includes training specifically orientated to

FACILTIES AND AMENITIES (cont)

PMCV Standards	RACGP 1	RACGP 3	ACRRM 1
7.4 (cont)			supporting learners in the practice setting and in the community together with their families when this applied.
7.5 The practice provides adequate consulting space for the HMO. RACGP Standard T.29 ACRRM Criterion 2.4	Refer Standard T.29 above		Refer Criterion 2.4 above

References:

ACRRM *Standards Required of ACRRM Teaching Posts and Teachers In Rural and Remote Medicine.*

ACRRM *Standards for Regional Training Providers (RTP) Recognition*

PGPPP *Program Guidelines for Training Collaborations*

RACGP, *Standards for General Practice Education and Training: Trainers and Training posts 2005*

RACGP, *Standards for General Practice Education and Training; Programs and Providers 2005*

RACGP *Standards for the Supervision of Prevocational Doctors in General Practice, December 2007*

PMCV/MPBV, *Part 2- Assessment against functions and standards*

Appendix 6 Mapping of learning opportunities in general practice to Australian Curriculum Framework for Junior Doctors

General Practice Curricula mapped to ACFJD

The tables found in appendix 6 and 7 are summary tables produced from a mapping tool developed by the PMCV Medical Director and Primary Consultant with SED Health Consulting, Dr Ian Graham.

The tool allows the user to build up individual spread-sheets matching items from the curriculum being mapped, to the ACFJD. This enables the generation of data describing the best match between the items being coded and the areas, categories, topics and capabilities listed in the ACFJD. If multiple spread sheets are developed (as has been the case with mapping the general practice curriculum) two summary spreadsheets can be generated. The first of these (Appendix 6) is a consolidated contents list of all curricula items mapped to the ACFJD, presented in a tabular form. The second (Appendix 7) presents the same information in a graphical display that highlights visually where there are gaps between the curricula or where they overlap, including both particular curricula modules mapped and a summary of all modules. The electronic version of tool (submitted with the report) contains additional information, not represented in either summary, including full reference details for each curriculum module and item that were mapped to the ACFJD.

Column 1 of the following table contains the general practice curricula items to be mapped to the ACFJD. These were taken from a number of RACGP and ACRRM curricula modules (references for which are contained in the electronic version of the mapping tool). Column 2 contains numerical codes that match the general practice curriculum to items within the ACFJD. Where this column contains 4 digits the general practice curriculum item has been matched to an area, category, topic and capability within the ACFJD. Where this column contains 3 digits it has been mapped to an area, category and capability. Where this column contains 2 digits it has been mapped to an area and category, and where it contains only 1 digit, it has been matched only to an area within the ACFJD. Column 3 details the ACFJD item to which the general practice item has been matched. As indicated, the numerical coding in column two can be use to determine whether the ACFJD item listed refers to an area, category, topic or capability.

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Describe how consultation environmental factors such as privacy, background noise and location can affect communication with the elderly	4.1.1	Patient Interaction - Context
Describe how families and carers may affect patient communication	4.1.4.1	Understand the impact of family dynamics on effective communication
Explain and discuss investigations and therapies of common diseases of the elderly to the patient and his/her carers and family	1.2.3	Patient Assessment - Problem formulation
Demonstrate how to take a history and examination in order to elicit common diseases that affect the aged,	1.2.2	Patient Assessment - History & Examination
Demonstrate how to take a history and examination in order to elicit common diseases that affect the aged,	1.2.2.2	Elicit symptoms & signs relevant to the presenting problem or condition
Demonstrate how to take a history and examination, involving carers when appropriate	4.1.4.2	Ensure relevant family/carers are included appropriately in meetings and decision making
Investigate and refer appropriately for diseases affecting the aged	1.2.4.1	Identify & understand the investigations relevant to a patient's presenting problems or conditions
Investigate and refer appropriately for diseases affecting the aged	1.2.5.1	Understand the criteria for referral or consultation relevant to a particular problem or condition
Describe how the biological process of aging affects the interpretation of investigations	1.2.4.3	Use investigation results appropriately to guide patient management
Describe how the biological process of aging affects the metabolism of drugs	1.4.2.1	Understand the actions, indications, contraindications & adverse effects of medications
Discuss the special issues of drug therapy in the aged, including changes in pharmacokietics and the special risks of drug therapy including polypharmacy	1.4.2.1	Understand the actions, indications, contraindications & adverse effects of medications
Identify common medical and psychological conditions that affect older people	3.	PROBLEMS & CONDITIONS (BY SYSTEM)
Outline the care issues resulting from age discrimination	5.1.2.1	Understand the social, economic & political factors in patient illness
Describe the stresses encountered by those who care for the aged	4.1.4	Patient Interaction - Meetings with families or carers
Identify how age discrimination impacts upon patient care	1.1.1.1	Understand the complex interaction between the healthcare environment, doctor & patient

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Identify how age discrimination impacts upon access to services	5.1.1	Doctor & Society - Access to healthcare
Discuss sensitive treatment of older patients, including issues relating to patient autonomy	4.1.2.1	Treat patients courteously & respectfully showing awareness & sensitivity to different backgrounds
Describe legislation relating to power of attorney and advanced medical plans	5.1.5.1	Understand the legal requirements in patient care e.g Mental Health Act, death certification
Describe effective discharge planning for the elderly, including planning for continuity of care	1.4.7.1	Know the elements of effective discharge planning e.g. early, continuous, multidisciplinary
Describe the indications for and regulatory requirements of various levels of residential care	1.4.7.3	Understand indications for & regulatory requirements of various levels of residential care (ADVANCED)
Describe the effect systems of care may have on the health of the elderly	1.1.1.1	Understand the complex interaction between the healthcare environment, doctor & patient
Demonstrate ability to reflect on use of communication skills in each consultation with children and their families	4.1.1.2	Use good communication and know its role in effective healthcare relationships
Demonstrate ability to reflect on use of communication skills in each consultation with children and their families	4.1.3.2	Communicate with patients & carers in ways they understand e.g. use interpreters, diagrams, less jargon
Demonstrate ability to reflect on the structure of each consultation with children and their families	4.1.1	Patient Interaction - Context
Demonstrate how to negotiate time alone with parents when the child is better protected from hearing their parents explicit concerns	4.1.1	Patient Interaction – Context
Demonstrate ability to reflect on the strengths and weaknesses of each consultation with a young person	4.1.1.2	Use good communication and know its role in effective healthcare relationships
Demonstrate ability to negotiate time alone with a young person when that is appropriate	4.1.1	Patient Interaction – Context
Demonstrate how to institute the immediate management of life threatening illnesses	1.3	EMERGENCIES
Discuss the elements of management plans to protect children who may not be seriously ill at the time of presentation, however, could become seriously unwell in the near future	1.4.1.2	Develop, implement & evaluate a plan of management relevant to a patient's problems or conditions

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Describe and implement evidence based strategies in the management of sleep deprivation and feeding difficulties in the first 12 months of life	1.5	SKILLS & PROCEDURES
Demonstrate how to perform a supra pubic bladder tap or catheter urine	2.2.9.1	Bladder catheterisation (M&F)
Show how to monitor growth and development	1.5	SKILLS & PROCEDURES
Demonstrate management of common adolescent specific conditions	1.4.1.2	Develop, implement & evaluate a plan of management relevant to a patient's problems or conditions
Demonstrate how to assess risk and protective factors, where appropriate, using schema such as HEADSS		
Discuss dangerous conditions (often called 'red flag' conditions) for anxiety, depression	3.6.2.2	Depression and anxiety
Discuss dangerous conditions (often called 'red flag' conditions) for eating disorder and suicidally	2.6.2.2	Suicide risk assessment
Demonstrate the skills required for health surveillance as recommended in chapter 3 of the RACGP red book for children and young people	1.1.4	Safe Patient Care - Public health
Demonstrate the skills required for health prevention and promotion as recommended in chapter 3 of the RACGP red book for children and young people	5.1.6	Doctor & Society - Health promotion
Discuss the implications of conflict between the management needs of patients, parents or doctors	4.1	PATIENT INTERACTION
Demonstrate non-judgmental approach to managing parents or young people	4.1.2.1	Treat patients courteously & respectfully showing awareness & sensitivity to different backgrounds
Demonstrate ability to seek assistance/supervision when appropriate	5.2.1.2	Demonstrate an appropriate standard of professional practice & work within personal capabilities
Demonstrate management of the professional boundaries between doctors and young people	5.2.1	Professional Behaviour - Professional responsibility
Demonstrate competence in the process of notifying children and young people at risk where legally appropriate	5.1.5	Doctor & Society - Medicine & the law

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Demonstrate competence in the process of notifying children and young people at risk where ethically appropriate	5.2.4	Professional Behaviour - Ethical practice
Communication skills and the doctor patient relationship	4.	COMMUNICATION
A critical appreciation of the nature of the relationship between patient and doctor and its therapeutic potential	4.1.1.2	Use good communication and know its role in effective healthcare relationships
An understanding of different consultation models	4.1	PATIENT INTERACTION
A patient centred approach	4.1.1	Patient Interaction – Context
The communication skills and attitudes needed to foster effective whole person care	4.1	PATIENT INTERACTION
The skills to undertake effective individualistic and opportunistic health education and promotion	5.1.6.1	Understand environmental & lifestyle risks to health & advocate for healthy lifestyles
Establish rapport and be empathetic with patients	4.1.2	Patient Interaction – Respect
Develop good listening and language skills appropriate to the patient	4.1.3.1	Understand the principles of good communication e.g. active listening, the role of information overload
Adopt appropriate verbal and nonverbal communicati9on styles for different situations (e.g. Emotional states, state of health, disadvantage, cultural background)	4.1.3	Patient Interaction - Providing information
Elicit the patient's issues, problems and concerns	1.2.2.2	Elicit symptoms & signs relevant to the presenting problem or condition
Engender confidence and trust (and advocate on the patient's behalf where appropriate)	4.1.2	Patient Interaction – Respect
Use body language and touch in an appropriate manner, to establish trust in a therapeutic relationship	4.1	PATIENT INTERACTION
Find common ground with patients about their problems and expectations	1.2.2	Patient Assessment - History & Examination
Negotiate an effective management plan and agree on respective responsibilities and limits with the patient and their family	1.4.1	Patient Management - Management options
Communicate effectively and appropriately with significant others (e.g. Partner and family)	4.1.4	Patient Interaction - Meetings with families or carers
Recognise opportunities for health promotion and education and respond appropriately to increase the patient's capacity for self care	5.1.6.1	Understand environmental & lifestyle risks to health & advocate for healthy lifestyles
Confirm the patient's understanding of the problem, management, advice and follow up.	4.1.3.3	Involve patients in discussions about their care

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Applied professional knowledge and skills	1.	CLINICAL MANAGEMENT
A knowledge of significant medical conditions	1.2.2.1	Know the modes of presentation of the listed problems and conditions
Approaches to undifferentiated problems	1.2	PATIENT ASSESSMENT
Skills in information gathering,	1.2.2.2	Elicit symptoms & signs relevant to the presenting problem or condition
Skills in physical examination,,	1.2.2	Patient Assessment - History & Examination
Skills in the undertaking of procedures,	1.5	SKILLS & PROCEDURES
Skills in clinical decision making	1.2.3	Patient Assessment - Problem formulation
A critical appreciation of the need for continuity and integration of care	4.2.6.1	Understand the importance of handover in patient safety & continuity of care
A critical appreciation of the need for cost effective investigations	5.1.7.3	Understand the nature & costs of the healthcare system (ADVANCED)
A critical appreciation of the need for rational prescribing	5.1.7	Doctor & Society - Healthcare resources
A critical appreciation of the need to continually undertake critical self appraisal	5.2.1.3	Reflect on personal experiences, actions & decision-making
Take a history and perform a physical examination relevant to presenting problems	1.2.2	Patient Assessment - History & Examination
Develop a working diagnosis from their knowledge and experience, and the information gathered	1.2.3	Patient Assessment - Problem formulation
Critically use investigations, and interpret the results, to refine the working diagnosis	1.2.4	Patient Assessment – Investigations
Recognise and manage significantly ill patients	1.3	EMERGENCIES
Consider the possibility of serious illness inherent in many common presentations	1.2.2.3	Understand the importance of a comprehensive patient assessment
Competently manage common problems (including undifferentiated illness)	1.4.1	Patient Management - Management options
Negotiate, prioritise and implement management plans	1.4.1.2	Develop, implement & evaluate a plan of management relevant to a patient's problems or conditions

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Prescribe safely from an informed knowledge base	1.4.1	Patient Management - Management options
Prescribe cost effectively from an informed knowledge base	5.1.7	Doctor & Society - Healthcare resources
Use hospital and community based expertise effectively	1.2.5.3	Recognise the role of other health professionals in patient assessment
Use hospital and community based resources and networks effectively	5.1.7.1	Use healthcare resources wisely to achieve the best outcomes
Make valid and timely decisions about referral and follow up	1.2.5	Patient Assessment - Referral & consultation
Develop and maintain essential procedural skills	1.5.4.3	Know & practice the appropriate technique
Recognise their own limitations, responding appropriately	5.2.1	Professional Behaviour - Professional responsibility
Accept and manage uncertainty	1.4.1	Patient Management - Management options
Be critical and discriminating in the use of information from a variety of sources	4.2.5	Managing Information - Evidence-based practice
Consistently apply universal precautions principles.	1.1.5	Safe Patient Care - Infection control
Population health and the context of general practice	1.1.4	Safe Patient Care - Public health
Have an understanding of demographic, epidemiology, public health problems and health needs of special groups	5.1	DOCTOR & SOCIETY
Be aware of patterns and prevalence of disease and be able to participate in population based preventive strategies	1.1.4	Safe Patient Care - Public health
Be able to participate in population based preventive strategies	5.1.6	Doctor & Society - Health promotion
Have critical appreciation of the impact on the health of the patient of their socio-political, economic, work, spiritual and cultural background and needs	5.1.2	Doctor & Society - Culture, society & healthcare
Have critical appreciation of the impact on the health of the patient of their relationships with family and significant others	4.1.1	Patient Interaction – Context
Possess skills in advocacy and in using community resources	5.1.6	Doctor & Society - Health promotion
Appreciate the importance of a public health perspective in general practice	5.1	DOCTOR & SOCIETY

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Elicit and take into account a patient's socio-political, economic, work, spiritual, linguistic and cultural background and needs, and their relationships with family and significant others in relation to their health	5.1.2	Doctor & Society - Culture, society & healthcare
Understand and respond to the special needs and characteristics of their practice population, including:	1.1.4	Safe Patient Care - Public health
Disease prevention and health promotion	5.1.6	Doctor & Society - Health promotion
Screening and recall systems	5.1.6	Doctor & Society - Health promotion
Access and equity issues	5.1.1	Doctor & Society - Access to healthcare
Use a working knowledge of, and be involved in, assisting the health of the community locally, regionally and nationally, including:	5.2.6	Professional Behaviour - Doctors as leaders
Participation in community based prevention and education strategies	5.1.6	Doctor & Society - Health promotion
Accessing available health services	5.1.1	Doctor & Society - Access to healthcare
Networking with other general practitioners, general practitioner organisations and health care providers	4.3	WORKING IN TEAMS
Understand and utilise the Australian health care system (including its funding planning, services, policies and community resources).	5.1.7	Doctor & Society - Healthcare resources
Professional and ethical role	5.2	PROFESSIONAL BEHAVIOUR
The special duty of care that arises when a patient-doctor relationship is established and the patient's needs involve the risk of injury. Doctors have a duty to exercise due care and skill to avoid any such injury and will become legally liable for the consequences of their own negligence	5.1.5	Doctor & Society - Medicine & the law
Reflective skills and self appraisal	5.2.1.3	Reflect on personal experiences, actions & decision-making
Maintenance of professional standards that imply that all doctors have an obligation to keep abreast of and be informed about technical advances, new techniques, and new therapies appropriate to their field of medicine (or field in which they profess to have special skills).	5.3	TEACHING & LEARNING
Exercise a special duty of care at all times	5.2.1	Professional Behaviour - Professional responsibility
Strive to maintain professional standards of practice according to contemporary ethical principles	5.2.4	Professional Behaviour - Ethical practice
Have skills in reflection and professional self appraisal	5.2.1.3	Reflect on personal experiences, actions & decision-making

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Be committed to life long learning and continuous professional improvement	5.3.1.3	Demonstrate commitment to continuous learning
Have the skills to fulfil their role as teachers, leader and change agent	5.3.2	Teaching & Learning – Teaching
Have an understanding of research and evaluation	5.3.1.2	Understand common research methodologies
Have an understanding of audit skills	1.1	SAFE PATIENT CARE
Develop professional networks and maintain their own wellbeing and that of their families	5.2.3	Professional Behaviour - Personal well-being
Responsibility for the optimal care of patients (including acting on patient cues, respecting patient-doctor boundaries and confidentiality, recognising own limitations, ensuring appropriate reporting and follow up, and undertaking advocacy as appropriate	5.2.1	Professional Behaviour - Professional responsibility
Respect for a patients' culture and values, and an awareness of how these impact on the therapeutic relationship	4.1.2.1	Treat patients courteously & respectfully showing awareness & sensitivity to different backgrounds
Understand the rights of patients to access competent, compassionate care	4.1.2	Patient Interaction – Respect
Understand the rights of patients to be fully informed	1.5.2	Skills & Procedures - Informed consent
Understand the rights of patients to self determination	4.1.2.3	Provide clear & honest information to patients & respect their treatment choices
The capacity for self awareness, reflection and self appraisal	5.2.1.3	Reflect on personal experiences, actions & decision-making
Skills of lifelong learning	5.3.1.3	Demonstrate commitment to continuous learning
Basic skills in clinical audit	1.1.1.3	Participate in continuous quality improvement e.g. clinical audit
Basic skills in critical appraisal and critical incident analysis, and professional networks for personal and clinical support	1.1.3	Safe Patient Care - Adverse events & near misses

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Time management and coping skills	5.2.2	Professional Behaviour - Time Management
Time management and coping skills sufficient to maintain care of self and family	5.2.3	Professional Behaviour - Personal well-being
Achieve and maintain professionally defined clinical practice standards	5.2.1	Professional Behaviour - Professional responsibility
Adhere to the professional codes of ethics	5.2.4	Professional Behaviour - Ethical practice
Contribute to the development of general practice by gaining skills in areas such as teaching, research and evaluation.	5.3	TEACHING & LEARNING
Organisational and legal dimensions	5.1.5	Doctor & Society - Medicine & the law
Ensure adequate arrangements are made for the availability and accessibility of care and to ensure safety netting, screening, and recall systems are in place	4.2.6	Managing Information – Handover
Have a critical appreciation of patient and practice information technology and management requirements, medical records and legal responsibilities, and reporting, certification and confidentiality requirements	4.2	MANAGING INFORMATION
Understand effective practice management principles and processes.	4.2	MANAGING INFORMATION
Use of personal, organisational and time management skills in practice	5.2.2	Professional Behaviour - Time Management
Accurate and legible recordings of consultations and referrals, to enable continuity of care by general practice and other colleagues	4.2.1	Managing Information – Written
Use and evaluation of practice management skills relating to: patient access guidelines, staff management, teamwork, office policies and procedures, financial and resource management		
Manage information and data systems relating to clinical standards, guidelines and protocols	4.2.2.1	Understand the uses & limitations of electronic patient information & decision-support systems
Manage information and data systems relating to medical records	4.2.4	Managing Information - Health records

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Manage information and data systems relating to information technology	4.2.2	Managing Information – Electronic
Manage information and data systems relating to communication and transfer of patient related information	4.2.4.2	Understand the role of the health record in continuity of care
Manage information and data systems relating to screening, recall and related systems	4.2.2	Managing Information – Electronic
Manage information and data systems relating to access and confidentiality	4.2.2.3	Understand & comply with policies regarding information technology e.g. passwords, e-mail & internet
Incorporate medicolegal knowledge and responsibilities relating to: certification, confidentiality, legal report writing, prescribing, informed consent, duty of care, litigation	5.1.5	Doctor & Society - Medicine & the law
Work within statutory and regulatory requirements	5.1.5	Doctor & Society - Medicine & the law
Meet acceptable practice standards	5.2.1.2	Demonstrate an appropriate standard of professional practice & work within personal capabilities
Clinical knowledge and skills for generalist practice	1.	CLINICAL MANAGEMENT
Function as an effective and appropriate clinician in generalist practice	5.2.1	Professional Behaviour - Professional responsibility
Establish a doctor patient relationship and use a patient centred approach to care	4.1	PATIENT INTERACTION
Obtain a clinical history that reflects the different contextual issues including: the presenting problem, epidemiology, culture, and geographical location	1.2.2	Patient Assessment - History & Examination
Perform an accurate physical examination that is relevant to clinical history, risks, and the age, gender and culture of the patient	1.2.2	Patient Assessment - History & Examination
Apply and describe diagnostic reasoning to arrive at one or more provisional diagnoses including common, and uncommon yet important, conditions	1.2.3	Patient Assessment - Problem formulation
Formulate and justify a plan of investigation and management related to the differential diagnosis	1.2.3	Patient Assessment - Problem formulation
Consider uncommon but clinically important differential diagnoses	1.2.3	Patient Assessment - Problem formulation

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Apply core procedural skills in clinical practice	1.5	SKILLS & PROCEDURES
Use specialised clinical equipment as required for further assessment and to interpret results	1.5.4	Skills & Procedures – Procedures
Communicate findings of clinical assessment effectively and sensitively to patients, their families and / or carers	4.1.3	Patient Interaction - Providing information
Negotiate a management plan with patients, their families and / or carers	1.4.1.2	Develop, implement & evaluate a plan of management relevant to a patient's problems or conditions
Revise the management plan and continually review and follow up as new information becomes available	1.4.1.2	Develop, implement & evaluate a plan of management relevant to a patient's problems or conditions
Use evidence based standard treatment protocols and guidelines to inform decision making	4.2.5.2	Use best available evidence in clinical decision-making
Use principles of universal precaution against infection in practice	1.1.5	Safe Patient Care - Infection control
Facilitate and coordinate access to services according to the individual patient needs	5.1.1	Doctor & Society - Access to healthcare
Develop and maintain clinical and service provider networks for effective patient care	4.3.3	Working in Teams - Teams in action
Demonstrate capacity to apply quality assurance mechanisms and to appropriately use resources	1.1.1.3	Participate in continuous quality improvement e.g. clinical audit
Refer clients for specialist care and other services judiciously	1.2.5	Patient Assessment - Referral & consultation
Extended Clinical Practice	1.	CLINICAL MANAGEMENT
Diagnose and manage complex, advanced or uncommon medical conditions across a broad scope of rural and remote medical practice	1.	CLINICAL MANAGEMENT
Justify the diagnosis and differential diagnosis by reference to the aetiology, pathogenesis and epidemiology of the condition	1.2.3	Patient Assessment - Problem formulation
Perform extended office and hospital-based diagnostic and procedural skills	1.	CLINICAL MANAGEMENT
Provide secondary and tertiary based care as required	1.	CLINICAL MANAGEMENT
Provide direct and distant clinical supervision and support for other rural and remote health care workers	5.3.3	Teaching & Learning – Supervision
Work as part of a rural or remote multi-disciplinary team that reflects the extended skills of other health professionals in providing effective patient care	4.3	WORKING IN TEAMS

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Provide team leadership, inter-agency liaison, and participate in risk management programs	5.2.6.3	Show an ability to work well with and lead others
Know their own limitations and when and how to refer	5.2.1.2	Demonstrate an appropriate standard of professional practice & work within personal capabilities
Safety and occupational health	5.1.6.1	Understand environmental & lifestyle risks to health & advocate for healthy lifestyles
Demonstrate the ability to undertake the relevant forensics responsibilities	5.1.5	Doctor & Society - Medicine & the law
Emergency care in generalist practice	1.3	EMERGENCIES
Undertake initial assessment and triage of patients with acute or life threatening conditions	1.3.2	Emergencies – Prioritisation
Stabilise critically-ill patients and provide primary and secondary care	1.3.5	Emergencies - Acute patient transfer
Provide definitive emergency resuscitation and management across the lifespan ion keeping with clinical need, own capabilities and available services	1.3	EMERGENCIES
Perform required emergency procedures and courses	1.3	EMERGENCIES
Arrange and / or perform emergency patient transport or evacuation when needed	1.3.5	Emergencies - Acute patient transfer
Demonstrate resourcefulness in knowing how to access and use available resources	5.1.1	Doctor & Society - Access to healthcare
Communicate effectively at a distance with consulting or receiving clinical personnel	4.3.3	Working in Teams - Teams in action
Participate in disaster planning and implementation of disaster plans, and post-incident analysis and debriefing	1.3	EMERGENCIES
Provide inter-professional team leadership in emergency care that includes quality assurance and risk management assessment in the rural and remote setting	5.2.6.1	Understand the leadership role that may be required of a doctor
Population health in generalist practice	1.1.4	Safe Patient Care - Public health
Analyse the social, environmental, behavioural, economic and occupational determinants of health that affect the community's burden of disease and community access to health-related services	5.1	DOCTOR & SOCIETY
Demonstrate an ability to apply a population health approach suitable to community practice profile	5.1.6	Doctor & Society - Health promotion
Integrate evidence based prevention, early detection and other health maintenance activities into practice at a systems level	5.1.6	Doctor & Society - Health promotion

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Undertake, supervise and monitor early detection strategies	5.1.6	Doctor & Society - Health promotion
Use brief interventions in managing chronic disease	5.1.7	Doctor & Society - Healthcare resources
Competently use clinical information and recall systems, particularly in the organised management and evaluation of chronic disease across the practice population	4.2	MANAGING INFORMATION
Provide health education and health promotion strategies in practice	5.1.6	Doctor & Society - Health promotion
Provide continuity and coordination of care for their own practice population	5.2.1	Professional Behaviour - Professional responsibility
Comply with statutory population health reporting and notification requirements	1.1.4.2	Inform authorities of 'notifiable diseases'
Evaluate the quality of health care for practice populations	4.2.5	Managing Information - Evidence-based practice
Access and collaborate with agencies responsible for key population health functions including, public health services, employer groups and local government	4.3	WORKING IN TEAMS
Understand the role of a medical advocate in the design, implementation and evaluation of interventions that address the determinants of that populations' health	5.1.6	Doctor & Society - Health promotion
Aboriginal and Torres Strait Islander health in generalist practice	5.1.3	Doctor & Society - Indigenous patients
Demonstrate an understanding of the links between the social, cultural, historical, economic and political framework that influence the health status of Aboriginal and Torres Strait Islander peoples	5.1.3.1	Understand the impact of history & the experience of Indigenous Australians on presentations
Apply clinical practice knowledge of the differing profile of disease among Aboriginal peoples and Torres Strait Islanders	1.1.4.1	Understand the key health issues of your community
Demonstrate an understanding of the differing cultural beliefs, values and priorities of Aboriginal and Torres Strait Islander peoples regarding their health and health care provision	5.1.3	Doctor & Society - Indigenous patients
Reflect on own assumptions, cultural beliefs and emotional reactions in providing culturally safe health care for Indigenous Australians	5.1.2.3	Identify your own cultural values that may impact on your role as a doctor
Communicate effectively and in a culturally safe manner with Aboriginal and Torres Strait Islander people	4.1.2.1	Treat patients courteously & respectfully showing awareness & sensitivity to different backgrounds
Identify key community contacts, mentors and support structures in the provision of effective health care	1.2.5	Patient Assessment - Referral & consultation
Develop capacity building and skills transfer strategies when working with Indigenous health care workers	5.3.2	Teaching & Learning – Teaching
Describe the common patterns and prevalence of disease, and use best evidence in the management of chronic diseases experienced by rural and remote Aboriginal and Torres Strait Islander peoples	1.1.4.1	Understand the key health issues of your community

Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Appreciate the role and effect of comprehensive Aboriginal community-controlled Primary Health Care including self-determination, collaboration, partnership and ownership	4.3	WORKING IN TEAMS
Use a primary health care approach in rural and remote Indigenous health practice	5.1.3	Doctor & Society - Indigenous patients
Discuss the different power-based structures and decision making that need to be taken into account when working in a community controlled organisation	4.3	WORKING IN TEAMS
Identify overt, covert and structural forms of discrimination in interactions with patients, health professionals and systems; and advocate for their resolution	5.1.2	Doctor & Society - Culture, society & healthcare
Work effectively and respectfully as part of a cross cultural team, and use local protocols for referral and involvement of health workers	4.3	WORKING IN TEAMS
Describe the role of the Aboriginal and Torres Strait Islander Health Worker	4.3	WORKING IN TEAMS
Apply principles of partnership, community ownership, consultation, capacity building, reciprocity and respect to health care delivery, health surveillance and health research	4.3	WORKING IN TEAMS
List potential strategies to address social, economic and environmental determinants of disease among Aboriginal peoples and Torres Strait Islanders, and advocate for change	5.1.3	Doctor & Society - Indigenous patients
Professional, Legal, and Ethical Practice in generalist practice	5.	PROFESSIONALISM
Manage appraise and assess own performance in the provision of health and medical care for patients	5.2.1	Professional Behaviour - Professional responsibility
Engage in continuous learning and professional development in rural and remote practice	5.3.1.3	Demonstrate commitment to continuous learning
Engage in education of other medical and health professionals	5.3.2.2	Incorporate teaching into professional practice
Provide accurate and ethical certification when required for sickness, employment, social benefits and other purposes	5.2.4	Professional Behaviour - Ethical practice
Apply knowledge of practice billing, insurance and health financing systems in clinical practice	5.1.7	Doctor & Society - Healthcare resources
Maintain confidentiality in small communities	4.1.2.2	Maintain privacy & confidentiality
Maintain professional and social boundaries	5.1.4.2	Adhere to professional standards
Use and undertake relevant research to inform practice	4.2.5.2	Use best available evidence in clinical decision-making
Demonstrate an ability to think critically and make informed decisions	5.2.1.3	Reflect on personal experiences, actions & decision-making

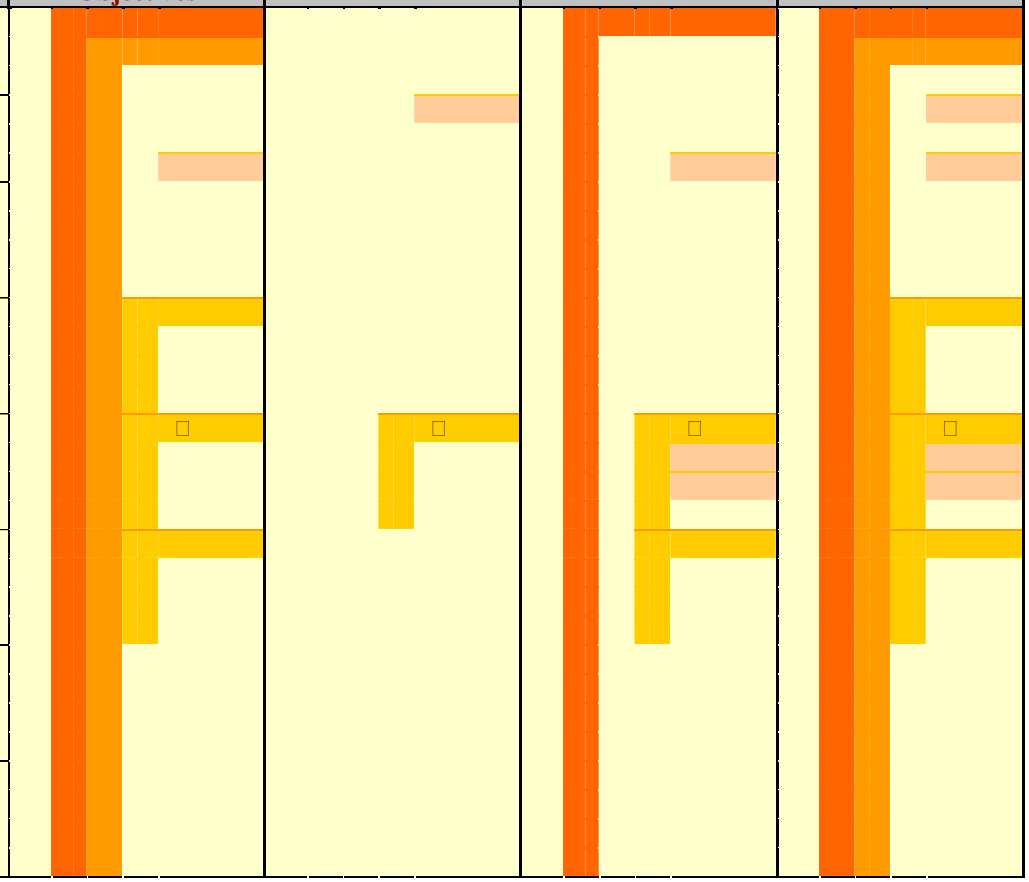
Learning Objective, Curriculum Item or experience to be mapped	ACFJD No.	ACFJD Area / Category / Topic / Capability Description
Use communication technology to network and exchange information with distant colleagues and for continuing educational purposes	4.2.2	Managing Information – Electronic
Contribute to the management of human and financial resources within a health organisation / medical practice	5.2.6	Professional Behaviour - Doctors as leaders
Identify and apply strategies for self-care, personal support mechanisms, debriefing, and caring for their family in the rural and remote context	5.2.3.2	Be aware of & optimise personal health & well-being
Recognise unprofessional behaviour and signs of the practitioner in difficulty among colleagues, and respond according to ethical guidelines and statutory requirements	5.2.5.2	Recognise the signs of a practitioner in difficulty
Be aware of duty of care issues arising from providing health care to self, family, colleagues, patients and the community	5.2.1	Professional Behaviour - Professional responsibility
Apply professional, ethical and legal guidelines to their practice	5.2	PROFESSIONAL BEHAVIOUR
Implement and adhere to occupational health and safety guidelines in practice	5.1.5	Doctor & Society - Medicine & the law
Rural and Remote context in generalist practice	5.1	DOCTOR & SOCIETY
Apply to their role of medical practitioner knowledge of the social, cultural, historical, economic and political issues facing rural and remote communities	5.1.2	Doctor & Society - Culture, society & healthcare
Demonstrate resourcefulness, independence, and self reliance while working effectively in geographic, social and professional isolation	5.2	PROFESSIONAL BEHAVIOUR
Respond to community needs	5.1	DOCTOR & SOCIETY
Identify and reflect upon their own personal strengths, values, attitudes, priorities and vulnerabilities in being able to maintain balance between personal, social and professional responsibilities and in managing isolation	5.2.1.3	Reflect on personal experiences, actions & decision-making
Respect local community norms and values in own life and work practices	5.1	DOCTOR & SOCIETY
Identify and acquire extended knowledge and skills as may be required in order to better meet the health care needs of the practice population	5.2	PROFESSIONAL BEHAVIOUR

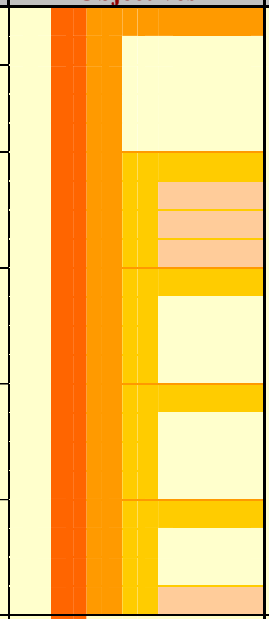
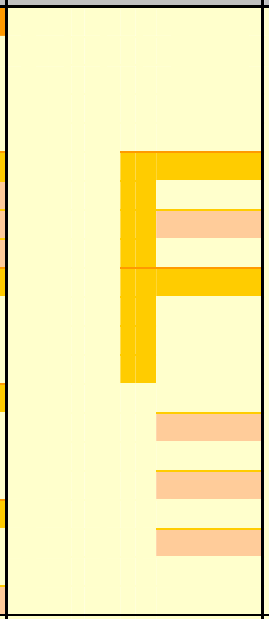
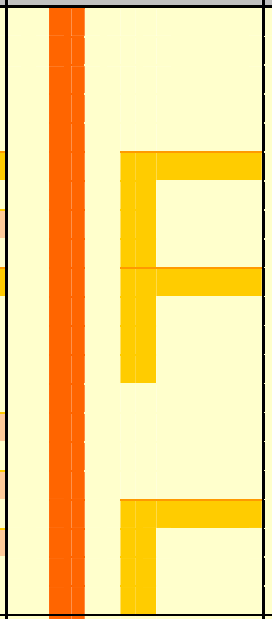
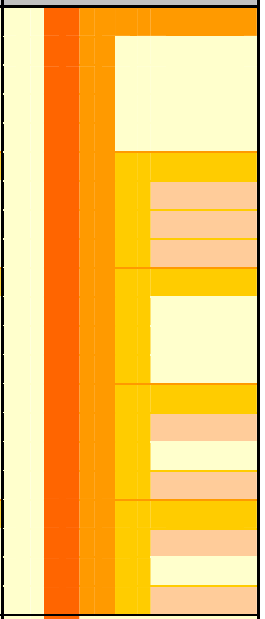
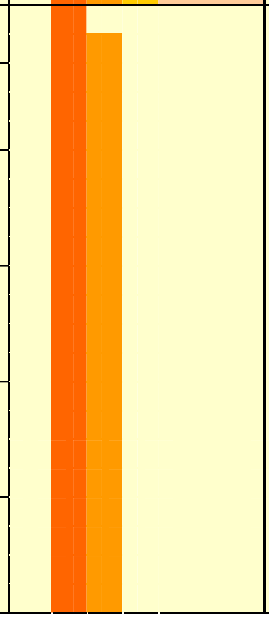
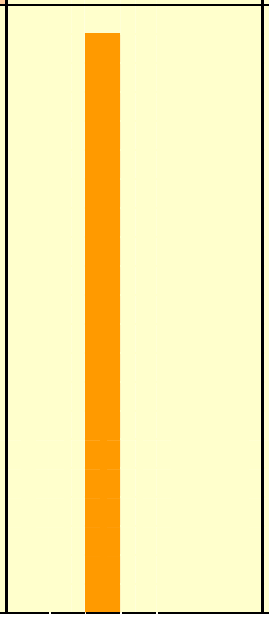
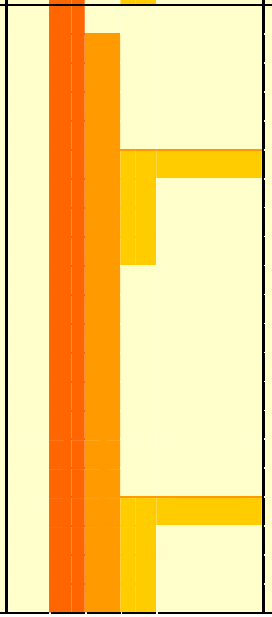
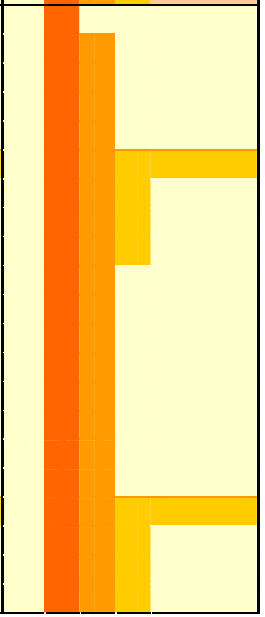
Appendix 7 Mapping Tool Summary

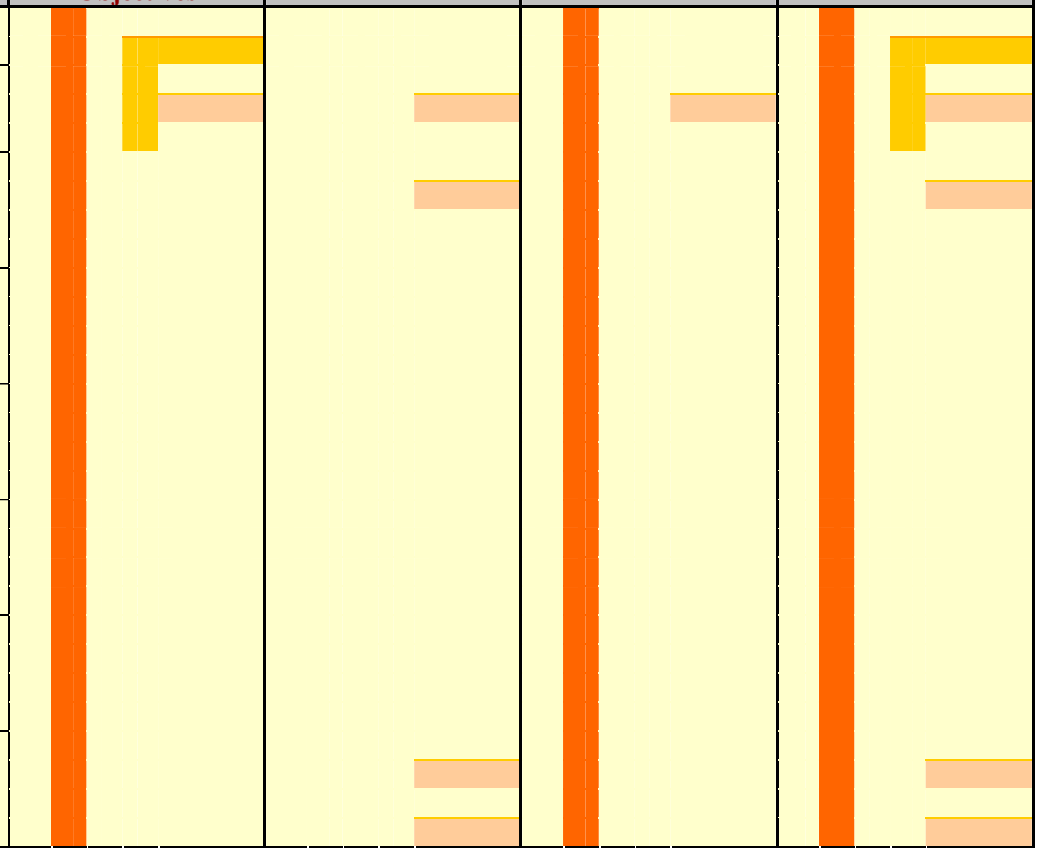
General Practice Curricula mapped to Australian Curriculum Framework for Junior Doctors (ACFJD)

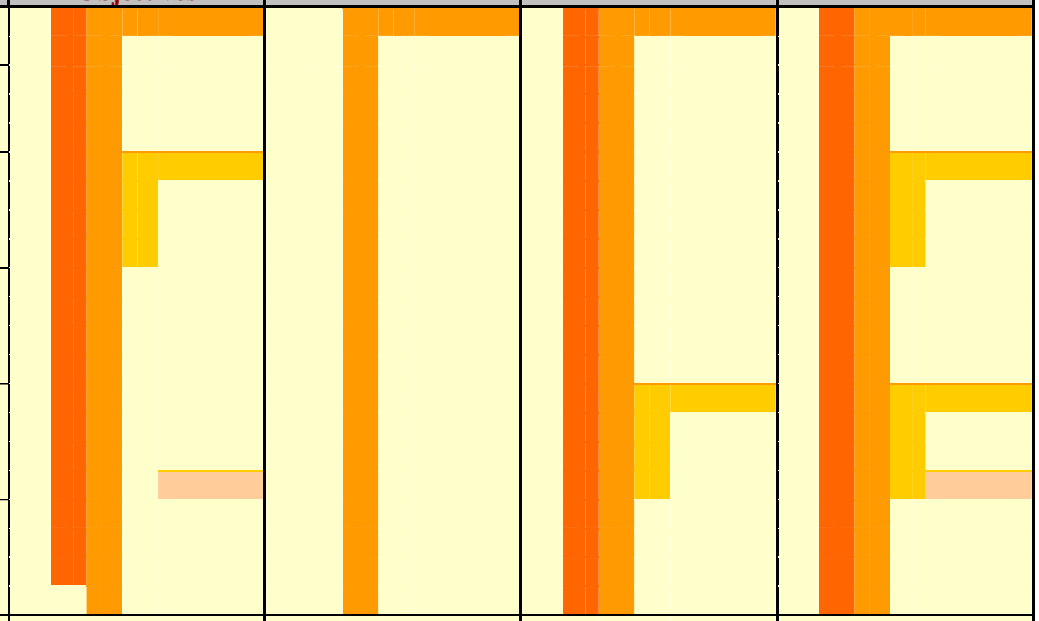
The following table contains a graphical display that highlights where there are gaps between the ACFJD and the GP curricula modules that have been mapped, and where they overlap. Column 1 contains the ACFJD curricula items, with areas and categories listed in capitals on the right of the column, and topics on the left. Columns 2-4 refer to the curriculum module that have been mapped, and Column 5 is a summary of all modules. The different colours used indicate the different levels at which the general practice curricula have been mapped to the ACFJD. The darkest shade of orange indicates a mapping at the level of area, the next darkest indicates a mapping at the level of category. Where the colour mustard appears there has been a mapping at the level of topic and where the colour salmon appears there has been a mapping at the level of capabilities. Please refer to Section 4.1 of the report (*Documentation of learning opportunities available to prevocational doctors within General Practice*) or Appendix 6, for further details of the mapping process.

Area / Topic / Capability		GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
CLINICAL MANAGEMENT					
SAFE PATIENT CARE	Systems				
	Risk & prevention				
	Adverse events & near misses				
	Public health				
	Infection control				
	Radiation safety				
	Medication safety				



Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
PATIENT ASSESSMENT				
Patient identification				
History & examination				
Problem formulation				
Investigations				
Referral & consultation				
EMERGENCIES				
Assessment				
Prioritisation				
Basic Life Support				
Advanced Life Support				
Acute patient transfer				

Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
PATIENT MANAGEMENT				
Management options				
Therapeutics				
Pain management				
Fluid & electrolyte management				
Subacute care				
Ambulatory & community care				
Discharge planning				

Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
SKILLS & PROCEDURES				
Decision-making				
Informed consent				
Preparation & anaesthesia				
Procedures				
Post-procedure				
SKILLS & PROCEDURES (BY SYSTEM)				
No System				
Dermatology / Integument				
Head & Neck / ENT				

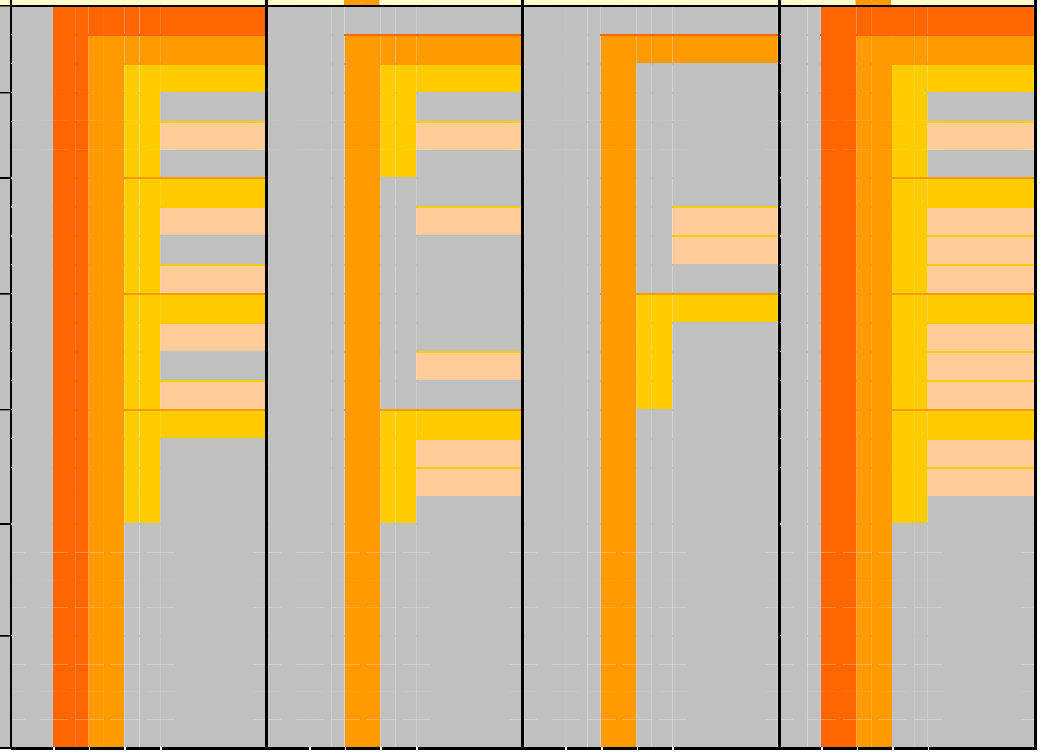
Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
Eyes				
Nervous System / Neurology				
Musculoskeletal / Orthopaedics / Rheumatology				
Circulatory System / Heart / Vessels				
Respiratory System / Lungs / Chest Wall				

Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
Gastrointestinal System / Abdomen / Abdominal Wall				
Renal System / Urology / Gynaecology				
Female Reproductive System / Obstetrics				
Breast / Endocrine System				
Haemopoietic System / Haematology / Blood Products				
Normal & Abnormal Growth & Development / Paediatrics				
Mental State / Intel. Funct. / Behavioural				
Major Psychiatric Disorders / Drug & Alcohol Abuse				
Infectious Diseases				

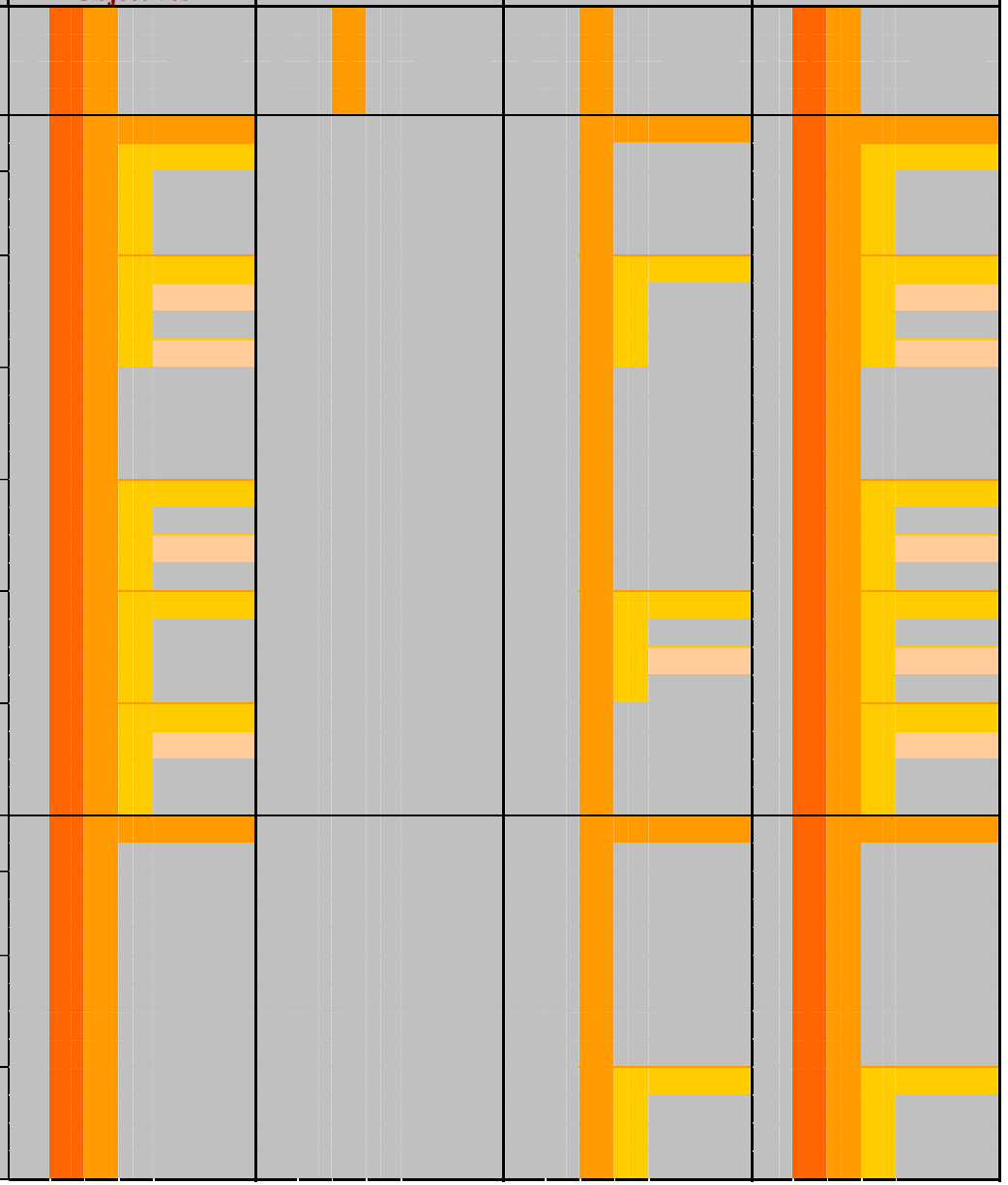
Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
Critical Care / Anaesthesia / Emergency Medicine				
PROBLEMS & CONDITIONS (BY SYSTEM)				
No System				
Nervous System / Neurology				
Musculoskeletal / Orthopaedics / Rheumatology				
Circulatory System / Heart / Vessels				

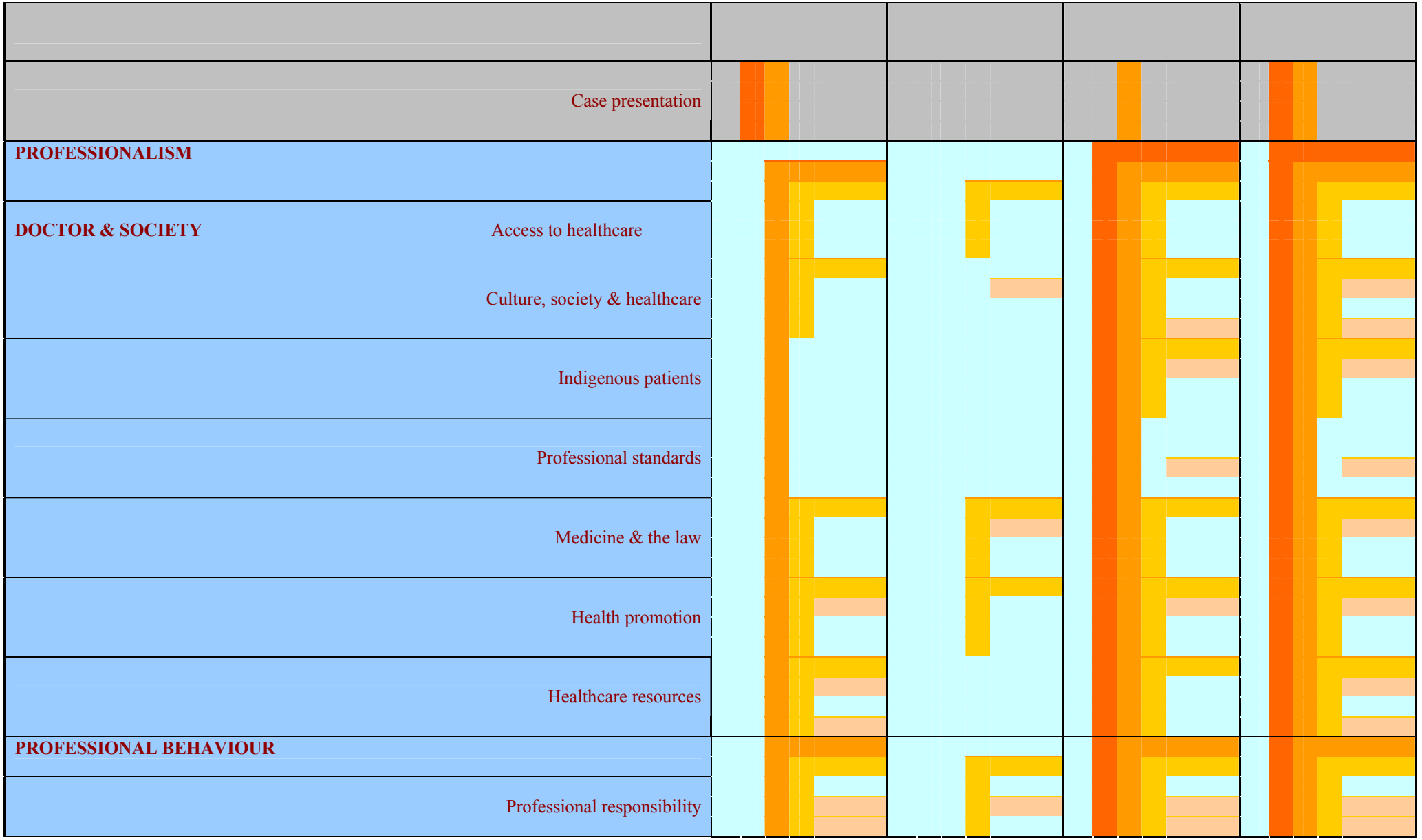
Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
Respiratory System / Lungs / Chest Wall				
Gastrointestinal System / Abdomen / Abdominal Wall				
Renal System / Urology / Gynaecology				
Female Reproductive System / Obstetrics				
Breast / Endocrine System				
Haemopoietic System / Haematology / Blood Products				
Nutrition / Metabolism				
Major Psychiatric Disorders / Drug & Alcohol Abuse				
Infectious Diseases				

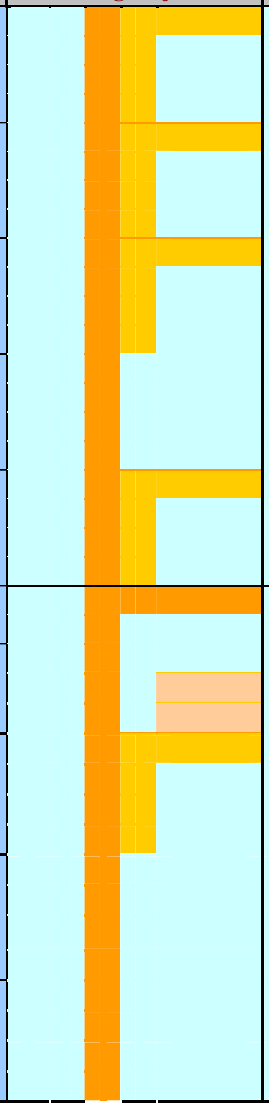
Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
Clinical Oncology				
Clinical Immunology				
Clinical Pharmacology				
Critical Care / Anaesthesia / Emergency Medicine				
COMMUNICATION				
PATIENT INTERACTION Context				
Respect				
Providing information				
Meetings with families or carers				
Breaking bad news				
Open disclosure				



Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
Complaints				
MANAGING INFORMATION				
Written				
Electronic				
Prescribing				
Health records				
Evidence-based practice				
Handover				
WORKING IN TEAMS				
Team structure				
Team dynamics				
Teams in action				




Case presentation
PROFESSIONALISM
DOCTOR & SOCIETY
Access to healthcare
Culture, society & healthcare
Indigenous patients
Professional standards
Medicine & the law
Health promotion
Healthcare resources
PROFESSIONAL BEHAVIOUR
Professional responsibility

Area / Topic / Capability	GP Common Learning Objectives	Aged and Children's	ACRRM Learning Outcomes	Summary
Time management				
Personal well-being				
Ethical practice				
Practitioner in difficulty				
Doctors as leaders				
TEACHING & LEARNING				
Self-directed learning				
Teaching				
Supervision				
Career development				

Appendix 8 Position Description for Prevocational General Practice rotations

Non-core General Practice rotation

(extract from *A Guide for Interns*, pp. 22-24)

As an intern you may be provided with the opportunity to complete a non-core rotation in general practice. Exposure to the craft of general practice and your time spent in the community (rural or metropolitan) will enhance your understanding of:

- the patient in their context
- the difference between illness and disease
- your role in the continuum of care.

The valuable insights gained from your time spent in general practice will enable an informed decision to be made on your future professional development.

The general practice rotation should provide you with an opportunity to manage a variety of patients in a highly supportive clinical setting. You should anticipate a patient case load of 40-70 patients per week, with a booking of one to two patients per hour. A 'Wave' Consulting Model, will normally be used in which:

- a patient will make an appointment to see you and a matching space will be left in the supervising doctor's appointment book
- you will see the patient and formulate the diagnosis and management plan
- the supervising doctor will then see you and the patient in a joint review
- there will be opportunities for feedback from both patient and supervisor.

Learning Objectives

Clinical Management

At the end of your non-core general practice rotation you should:

1. have developed and be able to demonstrate your applied professional knowledge and skills in:
    - knowledge of commonly prescribed drugs, their indications, interactions and use
    - the ability to take a concise history and perform an appropriate examination
    - competence in minor procedures such as suturing, skin biopsy, cryotherapy, and performing spirometry and Pap smears
    - competence in diagnosis and management of common general practice presentations
    - the ability to quickly recognise critically ill patients who need urgent referral for hospital treatment, and to organise safe transfer
    - skill in deciding which investigations are appropriate
    - ability to interpret investigation findings
    - ability to differentiate between illness and disease
    - coordination of whole patient care with referrals to specialists, allied health personnel and community support services.

2. be able to demonstrate your understanding of professional and ethical roles including:
    - knowledge and application of evidence based practice.

Communication

At the end of your non-core general practice rotation you should:

3. be familiar with and be able to demonstrate the following skills around communication and the patient/doctor relationship:
    - a respectful patient centred approach
    - skills in whole person care so that the doctor understands the patient, their context and the influence this can have on illness and behaviour
    - skills in educating patients about their condition, being able to fluently discuss such topics as immunisation, asthma management, diabetes, hypertension and hyperlipidaemia
    - appropriate communication skills with peers using medical terminology
    - appropriate communication skills with patients so that the doctor understands the patient's concerns and the patient understands the medical terms and concepts
    - a sensitivity to discussing topics that may be embarrassing or distressing for the patient
    - an awareness of patients' needs and vulnerabilities, in a non-judgemental context.
4. be able to demonstrate an understanding of organisational and legal requirements including:
    - efficient use of electronic software such as Medical Director, showing ability to access its resources and to file information.

Professionalism

At the end of your non-core general practice rotation you should:

5. be able to demonstrate an understanding of population health in the context of general practice including:
    - an appreciation of the role of general practice as community primary care
    - the use of preventative health care measures in the practice and in the community
    - the ability to educate patients about preventative health measures
    - delivery of culturally appropriate care, acknowledging individual and social differences
    - ability to deliver care to the whole family throughout their whole life cycle.
6. be able to demonstrate your understanding of professional and ethical roles including:
    - respect for professional boundaries and ethical practice
    - recognition of need for self care and for seeking help if required
    - respectful and appropriate actions if a colleague is in difficulty
    - a commitment to self-directed, life-long learning
    - continuing self-appraisal skills and involvement in peer assessment.
7. be able to demonstrate an understanding of organisational and legal requirements including:
    - understanding the Medicare and the private health care systems
    - understanding and appropriate use of the PBS
    - knowledge of the legal requirements of general practice and the ability to fulfil these while respecting the patient's rights and sensitivities
    - good time management skills.

Responsibilities

In a general practice rotation your responsibilities will depend on the organisation of each individual practice. However, you could be expected to:

- under the direction of a qualified general practitioner, consult on a wide range of patients
- discuss all patient consultations, management plans and prescriptions with the supervising general practitioner
- maintain practice standards, policies and protocols, ensuring familiarity with the Practice Policy and Procedure Manual provided
- follow the practice confidentiality policy
- accurately document on clinical management software, all patient consultations and the arrangements made for their follow-up
- arrange necessary patient appointments, referrals and investigations
- ensure up-to-date documentation of patients' past medical history, social history and current medication
- adhere to the Practice Recall policy as set out in the Practice Manual
- participate daily in the acute in-patient ward round at the/a local hospital
- complete any hospital paper work as requested by hospital and clinic nursing staff
- liaise with other staff members including nurses, the diabetic educator, local community health providers and associated allied health professionals
- when necessary, communicate clearly accurate information to the patient's family
- attend all practice meetings and participate in all the requirements of practice accreditation
- actively support all immunisation requirements and preventative health strategies undertaken by the practice.

On arrival you can expect to be given a full orientation to the general practice and time to adjust to the differences in your new work environment. Your supervisor will help you identify your learning needs and these will be documented and worked through during the rotation.

Appendix 9 Abstract for National Prevocational Medical Education Forum

MTRP PROJECT OVERVIEW: NATIONAL ACCREDITATION FRAMEWORK FOR GENERAL PRACTICE AND COMMUNITY SETTINGS PROJECT

Mauldon, E. *Postgraduate Medical Council of Victoria, Melbourne, Australia.*
Fawcett, R. *Postgraduate Medical Council of Victoria, Melbourne, Australia; Barwon Health, Geelong, Australia.*
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As the number of medical graduates grows, so too does the need for clinical training opportunities outside of public hospitals. Essential for the development and expansion of new clinical training rotations is an understanding of the governance structures within which they operate, the educational opportunities they afford Junior Doctors, and a sense of how these align with traditional placements in public hospitals. This project examined the provision of prevocational training in general practice and other community settings. A comparison was made between accreditation standards for hospital and general practice training positions, and learning opportunities within general practice rotations were mapped to the Australian Curriculum Framework for Junior Doctors. This enabled a revision and piloting of an accreditation survey instrument designed to better account for the requirements of training outside the hospital sector. Findings of the project were submitted to the National Accreditation Network to inform the development of the overall National Accreditation Framework.

This paper discusses similarities and differences between the accreditation of prevocational general practice placements by the state PMCs and by the RACGP and ACRRM, and their consequences for the development of a National Accreditation Framework.