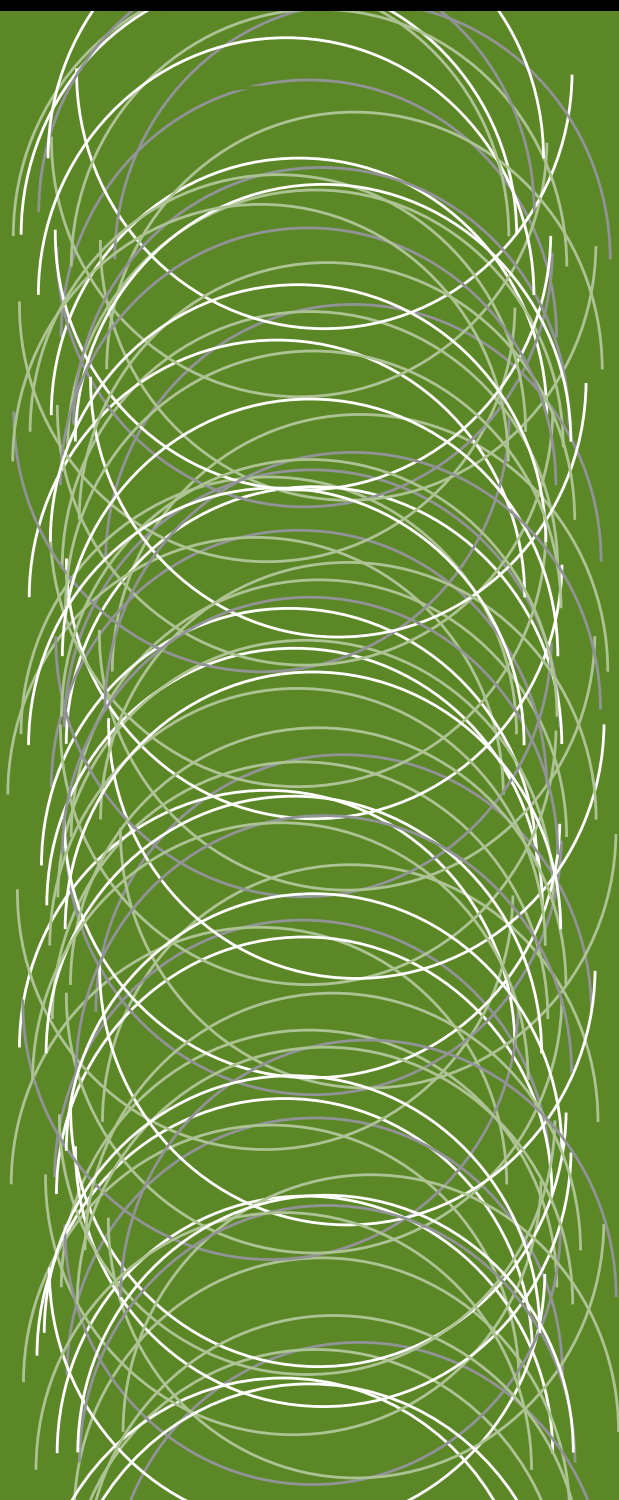Australian Medical Council Limited

# Accreditation Report: Training leading to Fellowship of the Australian College of Rural and Remote Medicine

AMC

# Contents

# Executive Summary: Australian College of Rural and Remote Medicine

The Australian Medical Council (AMC) document, *Procedures for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council 2013,* describes AMC requirements for accrediting specialist medical programs and their education providers.

In February 2007, the AMC, on the advice of its Specialist Education Accreditation Committee, granted the Australian College of Rural and Remote Medicine (ACRRM) initial accreditation as a standards body and provider of specific training and professional development programs for the specialty of general practice, subject to conditions. This decision included accreditation of education and training leading to fellowship of the Australian College of Rural and Remote Medicine and the College's professional development program.

An AMC assessment team assessed the training pathways leading to fellowship of ACRRM and the College's continuing professional development programs in 2010. On the basis of this assessment, the AMC Directors found the training pathways leading to fellowship of ACRRM and the College's continuing professional development programs substantially met the accreditation standards and granted accreditation until 31 December 2014, subject to conditions. In February 2014, the AMC Directors agreed to change the expiry date for accreditation from 31 December to 31 March and extended the accreditation of the College's programs from 31 December 2014 to 31 March 2015.

Between formal accreditations, the AMC monitors developments in education and training and professional development programs through progress reports from the accredited medical education providers. The College has reported regularly to the AMC on the accreditation conditions, with steady progress in some areas, but variable progress in some others.

In December 2014, an AMC team completed the follow-up assessment of the College's programs, considering the progress against the recommendations from the 2010 AMC assessment. Under the AMC accreditation procedures, the 2014 review may result in the extension of the accreditation to six years from the original accreditation decision, that is, until March 2018.

The team reported to the 26 February 2015 meeting of the Specialist Education Accreditation Committee. The committee considered the draft report and made recommendations on accreditation to AMC Directors within the options described in the AMC accreditation procedures.

This report presents the committee's recommendations, presented to the 11 March 2015 meeting of AMC Directors, and the detailed findings against the accreditation standards.

## Decision on accreditation

Under the *Health Practitioner Regulation National Law*, the AMC may grant accreditation if it is reasonably satisfied that a program of study and the education provider meet an approved accreditation standard. It may also grant accreditation if it is

reasonably satisfied that the provider and the program of study substantially meet an approved accreditation standard, and the imposition of conditions will ensure the program meets the standard within a reasonable time. Having made a decision, the AMC reports its accreditation decision to the Medical Board of Australia to enable the Board to make a decision on the approval of the program of study for registration purposes.

The AMC is reasonably satisfied that the education and training pathways leading to fellowship of the Australian College of Rural and Remote Medicine and the College's professional development program meet the accreditation standards.

Since its accreditation by the AMC in 2010, the College has significantly enhanced its educational and training activities. The College has undertaken an extensive consultative review of its governance resulting in a new constitution. The College has made considerable progress since 2010, in redefining its purpose as one of the two education providers for the specialty of general practice, including in its new constitution.

In 2013, the College completed a comprehensive review of the Primary Curriculum which has led to greater articulation between the 7 domains and the 18 areas of the curriculum statements. The Advanced Specialised Training curricula are currently in review and will be aligned with the format of the Primary Curriculum.

The College has enhanced engagement efforts both internally and with external stakeholders over the past four years. The collaboration with the Royal Australian College of General Practitioners in establishing the Bi-College Regional Training Provider Accreditation Program is seen as a real strength, which facilitates greater oversight of the accreditation of training providers.

Concerns remain about the impact of the variable relationships between the training providers and the College on graduate outcomes. Ongoing work with the training providers is needed to ensure directors of training, medical educators, and supervisors, are well versed in ACRRM curriculum and expectations.

This accreditation review took place in an environment of considerable governance and financial change in relation to general practice training. These changes have created an uncertain environment for the College in the management of general practice training. The College needs to continue its active involvement in the change process currently underway to reinforce its training leadership role and to ensure that in any new arrangements, its graduate outcomes can be achieved.

The March 2015 meeting of the AMC Directors resolved:

(i)     That the following training pathways and the continuing professional development program of the Australian College of Rural and Remote Medicine be granted ongoing accreditation to 31 March 2018, subject to satisfactory progress reports to the Specialist Education Accreditation Committee: the Vocational Preparation Pathway; the Remote Vocational Training Scheme Pathway; and the Independent Pathway.

(ii)    That this accreditation is subject to the conditions set out below:

(a) By the 2015 progress report, evidence that the College has addressed the following conditions from the accreditation report:

1   Review and promulgate the terms of reference for all College education committees to ensure currency and consistency with the 2014 Constitution. (Standard 1.1.2)

3   Adopt the College's approved definition of general practice for use in all College documentation to provide clarity of purpose for the College. (Standard 2.1)

17  Review the current Remediation Policy 2011–13 and implement a revised policy in line with the College's 2014–2016 Professional Development Program triennium requirements and the Medical Board of Australia's requirements. (Standard 9.3)

(b) By the 2016 progress report, evidence that the College has addressed the following conditions from the accreditation report:

2   Develop a plan to formally engage consumers and community representatives at all levels in the College's governance structure. (Standard 1.1.2)

6   Develop and document a process for considering the input of other relevant specialist medical colleges in the review of individual Advanced Specialised Training curricula. (Standard 3.2)

8   Progress and report on outcomes of the effectiveness of the case-based discussion assessment trial and decision whether to remove the summative mini clinical evaluation exercise (mini-CEX). (Standard 5.3)

12  Review and implement processes for the appointment of registrar representatives to the Registrar Committee to ensure registrars' views are considered in making appointments. (Standard 7.2)

15  Establish criteria for the selection of assessors, which define eligibility for appointment as an assessor, specifying differences for different assessments if applicable. (Standard 8.1.4)

(c) By the 2017 comprehensive report, evidence that the College has addressed the following conditions from the accreditation report:

4   Complete and report on the review of the Advanced Specialised Training curricula and the development and introduction of the Academic Practice curricula. (Standard 3.1 and 3.2)

5   Review the documentation and oversight to support the learning objectives of the clinical experience in the minimum six-month mandatory placement in a community or primary care setting. This review is to include the expectations of the training providers to support the placement and provide greater clarity to the registrars regarding the placement requirements. (Standard 3.2)

7   Review the balance in the assessment portfolio between simulated/theoretical assessment versus more authentic competency-

based or performance-based assessment modalities and as part of the review of all Advanced Specialised Training disciplines. (Standard 5.1.2)

9 Where survey feedback or related indicators have identified issues, implement processes to ensure a clearly articulated set of actions are put in place and connected to further evaluate and assess the desired outcomes. (Standard 6.1)

10 Monitor and report on changes to the selection processes for the Australian General Practice Training (AGPT) program in response to the changes to the structure of general practice training. (Standard 7.1)

11 Work actively to obtain the cooperation of the regional training providers and the Remote Vocational Training Scheme in implementing the College's selection criteria and standards for selection. (Standard 7.1)

13 Document, implement and subsequently evaluate a plan for ensuring that individuals involved in the supervision and delivery of ACRRM training across all pathways are trained and supported about the curriculum, training and assessment requirements, and expected standards of supervision for the ACRRM training program. (Standard 8.1.1)

14 Develop and implement strategies for improved relationships and engagement with regional training providers, directors of education, medical educators and supervisors, as well as mechanisms for using the accreditation process to assure compliance with ACRRM training policies and procedures. (Standard 8.1.1)

16 Progress and report on developments in accreditation processes affecting regional training providers, training posts and supervisors, focusing on the impact of Australian Government led changes to the funding and structure of general practice training provision. (Standard 8.2)

The accreditation conditions in order of standard are detailed in the following table:

| Standard | Condition: | | To be met by: |
|---|---|---|---|
| Standard 1 | 1 | Review and promulgate the terms of reference for all College education committees to ensure currency and consistency with the 2014 Constitution. (Standard 1.1.2) | 2015 |
| | 2 | Develop a plan to formally engage consumers and community representatives at all levels in the College's governance structure. (Standard 1.1.2) | 2016 |
| Standard 2 | 3 | Adopt the College's approved definition of general practice for use in all College documentation to provide clarity of purpose for the College. (Standard 2.1) | 2015 |
| Standard 3 | 4 | Complete and report on the review of the Advanced Specialised Training curricula and the development and introduction of the Academic Practice | 2017 |

| Standard | Condition: | | To be met by: |
|---|---|---|---|
| | | curytcula. (Standard 3.1 and 3.2) | |
| | 5 | Review the documentation and oversight to support the learning objectives of the clinical experience in the minimum six-month mandatory placement in a community or primary care setting. This review is to include the expectations of the training providers to support the placement and provide greater clarity to the registrars regarding the placement requirements. (Standard 3.2) | 2017 |
| | 6 | Develop and document a process for considering the input of other relevant specialist medical colleges in the review of individual Advanced Specialised Training curricula. (Standard 3.2) | 2016 |
| Standard 5 | 7 | Review the balance in the assessment portfolio between simulated/theoretical assessment versus more authentic competency-based or performance-based assessment modalities and as part of the review of all Advanced Specialised Training disciplines. (Standard 5.1.2) | 2017 |
| | 8 | Progress and report on outcomes of the effectiveness of the case-based discussion assessment trial and decision whether to remove the summative mini clinical evaluation exercise (mini-CEX). (Standard 5.3) | 2016 |
| Standard 6 | 9 | Where survey feedback or related indicators have identified issues, implement processes to ensure a clearly articulated set of actions are put in place and connected to further evaluate and assess the desired outcomes. (Standard 6.1) | 2017 |
| Standard 7 | 10 | Monitor and report on changes to the selection processes for the Australian General Practice Training (AGPT) program in response to the changes to the structure of general practice training. (Standard 7.1) | 2017 |
| | 11 | Work actively to obtain the cooperation of the regional training providers and the Remote Vocational Training Scheme in implementing the College's selection criteria and standards for selection. (Standard 7.1) | 2017 |
| | 12 | Review and implement processes for the appointment of registrar representatives to the Registrar Committee to ensure registrars' views are considered in making appointments. (Standard 7.2) | 2016 |

| Standard | Condition: | | To be met by: |
|---|---|---|---|
| Standard 8 | 13 | Document, implement and subsequently evaluate a plan for ensuring that individuals involved in the supervision and delivery of ACRRM training across all pathways are trained and supported about the curriculum, training and assessment requirements, and expected standards of supervision for the ACRRM training program. (Standard 8.1.1) | 2017 |
| | 14 | Develop and implement strategies for improved relationships and engagement with regional training providers, directors of education, medical educators and supervisors, as well as mechanisms for using the accreditation process to assure compliance with ACRRM training policies and procedures. (Standard 8.1.1) | 2017 |
| | 15 | Establish criteria for the selection of assessors, which define eligibility for appointment as an assessor, specifying differences for different assessments if applicable. (Standard 8.1.4) | 2016 |
| | 16 | Progress and report on developments in accreditation processes affecting regional training providers, training posts and supervisors, focusing on the impact of Australian Government led changes to the funding and structure of general practice training provision. (Standard 8.2) | 2017 |
| Standard 9 | 17 | Review the current *Remediation Policy 2011–2013* and implement a revised policy in line with the College's 2014–2016 Professional Development Program triennium requirements and the Medical Board of Australia's requirements. (Standard 9.3) | 2015 |

This accreditation decision relates to the College's programs of study and continuing professional development program in the recognised medical specialty of general practice.

In March 2018, before this period of accreditation ends, the AMC will seek a comprehensive report from the College. The report should address the accreditation standards and outline the College's development plans for the next four years. The AMC will consider this report and, if it decides the College is continuing to satisfy the accreditation standards, the AMC Directors may extend the accreditation by a maximum of four years (to March 2022), taking accreditation to the full period which the AMC may grant between assessments, which is ten years. At the end of this extension, the College and its programs will undergo a reaccreditation assessment by an AMC team.

**Overview of findings**

The findings against the nine accreditation standards are summarised below. Only those parts of the standards which are not met or substantially met are listed under each overall finding.

Conditions imposed by the AMC so the College meets accreditation standards are listed below in the accreditation decision (pages 13 to 20). The team's commendations in areas of strength and recommendations for improvement are given below for each set of accreditation standards.

| 1. The Context of Education and Training (governance, program management, educational expertise and exchange, interaction with the health sector and continuous renewal) | This set of standards is MET |
|---|---|

Standard 1.1.2 (governance structures describe the composition and terms of reference, and allow all relevant groups to be represented in decision-making) is substantially met.

*Commendations*

A    The College's recent review of its organisational structure, ensuring appropriate representation, expertise and professional integrity.

B    The demonstrable, extensive and effective communication and engagement efforts both internally and with external stakeholders over the past four years.

C    The College's proactive approach, in particular its joint policy position with the Royal Australian College of General Practitioners, to the current uncertain general practice training environment as a result of the Commonwealth Government changes relating to the closure of General Practice Education and Training (GPET) and the reduction in the number of regional training providers.

D    The College's education and training processes are supported by dedicated and expert College staff.

*Conditions to satisfy accreditation standards*

1    Review and promulgate the terms of reference for all College education committees to ensure currency and consistency with the 2014 Constitution. (Standard 1.1.2)

2    Develop a plan to formally engage consumers and community representatives at all levels in the College's governance structure. (Standard 1.1.2)

*Recommendations for improvement*

AA   With the increasing number of registrars over the near term, monitor and respond to the need for appropriate College staff support for the education and training of this expanded cohort. (Standard 1.2)

BB   Establish and maintain formal relationships with State and Territory Health Departments to clarify the College's role in general practice training. (Standard 1.4)

| 2. The Outcomes of the Training Program (purpose of the training organisation and graduate outcomes) | This set of standards is MET |
| --- | --- |

Standard 2.1 (organisational purpose) is substantially met.

*Commendations*

E     The College's innovative use of publically available video, pamphlets, policies, curricula and handbooks which provide information for registrars, potential registrars, supervisors, training providers and the community on the expected graduate outcomes.

*Conditions to satisfy accreditation standards*

3     Adopt the College's approved definition of general practice for use in all College documentation to provide clarity of purpose for the College. (Standard 2.1)

*Recommendations for improvement*

CC     Increase direct engagement with training providers to ensure training requirements are being consistently applied across all training providers. (Standard 2.2)

| 3. The Education and Training Program – Curriculum Content (framework; structure, composition and duration; research in the training program and continuum of learning) | This set of standards is SUBSTANTIALLY MET |
| --- | --- |

Standard 3.1 (curriculum framework) is substantially met. Standard 3.2 (curriculum structure, composition and duration) is substantially met.

*Commendations*

F     The 4th Edition Primary Curriculum, completed in 2013, supports the strong underlining principles and philosophy of the delivery of generalist health care in a rural and remote setting.

G     The College's formal engagement and consultation with key stakeholders in the review of the Primary and Advanced Specialised Training curricula.

H     The strengthening in the Primary Curriculum of the importance of research and education and the inclusion of an opportunity to pursue Advanced Specialised Training in Academic Practice.

I     The strong commitment and promotion to the vertical integration of all aspects of training and workforce development to support the practice of generalist medicine in rural and remote settings.

*Conditions to satisfy accreditation standards*

4    Complete and report on the review of the Advanced Specialised Training curricula and the development and introduction of the Academic Practice curricula. (Standard 3.1 and 3.2)

5    Review the documentation and oversight to support the learning objectives of the clinical experience in the minimum six-month mandatory placement in a community or primary care setting. This review is to include the expectations of the training providers to support the placement and provide greater clarity to the registrars regarding the placement requirements. (Standard 3.2)

6    Develop and document a process for considering the input of other relevant specialist medical colleges in the review of individual Advanced Specialised Training curricula. (Standard 3.2)

*Recommendations for improvement*

DD   Develop an engagement and stakeholder strategy to increase the regional training provider's understanding of the ACRRM curriculum and training requirements. (Standard 3.1 and 3.2)

EE   The Joint Consultative Committee for General Practice Procedural Surgery clearly defines the agreed areas for scope of practice of procedures in the Advanced Rural Generalist Surgery curriculum. Current areas of disagreement need to be defined and agreement made as to how the training experience in those areas will progress. (Standard 3.2)

FF   Review and develop a process to ensure there is policy and procedural alignment in the advice given by the training providers in relation to recognition of prior learning and ACRRM's clearly articulated policy. (Standard 3.4)

GG   Develop a statement of expectations regarding re-entry requirements for registrars who take an extended period of interrupted leave. (Standard 3.4)

| 4. The Training Program – Teaching and Learning | This set of standards is MET |
|---|---|

*Commendations*

J    The College's continued expansion of both the Rural and Remote Medical Education Online (RRMEO) education modules and its virtual classroom which provides registrars with up-to-date education in the rural and remote environment.

K    The introduction of learning plans for registrars on all training pathways, and the College's plans for the introduction of the Customer Relationship Management System which will provide improved access for supervisors and registrars to individualised learning plans as well as up-to-date information on registrar progress.

*Conditions to satisfy accreditation standards*

Nil

HH    Develop and implement strategies to promote to training providers, knowledge about, and implementation of the Rural and Remote Medical Education Online (RRMEO) platform for ACRRM registrars' learning with its specific focus on the rural and remote practice. (Standard 4.1.2)

II     Develop and implement processes to ensure that supervisors are adequately supported through their training provider or through the College directly, to ensure the programs of training and learning are fully supported in the practice, hospital and other training posts. (Standard 4.1.2)

| 5. The Curriculum – Assessment of Learning (assessment approach, feedback and performance, assessment quality, assessment of specialists trained overseas) | This set of standards is MET |
|---|---|

Standard 5.1.2 (range of assessment formats are appropriately aligned) is substantially met. Standard 5.3 (assessment quality) is substantially met.

*Commendations*

L     The College's ongoing commitment and development activity to build a comprehensive set of professionally managed and administered assessments that cover all curriculum components and the implementation of a revised operational structure which provides clear areas of responsibility and transparency in process.

M     The extensive revisions to the Procedural Skills Logbook in terms of both format (online) and content (inclusion of physical examination and a revised set of procedures).

N     The College's extensive work to prepare candidates effectively for examinations including the provision of mock examinations and tailored study group activity.

O     The review of assessment outcomes for both the suitability of the standard being applied and the availability of suitable examination preparation resources and processes should benefit the College and its registrars.

P     The Structured Assessment using Multiple Patient Scenarios (StAMPS) examination, run in both face-to-face and online formats to provide registrars with maximum choice in terms of location and format of examination. Both formats are run with notable professionalism and consistency from all involved including College staff and examiners.

O     The work to begin to implement a robust process for the assessment of overseas-trained specialist General Practitioners.

*Conditions to satisfy accreditation standards*

7     Review the balance in the assessment portfolio between simulated/theoretical assessment versus more authentic competency-based or performance-based assessment modalities and as part of the review of all Advanced Specialised Training disciplines. (Standard 5.1.2)

8 Progress and report on outcomes of the effectiveness of the case-based discussion assessment trial and decision whether to remove the summative mini clinical evaluation exercise (mini-CEX). (Standard 5.3)

*Recommendations for improvement*

JJ Develop an integrated online module in the next phase of the Customer Relationship Management (CRM) system development to better support examination management and data integrity. (Standard 5.1)

KK Delay the development of selection tests into training until the assessment suite has reached a steady and stable state and the necessary reviews (of feedback, balance and clinical performance) have been completed. (Standard 5.1)

LL Develop the systems by which blueprinting at the test level occurs. (Standard 5.1)

MM Complete the planned review of assessment feedback processes overall with a view to streamlining and ensuring long-term sustainability. (Standard 5.2)

NN Train local assessors to conduct the mini clinical evaluation exercise within the normal working day rather than relying on external assessors. (Standard 5.3)

OO Complete the planned online supervisor/assessor module maintaining a focus on providing feedback on assessments and strategies to enable registrars to effectively plan their own learning using the College's learning plan approach. (Standard 5.3)

PP Review and present evidence for the improvement in item quality for the Multiple Choice Question Examination. (Standard 5.3)

QQ Monitor the use and effectiveness of the individualised learning plan for international medical graduates. (Standard 5.4)

| 6. The Curriculum – Monitoring and Evaluation (Monitoring, outcome evaluation) | This set of standards is MET |
|---|---|

Standard 6.1 (ongoing monitoring) is substantially met.

*Commendations*

R The College's evaluation framework which provides a comprehensive overview of the processes undertaken to monitor and improve the quality of the training program.

*Conditions to satisfy accreditation standards*

9 Where survey feedback or related indicators have identified issues, implement processes to ensure a clearly articulated set of actions are put in place and connected to further evaluate and assess the desired outcomes. (Standard 6.1)

*Recommendations for improvement*

RR Collect data regarding the number of registrars who complete the program in the defined minimum time versus those who ultimately complete the program and compare with other similar programs. (Standard 6.2.1)

| 7. Implementing the Curriculum - Trainees (admission policy and selection, trainee participation in governance of their training, communication with trainees, resolution of training problems, disputes and appeals) | This set of standards is SUBSTANTIALLY MET |
| --- | --- |

Standard 7.1 (admission policy and selection) is substantially met. Standard 7.2 (formal processes and structures that facilitate and support the involvement of trainees in governance) is substantially met.

*Commendations*

S    The inclusion of registrar representatives at all levels of ACRRM's governance structure, including the ACRRM Board, and the College's responsiveness to registrar needs and issues during their training.

T    The College's extensive, widely adopted communication strategies using technology including Rural and Remote Medical Education Online (RRMEO) and the upcoming Customer Relationship Management (CRM) system. Social media is used as an effective means of communication, especially by the Registrar's Committee, and also by the College more generally, both to distribute information to, and to receive feedback from registrars.

*Conditions to satisfy accreditation standards*

10    Monitor and report on changes to the selection processes for the Australian General Practice Training (AGPT) program in response to the changes to the structure of general practice training. (Standard 7.1)

11    Work actively to obtain the cooperation of the regional training providers and the Remote Vocational Training Scheme in implementing the College's selection criteria and standards for selection. (Standard 7.1)

12    Review and implement processes for the appointment of registrar representatives to the Registrar Committee to ensure registrars' views are considered in making appointments. (Standard 7.2)

*Recommendations for improvement*

SS    Revise the process for verifying the candidate's recognition of prior learning and applying for selection to the Independent Pathway. (Standard 7.1)

TT    Build on existing work with General Practice Registrars Australia and regional training providers to improve advocacy for ACRRM registrars within these organisations and ensure their understanding of their shared responsibility. (Standard 7.2)

UU    Develop and implement a system of dating and version control on all curricula, handbooks, policies and online resources so version applicability and tracking is easily possible for these keys documents. (Standard 7.3)

| 8. Implementing the Training Program – Delivery of Educational Resources (Supervisors, assessors, trainers and mentors; and clinical and other educational resources) | This set of standards is SUBSTANTIALLY MET |
|---|---|

Standard 8.1.1 (defined responsibilities of practitioners who contribute to training) is substantially met. Standard 8.1.4 (processes for selecting assessors) is substantially met. Standard 8.2 (clinical and other educational resources) is substantially met.

*Commendations*

U    The significant contribution of ACRRM supervisors to the supervision, mentoring and assessment of registrars in training.

V    The College's processes for training and preparation of its assessors, including the use of practice examinations for training and the provision of online modules with high quality training videos.

W    The effective evaluation of assessor competence with appropriate use of registrar feedback to inform the College regarding assessor performance.

X    The collaboration with the Royal Australian College of General Practitioners in the establishment of the Bi-College Regional Training Provider Accreditation Program which facilitates greater oversight of accreditation of regional training providers.

Y    The College's use of a wide variety of training settings within the healthcare system for service-based training positions, facilitating a broad training experience for registrars in general practice.

*Conditions to satisfy accreditation standards*

13    Document, implement and subsequently evaluate a plan for ensuring that individuals involved in the supervision and delivery of ACRRM training across all pathways are trained and supported about the curriculum, training and assessment requirements, and expected standards of supervision for the ACRRM training program. (Standard 8.1.1)

14    Develop and implement strategies for improved relationships and engagement with regional training providers, directors of education, medical educators and supervisors, as well as mechanisms for using the accreditation process to assure compliance with ACRRM training policies and procedures. (Standard 8.1.1)

15    Establish criteria for the selection of assessors, which define eligibility for appointment as an assessor, specifying differences for different assessments if applicable. (Standard 8.1.4)

16    Progress and report on developments in accreditation processes affecting regional training providers, training posts and supervisors, focusing on the impact of Australian Government led changes to the funding and structure of general practice training provision. (Standard 8.2)

*Recommendations for improvement*

VV Through the accreditation of regional training providers, ensure that all operating training posts and supervisors have up-to-date accreditation status. (Standard 8.2)

WW Include registrar representatives on the accreditation teams for both the Bi-College Regional Training Provider Accreditation Program and training post accreditation. (Standard 8.2)

| 9. Continuing Professional Development (programs, retraining and remediation) | This set of standards is MET |
|---|---|

Standard 9.1 (remediation) is substantially met.

*Commendations*

Z The College's Professional Development Program continues to represent best practice with a focus on continual renewal, ease of access and optimal use of information and communication technology.

*Conditions to satisfy accreditation standards*

17 Review the current Remediation Policy 2011–2013 and implement a revised policy in line with the College's 2014–2016 Professional Development Program triennium requirements and the Medical Board of Australia's requirements. (Standard 9.3)

*Recommendations for improvement*

XX Review the requirement that fellows engaged in procedural work maintain procedural logbooks as part of their ACRRM Professional Development Program. (Standard 9.1)

YY Implement a process for new fellows to demonstrate an ongoing commitment to continuing professional development, perhaps on a pro-rata points basis for the remainder of the triennium following the attainment of their fellowship. (Standard 9.1)

ZZ Introduce multi-source feedback for fellows as part of the College's Professional Development Program requirements. (Standard 9.1)

# Introduction: The AMC accreditation process

The Australian Medical Council (AMC) was established in 1985. It is a national standards body for medical education and training. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

**The process for accreditation of specialist medical education and training**

The AMC implemented the process for assessing and accrediting specialist medical education and training programs in response to an invitation from the Australian Government Minister for Health and Ageing to propose a new model for recognising medical specialties in Australia. A working party of the AMC and the Committee of Presidents of Medical Colleges was established to consider the Minister's request, and developed a model with three components:

- a new national process for assessing requests to establish and formally recognise medical specialties
- a new national process for reviewing and accrediting specialist medical education and training programs
- enhancing the system of registration of medical practitioners, including medical specialists.

The working party recommended that, as well as reviewing and accrediting the training programs for new specialties, the AMC should accredit the training and professional development programs of the existing specialist medical education and training providers – the specialist medical colleges.

Separate working parties developed the model's three elements. An AMC consultative committee developed procedures for reviewing specialist medical training programs, and draft educational guidelines against which programs could be reviewed. In order to test the process, the AMC conducted trial reviews during 2000 and 2001 with funding from the Australian Government Department of Health and Ageing. These trial reviews covered the programs of two colleges.

Following the success of these trials, the AMC implemented the accreditation process in November 2001. It established a Specialist Education Accreditation Committee to oversee the process, and agreed on a forward program allowing it to review the education and training programs of one or two providers of specialist training each year. In July 2002, the AMC endorsed the guidelines, *Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures*.

In 2006, as it approached the end of the first round of specialist medical college accreditations, the AMC initiated a comprehensive review of the accreditation guidelines. In June 2008, the Council approved new accreditation standards and a revised description of the AMC procedures. The new accreditation standards apply to AMC assessments conducted from January 2009. The relevant standards are included in each section of this report.

A new National Registration and Accreditation Scheme for health professions began in Australia in July 2010. The Ministerial Council, on behalf of the Medical Board of Australia, has assigned the AMC the accreditation functions for medicine.

From 2002 to July 2010, the AMC process for accreditation of specialist education and training programs was a voluntary quality improvement process for the specialist colleges that provided training in the recognised specialties. It was a mandatory process for bodies seeking recognition of a new medical specialty. From 1 July 2010, the *Health Practitioner Regulation National Law Act 2009* makes the accreditation of specialist training programs an essential element of the process for approval of all programs for the purposes of specialist registration. Similarly, the Medical Board of Australia's registration standards indicate that continuing professional development programs that meet AMC accreditation requirements meet the Board's continuing professional development requirements.

From 1 July 2010, the AMC presents its accreditation reports to the Medical Board of Australia. Medical Board approval of a program of study that the AMC has accredited forms the basis for registration to practise as a specialist.

**Assessment of the Australian College of Rural and Remote Medicine training pathways**

In 2004–05, the AMC assessed an application for recognition of rural and remote medicine as a distinct medical specialty. The AMC report on this assessment (November 2005) indicated that there was no evidence of a defined and distinct field of practice in Australia that could be described as rural and remote medicine practice, rather rural and remote medicine was principally general practice with an additional set of advanced skills. The report also acknowledged the major health and healthcare needs of rural and remote Australians, the very significant Government support for a range of initiatives to address these needs, and the support for the Australian College of Rural and Remote Medicine as a professional body for rural and remote medical practitioners.

In December 2005, the Minister for Health and Ageing advised the AMC that he agreed with these findings. Since general practice is a recognised medical specialty in Australia, it was agreed that ACRRM could apply to the AMC to become accredited as a provider of education and training in general practice.

The AMC invited ACRRM to apply for initial accreditation. In February 2007, on the basis of a paper review, the AMC granted initial accreditation to ACRRM as a standards body and provider of specific training and professional development programs for the specialty of general practice, including accreditation of education and training leading to fellowship of ACRRM and the College's professional development program, subject to satisfactory annual reports.

Under AMC policy, initial accreditation continues subject to satisfactory annual reports and until the AMC conducts a full accreditation assessment of the training programs. The AMC proposed to undertake the full assessment once several cohorts had completed the College's summative assessment and had been awarded fellowship through an ACRRM training pathway. In late 2008, the AMC began discussions with

ACRRM concerning the timing of the full assessment and plans were made for the process to be completed in March 2010.

In June 2009, the AMC appointed Professor Gavin Frost to chair the assessment of the training pathways leading to fellowship of the Australian College of Rural and Remote Medicine, referred to as the College from here on in the report. The AMC then began discussions with the College about the timing of the review and the process that would be followed in the review.

The AMC appointed other members of the assessment team (called 'the team' in this report) in September 2009 after the College had an opportunity to comment on the individuals proposed. The members of the 2010 team are listed in Appendix 1.

The review process followed the standard AMC accreditation procedures, namely:

- preparation by the College of a detailed accreditation submission
- a team meeting in November 2009 to consider the College's submission and plans for the assessment
- feedback to the College on the team's preliminary assessment of the submission, the additional information required, and the plans for visits to accredited training practices and providers and meetings with College committees
- AMC surveys of general practice registrars completing training towards Fellowship of ACRRM and their supervisors
- invitations to other specialist medical colleges, medical schools, health departments, general practice and rural health organisations, and health consumer organisations to comment on the College's plans and programs
- a program of site visits and meetings in the Northern Territory, Queensland, South Australia, Tasmania, Victoria and Western Australia between 23 February and 15 March 2010
- a series of meetings at the College offices from 15 to 18 March 2010.

The AMC preparation of the accreditation report was delayed beyond the planned August 2010 completion. In February 2011, the AMC asked the College to provide an update on the key areas identified as concerns in the team's 2010 preliminary statement of findings. Where relevant, the 2010 report included additional information from the College and this information was taken into consideration in framing the accreditation recommendations.

In July 2011, having considered the report on this assessment, the AMC Directors agreed:

(i)     That the following programs of the Australian College of Rural and Remote Medicine be granted ongoing accreditation to 31 December 2014, subject to satisfactory progress reports to the Specialist Education Accreditation Committee: the Vocational Preparation Pathway, the Remote Vocational Training Scheme and the Professional Development Program.

(ii)     That the Independent Pathway of the Australian College of Rural and Remote Medicine be granted ongoing accreditation to 31 December 2014, subject to review of the criteria for selection into the Pathway by October 2011 and, by the College's 2012 progress report to the AMC, review of the aims and objectives of the Pathway. This review should take account of the development of the College's specialist assessment pathway and competent authority pathway, and the nationally agreed approach to the assessment of international medical graduates.

(iii)    That the accreditation is subject to satisfactory progress reports and to the conditions set in the 2010 accreditation report.

Between formal accreditations, the AMC monitors developments in education and training and professional development programs through progress reports from the accredited medical education providers. The College has provided four progress reports to the AMC since its accreditation in 2010. These reports have been reviewed by a member of the AMC team that assessed the program in 2010, and the reviewer's commentary and the progress report then considered by the AMC Specialist Education Accreditation Committee.

The conditions on the 2010 accreditation required a follow-up assessment in 2014. In 2013, the AMC began the preparations for the review of the College's programs. On the Specialist Education Accreditation Committee's recommendation and after the College had an opportunity to consider the proposed membership, the AMC Directors appointed a team to complete this review. The 2014 team was chaired by Professor Ian Civil. The membership of the 2014 team is given at Appendix 2.

In July 2014, the College provided an accreditation submission outlining progress on the recommendations and challenges facing the College. The team met in August 2014 to consider the submission, and then discussed plans for the review with College officers and staff. In October 2014, the AMC wrote to other specialist medical colleges, medical schools, health departments, general practice and rural health organisations, and health consumer organisations requesting feedback on the College's programs. A list of the organisations that made a submission to the AMC team is at Appendix 3.

The 2014 review comprised a program of meetings with registrars, training supervisors, medical educators, training providers and other key stakeholders; and meetings with College officers, committees and staff. The team completed its review from 1 to 3 December 2014 at the College's office in Brisbane.

## Appreciation

The team is grateful to the fellows and staff who prepared the accreditation submission and managed the preparations for the assessment. It acknowledges with thanks the support of fellows who met with team members during this assessment.

Summaries of the program of meetings and visits for the 2010 assessment are at Appendix 4 and for the 2014 assessment at Appendix 5.

## Report on the 2010 and the 2014 AMC assessments

This report contains the findings of both the 2010 and 2014 AMC assessments.

Each section of the report begins with the relevant accreditation standards, current at December 2014. The findings of the 2014 team are provided as commentaries following the relevant sections of the 2010 report. It should be noted that the report by the 2014 team addresses progress by the College against conditions and recommendations made by the AMC in 2010. In areas where the College has made no substantial change and no recommendations were made in 2010, the 2014 team has not conducted a comprehensive assessment.

# 1 The context of education and training

## 1.1 Governance

The accreditation standards are as follows:

- The education provider's governance structures and its education and training, assessment and continuing professional development functions are defined.

- The governance structures describe the composition and terms of reference for each committee, and allow all relevant groups to be represented in decision-making.

- The education provider's internal structures give priority to its educational role relative to other activities.

### 1.1.1 General practice education in Australia in 2010

*Since the delivery and funding of general practice education in Australia differs from education in the other specialist medical training programs, the report includes below a brief summary of the management and structure of general practice training.*

*Vocational training in general practice began in Australia in 1973. The program was managed by the Royal Australian College of General Practitioners (RACGP), under contract with the Government. Initially it was a voluntary scheme. From 1974 to 2001 the Federal Government funded the RACGP to select candidates for general practice training, deliver that training, accredit training practices and assess registrars for fellowship. A 1998 review of general practice training recommended the development of local collaborative consortia to deliver general practice education and the establishment of a national body to coordinate that delivery. These two recommendations were adopted.*

*In 2001, a new program, the Australian General Practice Training (AGPT) program was established to deliver training in general practice. General Practice Education and Training Limited (GPET), a government owned company, funds and manages the AGPT program across Australia, on behalf of the Commonwealth Department of Health and Ageing. GPET's mission is 'General practice education and training delivered through high quality, innovative and regionally based programs to produce a workforce that meets the primary health care needs of the Australian community.' GPET is governed by a Board of Directors, whose members are nominated by the principal stakeholder bodies in Australian general practice, including the two colleges, ACRRM and RACGP.*

*GPET contracts with regional training providers (RTPs) Australia-wide, which deliver the AGPT program in their geographic locations. RTPs are independent business entities. They are required to participate in monitoring, accreditation, review, evaluation and reporting processes implemented and overseen by GPET. Initially 22 regional training providers were selected by GPET following a tender process. In 2009–10, GPET and the RTPs negotiated new three-year contracts for the delivery of the AGPT program. In this period there was also a rationalisation of the number of RTPs and some RTP mergers.*

*Among other things, GPET has contractual responsibilities with the Commonwealth to:*

- *fund, manage, monitor and review training provided by regional training providers*

- *manage the annual selection of registrars into the training program*

- *accredit regional training providers*

- *develop performance measures and benchmarks for regional training providers*

- *monitor and review the performance of regional training providers.*

*GPET distributes training places across Australia to meet workforce imperatives, the demand for places, and community need. The AGPT program directs a minimum of 50% of all training activity to rural, regional and remote locations across Australia. There is a quota on general practice training places. In recent years, the number of entry training places for general practice has increased annually from 600 in 2008 to 700 in 2010 with further increases planned.*

*The specialty of general practice is unique in Australia in that there are two colleges providing education and training programs leading to qualifications for the purposes of specialist registration. The AGPT program prepares registrars to be eligible for fellowship of either or both of the two colleges accredited by the AMC as education providers for the specialty of general practice: Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) or fellowship of the Royal Australian College of General Practitioners (FRACGP). Training in the AGPT program is based on the curricula prescribed in the specialty of general practice by RACGP and ACRRM. The colleges and GPET work together to ensure that college training standards for fellowship of RACGP and ACRRM are maintained and adhered to by the RTPs.*

*The AGPT program has two training pathways: a rural pathway and a general pathway. Doctors are offered an AGPT training place with a particular RTP in either pathway. Under the rural pathway, doctors complete all their general practice placements in rural and/or remote areas of Australia (now defined as Australian Standard Geographical Classification Remoteness Areas 2 to 5). Generous financial incentives are available for rural pathway registrars. The general pathway registrars are required to undertake a minimum of 12 months training in a rural and/or outer metropolitan location and/or an Aboriginal medical service.*

*GPET has set a range of policies that relate to participation in the AGPT program, including policies on extending training time, leave, appeals, remediation, transfer between RTPs and withdrawal from training.*

### 1.1.2   General practice education in Australia in 2014

A number of significant changes are occurring in the structure and funding arrangements for general practice training in Australia. These changes include:

- The closure of General Practice Education and Training (GPET) by 31 December 2014. At the time of the 2014 AMC review of ACRRM, GPET was winding down and its functions transferring to the Australian Government Department of Health. It is possible that some of GPET's responsibilities will be transferred to ACRRM and the Royal Australian College of General Practitioners (RACGP). The two Colleges share a joint policy position on what role the Colleges should have in the new governance arrangements and are working collaboratively to influence the outcome.

- The reduction in the number of regional training providers (RTPs) by 31 December 2015. The number of RTPs will be reduced from 17 to a smaller number by a retender process managed through the Department of Health.

These changes create an uncertain environment for general practice training and the two affected Colleges (ACRRM and RACGP) and make decision making and management of training difficult in the current state of flux.

The team was cognisant of the fact that this review was taking place in an environment of considerable governance and financial change to general practice training. The team was aware of the resulting uncertainties for the future arrangements under which the College will provide general practice training and professional development. The team's deliberations took this situation into account.

Since 2010, the number of general practice training places has increased from 700 to 1,200 in 2014. In the 2014 Federal Budget, the Australian Government announced it will be significantly expanding general practice training capacity by 2015 by increasing the number of training places from 1,200 to 1,500 per year.

### 1.1.3   Australian College of Rural and Remote Medicine in 2010

*ACRRM was incorporated in March 1997. It is a company limited by guarantee, with its registered office in Brisbane.*

*The College admitted its first fellows, experienced rural practitioners, by a process of 'grandfathering' which ended in December 1999. It accepted 696 fellows under this provision. An additional 598 fellows were admitted through the Pioneer pathway, and an additional small number through the Experience Based Pathway. ACRRM began a formal vocational training program which would lead to fellowship by examination in 2000.*

*At the time of the 2010 assessment, the College had more than 2400 members. Members include:*

- *practising rural doctors from any medical discipline*
- *registrars in training*
- *pre-vocational junior doctors and undergraduates*
- *affiliate organisations (e.g. rural clinical schools, university departments of rural health).*

*Of the members, 1,376 were fellows and 291 were registrars. Based on the information the College has provided to the AMC for previous assessments, over the last five years the number of members has grown by about 500, the number of fellows has increased by about 30 and the number of registrars in ACRRM training has increased by about 250.*

*ACRRM is governed by a national Board of Directors that is elected from the College members in line with the Constitution. There are directors in the following categories: directors from each state/region; an academic elected director; a 'Women in rural practice' director; a Rural Doctors Association director; a remote elected director, and a registrar elected director. Members may also elect an Indigenous director. Ex-officio*

*directors include the President, Vice President and Treasurer. Ex officio members of the Board include the Censor, the Chief Executive Officer, the Immediate Past President and the Honorary Director Education.*

*The President can remain in the role for one term, which is two years. A past President is eligible to be elected to the presidency again following the term of another director as President.*

*The Board meets every two months, primarily by teleconference but with two to three face-to-face meetings each year. At least twice a year it undertakes a facilitated strategic review of the organisation. The Board has a strategic priorities list which includes consolidation, improved recognition internationally, engagement with registrars, fellows and key stakeholders, and developing research capacity within the College. The Board formally evaluates its performance and all directors undertake corporate governance training.*

*The ACRRM Board is supported by a range of committees. ACRRM standing committees have delegated authority to make and manage decisions independent of the Board. The Board is ultimately responsible for setting and reviewing all College policies.*

*There are organisational standing committees for Executive, Finance, Registrars, Members and Research functions.*

### 1.1.4  *Australian College of Rural and Remote Medicine in 2014*

Since 2010, the College has undergone a process of reflection and adaptation of its organisational structure, ensuring appropriate representation, expertise and professional integrity. This has included revision of its constitution, standing committees, and its staff management structure.

During this period, ACRRM's programs have substantially expanded and the organisational structure has been reconstituted to meet its wider scale of operations. As at November 2014, the College had approximately 3,700 members (an increase of 1,300 from 2010) and 700 associate members. Of these members, approximately 1,500 are fellows and 600 are registrars. The College's capacity to meet its responsibilities is demonstrated by an increase in new College fellowships from 27 in 2010 to 73 in 2013 and registrar enrolments are continuing to rise.

In its accreditation submission, the College indicates that its general organisational approach has been maintained. The College considers its structure appropriate for an organisation providing training and professional development for general practitioners in rural and remote communities.

The College's organisational structure has four divisions under the Chief Executive Officer, as follows:

- Programs and Operations, which includes general operations, marketing, membership, communications, evaluation, prevocational training, training & assessment and fellowship services.

- Standards and Recognition, which encompasses the role of Censor in Chief and education (content).

- Corporate Services and Support, which includes finance, online services and international medical graduate operations.

- Policy and Strategic Projects, which includes e-health and international programs.

The College is maintaining its current administrative structure with a central administrative office in Brisbane and medical educators and key administrative staff located in rural locations across the country. The College has established videoconferencing and remote collaboration arrangements to connect staff in a virtually connected environment.

Over the past three years, the College has undertaken a significant consultative review of its governance and constitution, resulting in revised Articles of Association, Memorandum of Association, and a new constitution which was adopted at the ACRRM Annual General Meeting held on 1 November 2014. The scope of the College's structure and functions are defined by the Articles of Association, Memorandum of Association; and are implemented through the ACRRM Board and committee structure.

With the adoption of the new constitution, the governance structure has undergone some changes. The Board is now a smaller, skills-based board and the larger member-elected body (formerly known as the Board) has become the College Council. The role of the College Council is to provide strategic and policy advice to the Board and to provide more members with a forum for discussing issues and advocacy, without the need to take on the legal, fiduciary and administrative roles of company directors.

The ACRRM Board is still accountable for the governance of ACRRM and is responsible for setting all policy and standards. Oversight of these and other clinical governance matters are delegated to the Education Council. The Chief Executive Officer, Censor-in-Chief, Education Director and all eleven College Committees are appointed by the Board.

The new Board is elected by members of Council. The Board comprises five directors (elected by the Council), the President (elected by the members), a Registrar representative (also elected by the members) and up to three Board-appointed Directors, enabling the Board to fill relevant experience and skills gaps potentially with non-members, to complement the skills of Council-elected directors. The Board Chair is elected by the Board. The minimum number of directors is three and directors have three-year terms with a maximum of three consecutive terms. Transitional arrangements provide for continuity through the staggered replacement of directors.

## 1.2    Program management

The accreditation standards are as follows:

- The education provider has established a committee or committees with the responsibility, authority and capacity to direct the following key functions:
  - planning, implementing and reviewing the training program(s) and setting relevant policy and procedures

- o setting and implementing policy and procedures relating to the assessment of overseas-trained specialists
- o setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activities.

- The education provider's education and training activities are supported by appropriate resources including sufficient administrative and technical staff.

### 1.2.1 Program management in 2010

*The Board is supported by a series of Professional/Standards Standing Committees. The terms of reference of these committees all describe responsibilities for overview and review of relevant standards policy, for ensuring accountability in their areas of responsibility through appropriate systems and controls, and for data collection systems.*

*The established Professional/Standards Standing Committees are as follows:*

*The **Censors Committee** is responsible for setting, reviewing and monitoring the professional standards and requirements for fellowship of ACRRM. This includes development and maintenance of policy and procedures relating to curriculum, training, assessment, certification, recertification, and quality and safety issues. The Committee is chaired by the national censor. Its members include the chairs of the committees listed below and four senior fellows of the College.*

*The **Vocational Training Committee** overviews and reviews the development of vocational training standards and policy. It also provides direction and guidance as required for the implementation of the Vocational Training Program within the approved training provider environments.*

*The **Assessment Committee** is responsible for assessment policy and standards development, and may establish working groups to carry out specific assessment tasks. The Committee ensures systems are in place for quality assurance, monitoring and review of the program; oversees the development of a standardised training program for examiners/invigilators; ensures assessment item development, construction and administration are appropriate; ensures appropriate security and storage processes for question banks and other assessment tools; ensures sharing of ideas and information in the College with respect to assessment and ensures integration with other education and training activities; and reviews the marks and grades of individual candidates within the overall confirmation of assessment results process.*

*The **Professional Development Committee** overviews and reviews the development of professional development standards and policy.*

*The **International Medical Graduate (IMG) Assessment Committee** overviews and reviews the development and implementation of the IMG assessment program and policies; reviews reports on the outcomes of applicant interviews and recommended professional review period learning and assessment plans, and make decisions on comparability and required periods of professional review; approves and overviews implementation plans for overseas-trained general practitioner professional review periods; approves supervisors and training posts; reviews supervisors' reports and, if required, implements remediation*

*processes; and receives completion of requirements forms and makes recommendations to the Censor concerning invitations to apply for fellowship.*

*The College indicated that committee terms of reference are reviewed at least every three years, more often if required. The Board receives copies of all committee minutes and the respective Chair addresses any issues warranting Board focus. There is a strong use of electronic communication, supporting the operations of the geographically dispersed membership.*

*At the time of the AMC visit, elements of the committee structure were still being implemented. The College was still finalising terms of reference and chairs for the Quality & Safety Committee, the Research Committee (formerly called the Research and Evaluation Committee), the Members Committee and the Post-Fellowship Education Committee. The Post-Fellowship Education Committee will identify areas of extended or specialised skills that would benefit from structured programs of education, training and certification by ACRRM either independently or in collaboration with other standards setting bodies.*

*For each state/territory, there is a State Director position. This position is intended to identify the Board member elected to represent the interests and perspectives of each state/territory at the Board. State Directors chair State Member Groups, which have been established over the last 18 months, to contribute state-based perspectives to College deliberations.*

### 1.2.2 Program management in 2014

The established Professional/Standards Standing Committees have remained largely as they were in 2010, except for the establishment of a Board of Examiners Committee, which reports to the Assessment Committee. The Board of Examiners Committee, which meets every two months, is chaired by the College Censor and comprises two members from the Assessment Committee (including its chair) and two members from the Education Council.

In addition, the Censors Committee has essentially been replaced by the Education Council with overarching responsibility to:

- deliver leadership and clinical governance to inform College policy, advocacy and programs
- provide a forum for informed debate, communication, ideas sharing and peer review by College Standards Committees
- provide recommendations and advice to the College Board regarding the accreditation of third-parties who seek delegation of ACRRM authorities to deliver education or training
- provide advice and support to internal and external staff, committees and working groups to support the development of appropriate curricula, educational resources, tools and products.

The Education Council ensures standards and programs are appropriately aligned and integrated to minimise duplication. It provides flexible, time-efficient education and

training options and supports the role of the Censor in Chief by continually seeking opportunities to improve the standards, including how effectively they are able to be implemented and adjudicated. The Council's chair is appointed by the ACRRM Board and its membership comprises the chairs of the eight principal education committees and four senior fellows.

The College's governance structure as at December 2014 is shown at Appendix 6.

### 1.3    Educational expertise and exchange

The accreditation standards are as follows:

- The education provider uses educational expertise in the development, management and continuous improvement of its education, training, assessment and continuing professional development activities.

- The education provider collaborates with other educational institutions and compares its curriculum, training program and assessment with that of other relevant programs.

### 1.3.1  Educational and professional expertise available to the College in 2010

*The College has a staff complement of 45 full-time equivalents, with 39 full-time staff and 12 part-time staff. While the majority are based in the College head office in Brisbane, there is a small Melbourne office which fulfils the functions of post and practice accreditation, Independent Pathway trainee support, continuing professional development accreditation and research into career pathways. There is also a part-time staff member based in Tasmania and two project-funded positions in far north Queensland.*

### 1.3.2  Educational and professional expertise available to the College in 2014

The College's education and training activities are supported by dedicated and expert College staff and fellows with resources matched to current demand and requirements. Since 2010, there has been a significant increase in staffing numbers. Currently there are 61 core College staff and of these, 45 staff (42.1 full-time equivalent) are engaged directly in education, education support, and standards services delivery.

There is a core team of six qualified medical educators and an additional educator is being recruited to enhance the College's capacity to deal with the increasing numbers of registrars in the near term.

In addition, the College in 2013 contracted 215 certified practitioners (fellows and others) to contribute to the College's education activities, including remediation and examiner roles to meet the requirements of increasing registrar numbers.

Educational staff regularly review the curricula of similar specialist medical colleges around the world, including the Royal Australian College of General Practitioners, the Royal New Zealand College of General Practitioners, the Division of Rural Hospital Medicine New Zealand, the Royal College of General Practitioners, the College of Physicians Canada and the American Board of Family Practice, with such comparisons being invariably positive. The College has also established an internationally-based

network of like-minded academics to provide input into, and to critique its educational activities.

The College delegates delivery of the Australian General Practice Training (AGPT) program and some aspects of training post accreditation to ACRRM-accredited regional training providers. Similarly, training of registrars on the Remote Vocational Training Scheme (RVTS) is delivered by the staff of the RVTS program.

### 1.3.3 2010 team findings on governance, program management, and educational expertise and exchange

*Since the 2007 AMC accreditation, there has been significant growth in ACRRM's education and training activities. The College's continued growth is commendable, but this has potential to disrupt good governance. ACRRM is reviewing structures to ensure they remain appropriate.*

*ACRRM has indicated its commitment to adapting its governance and program management structures to meet future challenges. At the time of the team's visit, the College was undertaking a constitutional review to identify and address weaknesses in the current College structure and operations. The team identified the following areas as worthy of review by the College.*

*The College has been well served by the strong commitment of a group of foundation fellows who have remained active in College activities since its inception. As the College grows, it must develop strategies to broaden the involvement of other fellows and stakeholders in College activities and business.*

*Board members are elected every two years. This can lead to a situation where there is a level of director turnover which may disrupt good governance.*

*The team recommends the College review its electoral rules and timing of Board director appointments to provide for a smoother cycle of new and departing Board directors for business and corporate continuity. For the same reason, it recommends that the College consider choosing the President from the directors or reviewing the current situation where a President can be elected from the membership without having served any time on the Board.*

*The College has recognised that it must actively engage registrars in the governance structures and decision-making of the College. Its processes are outlined in more detail in Standard 7 of the 2010 findings. The Board has a Registrar Committee, with the chair of that Committee also serving as a Board Director. The College should regularly review the effectiveness of registrar engagement and pursue opportunities for enhancing registrar engagement and involvement.*

*The role of the State Director is confusing. A number of stakeholders believed these positions represented a formal role within each jurisdiction, involving administrative oversight, a significant time commitment to state-based College activities and local representation of College views to stakeholders. It is recommended that the College review and clarify the role of State Director and disseminate this information widely.*

*ACRRM has a centralised structure, concentrated in the Brisbane office. The ACRRM Board indicated that this structure allowed for fast decision-making and flexibility as ACRRM was establishing itself. As ACRRM's role in providing training in a national system has developed, it is time for the College to review its centralised structure and resourcing so it will meet the needs of all trainees and supervisors, and the training and service needs of all jurisdictions.*

*In its report to the AMC in March 2011, the College indicated that its 2010 review had determined that the constitution was appropriate and functional in outlining the principles, roles and structure for the College and that no formal change to the constitution was planned. The College indicated it had noted the AMC team's suggestions and these would be considered by the College when it next reviews its constitution.*

*The College is now well established as an organisation, as is its role in advocating and supporting rural medical practice. Its formal training role is still relatively new. As would be the case for any new education provider, it faces a number of challenges as it becomes established in this role.*

*The team considers that the College structure gives priority to educational roles relative to other activities but the College needs to keep these priorities under review. The College has a considerable range of educational activities, including the three training pathways to fellowship of ACRRM and the continuing professional development program covered by this assessment, its strong engagement in the prevocational training phase, the rural generalist program, and developing assessment processes for international medical graduates. This report identifies a number of areas that require attention: the review of the Primary Curriculum needs to be prioritised, and the recently developed advanced specialised training curricula will need to be evaluated and reviewed with appropriate engagement of the relevant specialist medical colleges. These improvements will require appropriate resources over the next few years. While the College applies enthusiasm and commitment in each of these educational endeavours, the team is concerned the capacity and resources of the College are spread thinly. Important priorities in relation to existing roles and functions covered by the AMC accreditation may progress slowly while attention is focussed on new roles.*

*The College's operations are currently underpinned by appropriate resources. The College is continuing to grow and senior officers acknowledge that ACRRM will need to resource its developing role as a standard setting body and provider of general practice training.*

*The staffing levels are currently sufficient to ensure the educational and other activities of the College are effectively delivered. However, this will require ongoing review.*

*As gaps have been identified in curriculum development and assessment, the College has sought and brought in appropriate educational expertise. This includes the engagement of an educationalist expert in assessment techniques and the appointment of the Academic Director to the Board. By establishing the important position of Academic Director, the College has recognised the need to enhance the research capability and to promote the academic pursuits of the College at Board level.*

*The College is commended for its focus on, and achievements in, the development and utilisation of remote learning tools to reach its dispersed and diverse membership. The Team's comments on these tools, and particularly Rural and Remote Medical Education Online (RRMEO), are in Sections 4 and 9 of the report. Given the multiple demands on the College's information technology service, the College will need clearer prioritising of information technology activities and developments to ensure that the skilled, but limited, information technology resources are applied to best strategic effect.*

*As is the case for all the Australian colleges, some individual fellows make substantial contributions to governance and to the management of key functions. In ACRRM, some of these contributions have been over many years. As a result some College processes depend heavily on the expertise of individuals. This knowledge and these processes all need to be documented so that processes for making training decisions are formalised and can be demonstrated to be consistent and transparent.*

### 1.3.4  2014 team findings on governance, program management, and educational expertise and exchange

In 2010, the AMC set three conditions on accreditation relating to the College's governance and program management, including providing appropriate priority for the ongoing review and improvement of its curriculum documentation (condition 1); prioritising its information technology activities and developments to better support the accredited training programs (condition 2); and engaging appropriate resources and technical staff resources to meet current and future educational activities (condition 3).

The College addressed condition 2 in 2012 by providing a detailed program outlining priorities for its information technology development work to support the vocational training and membership areas of the College. The College also addressed condition 3 in 2012 reporting an increase in staffing numbers and in particular the establishment of a new Director of Education position. Condition 1 was addressed in 2013 with the College finalising its review of the Primary Curriculum and commencing its review of the Advanced Specialised Training curricula. This is discussed in further detail under standard 3 of this report.

Since 2010, the College has undertaken a significant review of its governance and implemented a new constitution. This constitution articulates the objects of the College and creates a clear separation between a smaller governance Board and a broader member Council providing advice and member engagement. The team commends the College on these changes.

As discussed under standard 2 of this report, the team noted that the newly adopted constitution does not contain a definition of general practice relevant to ACRRM, although there are several definitions used across various College activities depending on the context. The team considers that a clear, articulated definition of general practice is important when the College has to deliberate and enunciate its core purpose and outcomes. The team recommends that the Board adopt the College's approved definition of general practice to be used in all documentation and to provide clarity of purpose for the College.

The changes to the College's governance structure address the 2010 recommendations that the College develop and implement strategies to engage a wider range of fellows in ACRRM governance and decision making and review the electoral rules and timing of Board director appointments to provide a smoother cycle of new and departing Board directors for business and corporate continuity.

The College's education and training committees have appropriate terms of reference, and membership, with clear reporting lines and documented minutes. These committees function appropriately to deliver on the educational needs of the College. However, the team did note that several Board committees (International Medical Graduate Assessment, Research, Finance and Post-Fellowship Assessment Committees) have terms of reference which have not been reviewed since 2009/10. In addition, a range of constitutional and organisational changes may impact on the currency of various terms of reference. It is therefore recommended that, with the new constitution adopted, the College should now review the terms of reference of all its committees to ensure currency and consistency with the constitution.

In addition, the recent College governance changes have seen the dissolution of the role of State Directors, hence addressing the 2010 recommendation that the College review and clarify the role of State Directors and disseminate this information widely, thus removing the confusion around the functions of these positions. The governance changes address the 2010 recommendation that the College should ensure that the balance between central and regional governance of educational activities is appropriate to meet current and future needs.

The team notes that the College Board and Executive Committees do not have any permanent community representatives. With the constitutional change now having been adopted and the Board moving to a skills-based structure and a larger representative Council, the College indicates it is open to exploring further involvement of community representatives in its operations. The team supports this development. It is recommended that the College develop a plan for engagement with consumers and community representatives at all levels of College governance.

The team recommends that, with the increasing number of registrars over the near term, the College continues to monitor and respond to the need for appropriate staff support for education and training of this expanding cohort.

The College is commended for its responsiveness to registrar needs and issues, having mediated many regional training provider issues for registrars, and for its extensive, widely adopted communication strategies utilising technology including Facebook, the Rural and Remote Medical Education Online (RRMEO) platform, and the upcoming Customer Relationship Management (CRM) system. This is discussed in further detail under standard 7 of this report.

## 1.4 Interaction with the health sector

The accreditation standards are as follows:

- The education provider seeks to maintain constructive working relationships with relevant health departments and government, non-government and community

agencies to promote the education, training and ongoing professional development of medical specialists.

- The education provider works with healthcare institutions to enable clinicians employed by them to contribute to high quality teaching and supervision, and to foster peer review and professional development.

### 1.4.1 Relationships to promote education, training and professional development of specialist general practitioners in 2010

*ACRRM's accreditation submission indicates that the majority of its advocacy, policy and/or working relationships occur at federal level, in particular with Medicare Australia and the Department of Health and Ageing as the lead jurisdiction for primary care matters in Australia.*

*In Queensland, the College works closely with Queensland Health. Most recently, it has contributed significantly to the rural generalist program, which is a local initiative to provide incentives for medical graduates to commit to a career in regional and/or rural hospital practice. From both written submissions and subsequent team meetings with state health executives, other state health departments consistently indicated that they had very limited interactions with ACRRM. Some would welcome a stronger local ACRRM presence.*

### 1.4.2 2010 team findings

*ACRRM is a maturing organisation which has taken great strides in a relatively short timeframe. The College needs now to consider how best to contribute to policy and strategy development within the complex Australian general practice training environment to achieve appropriate local, national and international recognition.*

*Many organisations contribute to general practice training. Similarly, a large number of programs and processes apply to rural and remote medicine. This complex environment can cause uncertainty for the College and confusion for other organisations that deliver training, and for registrars and supervisors. Success in this environment requires the College to develop and take a leadership role in establishing productive working relationships, and to work with other stakeholders to clarify lines of responsibility and communication.*

*The College's relationship with GPET is key. ACRRM has two nominees on the GPET Board, and it is essential that the College maximises every opportunity to influence and build constructive relationships. The College needs to continue to explore how its nominees on the GPET Board raise issues of concern and positively contribute to policy development and decision making at GPET.*

*The College's relationships with the RTPs are also central to the successful delivery of ACRRM training in two of the three College training pathways. For registrars training in the AGPT program, there are overlapping responsibilities between the College and the RTPs. The challenge for ACRRM is to work with the RTPs to clarify ACRRM requirements and standards, to identify training needs and to build opportunities for training delivery. ACRRM's vocational training role became part of the AGPT program after the program's establishment and the negotiations and work between GPET, RTPs and the Royal*

*Australian College of General Practitioners (RACGP) to embed the new program. This creates an additional need for ACRRM to work collaboratively and proactively with the training providers to ensure that its specific requirements are known and are implemented.*

*Given the history of the development of ACRRM as the second training organisation for the specialty of general practice, a significant challenge for the College is to work to improve relationships with RACGP. The two Colleges continue to share a large number of registrars and supervisors, and provide training within the same program structure.*

*The team was impressed by the constructive relationships that have developed with a number of the rural clinical schools. These relationships provide a sound platform to support medical students during rural training and to enhance the recruitment of students to subsequent rural vocational training.*

*There is a challenge to strengthen engagement with state/territory health jurisdictions with the appropriate level of organisational decentralisation while ensuring that national standards are consistently applied. The team encourages the College to consider the effect of its centralised governance structure on its capacity to interact with and meet the needs of all states and territories.*

*In March 2011, the College reported it was unlikely the College will establish formal organisational structures (e.g. state faculties) at this time. It wished to build greater awareness and positioning of ACRRM amongst the jurisdictions prior to establishing organisational structures and investing significant operational capital in this process. The College indicated that strategies to engage state and regional jurisdictions are being actively developed and trialled.*

### 1.4.3 Relationships to promote education, training and professional development of specialist general practitioners in 2014

Since 2010, the College has continued to maintain a strong relationship with the Queensland Department of Health and is actively involved in a large number of state-/territory-based committees and reference groups across the country.

The College also actively participates in jurisdictional meetings, usually held quarterly, between state health departments and peak bodies for general practice in Queensland, New South Wales, Western Australia and South Australia. These meetings include ACRRM, RACGP, Medicare Locals, Rural Workforce Agencies and the Association of Academic General Practice.

The College's curriculum, accreditation and assessment requirements for Advanced Specialised Training in Anaesthetics, Surgery, Obstetrics and Gynaecology have been established through Joint Consultative Committee processes involving ACRRM, RACGP and the relevant specialist college.

### 1.4.4 2014 team findings

The enhanced focus and effort on stakeholder relationships demonstrated by the College since 2010 addresses condition 4 from 2010 that the College take a leadership

role in establishing productive working relationships with other bodies that contribute to general practice training.

However, the state and territory health departments, other than Queensland, remain equivocal about the level of engagement with, and understanding of, the role of the College. This seems to represent both a short-term risk and an opportunity given the recent dissolution of the ACRRM State Directors role and the current uncertainty related to closure of GPET and changes to the number of RTPs. The team recommends that the College actively pursue formal relationships with state and territory health departments to clarify the College's role in general practice training as a priority focus in the near term.

The current environment of change with the closure of GPET and the likely new relationships with the regional training providers (RTPs) will provide the College with an opportunity to ensure more directly that its training requirements are being adhered to appropriately across the various RTPs. As discussed in other sections of this report, the College will need to continue to collaborate with the other general practice training providers including the RTPs.

The team was impressed with the maturation of the ACRRM and RACGP relationship, demonstrated by the joint united approach to the Commonwealth Government changes related to the closure of GPET. The two colleges have also worked collaboratively in the implementation of the Bi-College RTP Accreditation Program. This joint accreditation process is described in further detail under standard 8.2 of this report.

In addition, the Joint Consultative Committees in Anaesthesia, and Obstetrics and Gynaecology, appear to be working well and much progress has been achieved with the Royal Australasian College of Surgeons.

## 1.5    Continuous renewal

The accreditation standards are as follows:

- The education provider reviews and updates structures, functions and policies relating to education, training and continuing professional development to rectify deficiencies and to meet changing needs.

### 1.5.1  Continuous renewal in 2014

The College's accreditation submission outlines a variety of ways that the College has reviewed and improved its training and professional development programs. During the assessment visit, the team saw evidence of considerable activity and this is delivering appreciable benefits to the College.

The priorities for the College from 2015 onwards are:

- establishing closer working relationships with the regional training providers to increase awareness of the ACRRM training and assessment requirements
- building strong relationships with health services at regional and state levels with Medicare locals, local hospital network boards and individual hospitals

- implementing the Customer Relationship Management system and rolling out with registrars, supervisors, training providers and fellows
- reviewing the Advanced Specialised Training curricula and developing the Academic Practice curricula.

## 2010 Accreditation Conditions and Recommendations

*2010 Commendations*

A    The College's governance processes, including regular self-assessment, strategy review, governance training for directors and regular performance review of the Chief Executive.

B    The identification of gaps in educational expertise and actions to address these through acquisition of appropriately skilled educationalists.

C    ACRRM's constructive relationships with a number of the Rural Clinical Schools which provide a sound platform to support medical students during rural training, and to enhance recruitment to rural vocational training.

*2010 Conditions to satisfy accreditation standards*

1    Provide evidence of appropriate priority for the ongoing review and improvement of curriculum documentation that underpins the training pathways covered by this accreditation assessment and of College processes to support longer-term evaluation, review and subsequent changes to the curriculum and its components. (Standard 1.1)

2    Given the multiple demands on the College's information technology service, prioritise information technology activities and developments to ensure that the information technology resources are applied to best support the accredited training programs. (Standard 1.2)

3    In recognition of the continued growth of the College, provide evidence of appropriate resources and technical staff to meet current and future educational activities. (Standard 1.2)

4    Put in place structures to support constructive working relationships with all relevant health departments to promote the College's education, training and ongoing professional development activities. (Standard 1.4)

*2010 Recommendations for improvement*

AA    Develop and implement strategies to engage a wider range of fellows in ACRRM governance and decision making. (Standard 1.1)

BB    Review the electoral rules and timing of Board Director appointments to provide a smoother cycle of new and departing Board directors for business and corporate continuity. (Standard 1.1)

CC    Review and clarify the role of State Director and disseminate this information widely. (Standard 1.1)

| DD | Ensure that the balance between central and regional governance of educational activities is appropriate to meet current and future needs. (Standard 1.1) |
|----|---|
| EE | Take a leadership role in establishing productive working relationships with other bodies that contribute to general practice training. (Standard 1.4) |

The 2014 team considers conditions 1, 2, 3 and 4 from 2010 have been met.

## 2014 Accreditation Conditions and Recommendations

*2014 Commendations*

| A | The College's recent review of its organisational structure, ensuring appropriate representation, expertise and professional integrity. |
|---|---|
| B | The demonstrable, extensive and effective communication and engagement efforts both internally and with external stakeholders over the past four years. |
| C | The College's proactive approach, in particular its joint policy position with the Royal Australian College of General Practitioners, to the current uncertain general practice training environment as a result of the Commonwealth Government changes relating to the closure of General Practice Education and Training (GPET) and the reduction in the number of regional training providers. |
| D | The College's education and training processes are supported by dedicated and expert College staff. |

*2014 Conditions to satisfy accreditation standards*

| 1 | Review and promulgate the terms of reference for all College education committees to ensure currency and consistency with the 2014 Constitution. (Standard 1.1.2) |
|---|---|
| 2 | Develop a plan to formally engage consumers and community representatives at all levels in the College's governance structure. (Standard 1.1.2) |

*2014 Recommendations for improvement*

| AA | With the increasing number of registrars over the near term, monitor and respond to the need for appropriate College staff support for the education and training of this expanded cohort. (Standard 1.2) |
|----|---|
| BB | Establish and maintain formal relationships with state and territory health departments to clarify the College's role in general practice training. (Standard 1.4) |

# 2    Organisational purpose and outcomes of the training pathways

## 2.1    Organisational purpose

The accreditation standards are as follows:

- The purpose of the education provider includes setting and promoting high standards of medical practice, training, research, continuing professional development, and social and community responsibilities.

- In defining its purpose, the education provider has consulted fellows and trainees, and relevant groups of interest.

### 2.1.1    College purpose in 2010

*The College's mission is clearly defined and available to all stakeholders via the website. The mission statement is: 'To advance and promote high quality professional standards, education, clinical best practice and patient safety in Rural and Remote Medicine.'*

*The objectives of ACRRM are:*

*1    To define and promote professional standards in Rural and Remote Medicine by:*

  o  *documenting and upholding quality of care and educational standards for the discipline*

  o  *conducting prevocational and vocational training programs*

  o  *conferring appropriate qualifications to individuals that have demonstrated attainment of the requisite standards*

  o  *conducting continuing professional development programs*

  o  *communicating with government and other agencies regarding professional standards and practice principles.*

*2    To promote education in Rural and Remote Medicine by:*

  o  *fostering career paths in rural medicine*

  o  *advancing teaching and learning opportunities in the discipline*

  o  *promoting continuing professional development to Fellows and practitioners*

  o  *collaborating with other organisations to provide and support appropriate resources for education.*

*3    To advocate and support rural medical practice:*

  o  *interact with other professional bodies and the international community to share knowledge, skills and developments*

  o  *provide advice to Government and other stakeholders on matters relating to rural practice and rural medical practitioners*

  o  *support research in the discipline*

  o  *ensure a sustainable organisational infrastructure and capacity for Rural and Remote Medicine.*

### 2.1.2  2010 team findings

*ACRRM has defined its purpose to include setting and promoting high standards of medical practice, training, research, continuing professional development, and social and community responsibilities. Its mission and objectives reflect its historical development and its strong advocacy for the health needs of rural and remote Australians.*

*Nevertheless, as indicated in its accreditation submission and in other material, ACRRM is one of two medical colleges in Australia accredited by the AMC as a standards setting and training provider for the specialty of general practice. While recognising that ACRRM's focus is on rural and remote practice environments, its objectives need to link to the broader specialty for which it sets professional standards and in which it provides education and continuing professional development.*

### 2.1.3  College purpose in 2014

The AMC recommended in 2010 that the College consider its overall purpose and develop a better definition of its purpose in relation to the specialty of general practice (condition 5). In 2013, the College amended its Memorandum and Articles of Association at its Annual General Meeting to include reference to its role in general practice. This included a technical definition of general practice as follows:

> "General Practice" means the field of medical specialty approved by the authority of the Australian Health Workforce Ministerial Council pursuant to Health Practitioner Regulation National Law Act 2009 (as amended from time to time).

These amendments were completed as a temporary measure to address condition 5 and, pending the implementation of a new constitution, to replace the Memorandum and Articles of Association.

The 2013 amendments to the Objects, which embedded the College's role in general practice in its purpose, were repeated in the November 2014 constitution, in particular 2.1 (a) and (c) as detailed below:

(a) to set professional medical standards for training, assessment, certification and continuing professional development in the specialty of General Practice particularly for rural and remote contexts

(b) supporting the delivery of high quality, safe and sustainable health services to communities by providing appropriate standards, education, support, and strong representation for medical practitioners

(c) establishing and maintaining high standards of knowledge, experience, competence, learning, skills and conduct of General Practice particularly for rural and remote contexts

(d) developing curricula for the training of medical practitioners at traineeship and post-graduate levels

(e) developing curricula for the training of medical students at undergraduate levels

(f) recognising and accrediting the previous education and experience of medical practitioners

(g) developing, designing and implementing education programs at the undergraduate and post graduate levels to extend knowledge and skills of practitioners, and ensure standards of patient care are improved

(h) accrediting organisations, programs, individuals, posts and medical practices to train medical practitioners in the field of rural and remote medicine

(i) offering awards or by giving of fellowships to medical or health practitioners or suitably qualified persons in recognition of their competence in the field of rural and remote medicine

(j) liaising and communicating with rural and remote communities

(k) conducting research and evaluation of medical practice and education in rural and remote areas

(l) co-operating with other organisations on matters related to the health of people in rural and remote areas.

### *2.1.4   2014 team findings*

The College is commended on the considerable progress it has made since 2010, in redefining its purpose as an education provider in the setting and promoting of high standards of medical practice in the specialty of general practice. The College now emphasises its purpose as one of the two specialist medical colleges for general practice in much of its documentation, including in its 2014 constitution.

During the assessment, the team found that although the College's definition of general practice was included in the 2013 Articles of Association, it had been omitted from the 2014 constitution. The College confirmed this omission was an oversight. The team also noted that the College's 2013 technical definition of general practice did not adequately describe the characteristics to which the College could link its educational activities. The team found that there are several definitions used across various College activities depending on the context.

On the College's website, under the heading "About rural and remote medicine" (https://www.acrrm.org.au/about-rural-and-remote-medicine), ACRRM sets out the following definition:

> In Australia the term "general practice" is used to describe the medical specialty that provides primary continuing comprehensive whole-patient medical care to individuals, families and their communities. However, when general practitioners care for patients in certain contexts - typically within rural and remote areas - there are a clear set of additional skills, competencies and professional values that are required in order to provide safe and appropriate care. The Australian College of Rural and Remote Medicine (ACRRM) refers to this unique scope and nature of general practice as "Rural and Remote Medicine".
>
> Rural and Remote Medicine is typically delivered through private community based practice facilities and hospitals, however, it can also occur on roadsides, in remote clinics, jails, Aboriginal medical services or via telephone or e-health systems. It is one of the hallmarks of a rural and remote practitioner that they have highly developed clinical judgment and extended skill sets which allow them to safely care for patients in a variety of ways that would not be typical of general practitioners in more urban settings. This includes providing certain specialised areas of care such as surgery or obstetrics, and admitting and caring for adults and children in hospital (secondary) care settings.

The clinical scope, practices and values that characterise Rural and Remote Medicine within the medical specialty of general practice are outlined in the curricula and professional standards that are set and maintained by ACRRM. General practitioners who achieve these standards are recognised through the award of Fellowship of ACRRM. Fellows of ACRRM receive full vocational recognition and are able to practise in any location throughout Australia.

The College's definition of general practice is also provided as a separate document on the College's website under the heading "About rural and remote medicine", as follows:

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

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

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

It is therefore possible, through these different explanations, to imply characteristics of what the College understands by general practice, including its distinctive role in the rural and remote context. However, given that the College is responsible for training general practitioners who can practise anywhere in Australia, it is important that that the College now develops an agreed definition (including expected graduate outcomes) of general practice training.

The College's sponsorship of international collaboration on the establishment of a definition of rural generalist medicine is acknowledged. The May 2014 Cairns Consensus Statement[1] sets out a definition of rural generalist medicine, which could provide a starting point for the College's definition of general practice, particularly in the rural and remote context. This definition is as follows:

Rural Generalist Medicine is defined as the provision of a broad scope of medical care by a doctor in the rural context that encompasses the following:

o    Comprehensive primary care for individuals, families and communities;

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[1] Australian College of Rural and Remote Medicine (ACRRM). *Cairns Consensus Statement on Rural Generalist Medicine – improved health for rural communities through accessible, high quality healthcare*. ACCRM 2014.

o   Hospital in-patient and/or related secondary medical care in the institutional, home or ambulatory setting;

o   Emergency care;

o   Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues;

o   A population health approach that is relevant to the community;

o   Working as part of a multi-professional and multi-disciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs.

The practice of Rural Generalist Medicine is unique in the combination of abilities and aptitude that is required of a doctor for a distinctly broad scope of practice in a rural context. Rural Generalist Medicine is a concept that is grounded in the needs of rural communities…

The Consensus Statement recognises that general practice of this more inclusive kind still occurs in urban settings in many overseas jurisdictions and in Australia. This can be seen as an important delineator of the College's purpose in training general practitioners for any location. New models of primary care grounded in the needs of communities both urban and rural are emerging. The ACRRM model of general practice and some of the criticisms made by stakeholders as part of the assessment process can perhaps best be seen as part of this broader philosophical and practical shift and debate about the scope and nature of primary care.

That said, it is crucial that ACRRM's documentation reflect its national approval as a specialist college in the area of general practice, rather than rural generalism. The College itself frequently acknowledges and promotes the fact that its qualifications allow fellows to practice as a general practitioner anywhere in Australia. It is therefore important that there is a clear endorsement by the College Board of a definition of general practice which recognises this.

An agreed ACRRM definition of general practice could be customised to fit the vast array of different contexts in which care is delivered in the rural, remote and other general practice settings. This can complement the College's other areas of focus set out in the constitution and other documents of rural generalist practice. Such an arrangement would allow the College to clearly articulate its role within the context of its accreditation as a general practice training provider, rather than as a rural and remote training provider. At the same time, it would enable the College to set out more completely its understanding and its training of fellows for rural generalist practice. It would also allow the College to enunciate its role in the various Rural Generalist Pathways, established by state and territory governments, without the risk of losing its focus on it central accredited purpose as a general practice training provider.

In March 2015, in its response to the draft accreditation report, the College advised that the College's approved definition of general practice is described correctly in the 2013 fourth edition of the ACRRM Primary Curriculum and the separate document provided on the College's website.

The team considers a clear, articulated definition of general practice is important. It is recommended that the College use the approved definition of general practice consistently in all College documentation to provide clarity of purpose for the College.

## 2.2 Graduate outcomes

The accreditation standards are as follows:

- The education provider has defined graduate outcomes for each training program including any sub-specialty programs. These outcomes are based on the nature of the discipline and the practitioners' role in the delivery of health care. The outcomes are related to community need.

- The outcomes address the broad roles of practitioners in the discipline as well as technical and clinical expertise.

- The education provider makes information on graduate outcomes publicly available.

### 2.2.1 Graduate outcomes in 2010

*Presently there are three training pathways to fellowship of ACRRM (FACRRM):*

- *the Vocational Preparation Program introduced in 2003*

- *the Remote Vocational Training Scheme Pathway, introduced in 2000, which qualifies participants for award of both FACRRM and fellowship of the Royal Australian College of General Practitioners (FRACGP)*

- *the Independent Pathway, introduced in 2003, suspended in 2007, and then reviewed and reintroduced in 2009.*

*Each pathway is intended to provide training opportunities for different groups of doctors: the Vocational Preparation Pathway for new medical graduates; the Independent Pathway for experienced medical practitioners who are working in rural and remote communities; and the Remote Vocational Training Scheme Pathway for isolated rural medical practitioners who under ordinary circumstances could not complete training except by leaving their communities. Despite their differences, the team considered that the three pathways leading to fellowship of ACRRM are converging both in education content and overall aims. Curriculum development and review are contributing to this, as are ACRRM assessment requirements.*

*The ACRRM Primary Curriculum, which underpins training leading to fellowship of ACRRM in all three pathways, aims to produce fellows who can function as safe, confident and independent general practitioners across a full and diverse range of healthcare settings in Australia, with particular focus on rural and remote settings.*

*The learning outcomes are organised under seven domains of practice: core clinical knowledge and skills; extended clinical practice; emergency care; population health; Aboriginal and Torres Strait Islander health; professional, legal and ethical practice; and rural and remote context.*

*The ACRRM accreditation submission indicates that these domains describe the assessable knowledge, skills and attitudes that general practitioners require to be able to work anywhere in Australia, and particularly in rural and remote settings. The learning*

*outcomes were developed through consultation with rural and remote practitioners, and by analysing the Australian and international literature.*

*The Primary Curriculum describes the scope of rural and remote medicine in the following terms:*

> *Rural and remote medicine is a broad, horizontal field of practice that intersects many medical specialties. General practitioners in rural and remote communities are commonly called upon to provide a continuum of care from primary presentation to resolution, and deal with issues associated with public health in small communities. Because rural and remote practitioners are required to undertake many of the tasks that their urban counterparts would refer to specialists, their practice is both advanced and extended. They may provide services in areas such as obstetrics, surgery, anaesthetics, and emergency care, and may do so across primary, secondary and tertiary settings. Their office-based consultations will often require more complex decision-making and the use of more diverse clinical and procedural skills. There is considerable evidence that general practitioners working in rural and remote areas both in Australia and overseas are providing an increased range of procedural, emergency and other advanced care services[2].*

### 2.2.2   2010 team findings

*The accreditation standards require that colleges have defined graduate outcomes for each training program, and that these outcomes be based on the nature of the discipline and the practitioners' role in the delivery of health care.*

*The overall statements of goals and outcomes in the ACRRM Primary Curriculum do relate the ACRRM training pathways to the nature of the discipline of general practice and to the broad generalist frame, with appropriate emphasis on the knowledge, skills and attitudes relevant to medical practice in Australian rural and remote settings. ACRRM has compared the goals of its training programs with those of similar training programs, including those of the Royal Australian College of General Practitioners, Royal New Zealand College of General Practice, and the UK, Canadian and US standards setting bodies for general practice.*

*The ACRRM Fellowship Vocational Training Handbook 2009 expands on the training program goals, indicating that they are achieved by:*

- *working in settings which provide exposure to a broad and comprehensive range of experiences relevant to general practice*

- *working with, and being supervised or mentored by general practitioners who are either Fellows of ACRRM or have equivalent qualifications and experience*

- *delivering safe, high quality, cost effective health care within the Australian health system*

- *working with health teams and communities*

- *engaging in self-directed and supported educational activity which relates to ACRRM curricula.*

*The team supports these statements.*

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[2] *Page 9 Third Edition ACRRM Primary Curriculum Revised 2009*

*Some of ACRRM's documents still seem to reflect earlier College thinking on the purpose of ACRRM training. The team considers that ACRRM should review its policy statements and training documents to identify any which do not reflect the nature of the discipline of general practice and enhance their link to community and primary care as well as to rural and remote contexts. The team's concerns that current policies may allow registrars to complete ACRRM training without a clearly identified period of experience in community and primary care illustrate the need for this review. Following the team's visit, ACRRM advised that it had reviewed its policies, and that it would now require a defined period in community and primary care. The College's definition and the team's continuing concerns about this issue are discussed in Standard 3 of this report.*

*Outcomes should be related to the community's diverse needs. As is the case for all colleges, ACRRM needs to strengthen its processes for understanding community need. The challenge for ACRRM is to provide opportunities for meaningful consumer participation in its curriculum development, review and evaluation processes.*

### 2.2.3 Graduate outcomes in 2014

The three training pathways to fellowship (the Vocational Preparation Pathway, the Remote Vocational Training Scheme and the Independent Pathway) still continue and provide flexible means to fellowship of the College. The College makes it clear in all documentation that whatever pathway is undertaken, the expected graduate outcomes are the same. This is based on the established criteria set out in the Primary Curriculum and Advanced Specialised Training curricula, the assessment requirements and other requirements as set out in the *Completion of Training policy*.

The ACRRM Primary Curriculum was revised in 2013 to produce the fourth edition. The curriculum has maintained the 11 underpinning principles to support the generalist practice of medicine in rural and remote settings. The seven domains which describe the different contexts of general practice, particularly for the rural and remote practice have been revised. These changes reflect a broader understanding of the College's roles and responsibilities across the different general practice environments. This is described in further detail under standard 3 of this report.

The College's website contains information on expected graduate outcomes as well as the processes for training and assessment. This information includes online written resources, such as the booklet *Qualify to be a General Practitioner Work Anywhere in Australia – Training towards Fellowship of ACRRM (October 2013)*, the Primary Curriculum, Advanced Specialised Training curricula (except Academic Practice), *Fellowship Assessment Handbook* and all ACRRM policies. The College also makes available online videos on the requirements for both training and assessment.

The College's *Completion of Training Policy* sets out the requirements for completion of training and for the award of fellowship. Registrars either complete these requirements or apply for recognition of prior learning (RPL) and have the College assess that the requirement (or some part of it) is satisfied through RPL. These requirements are available on the College's website.

## 2.2.4   2014 team findings

The AMC recommended in 2010 that the College review its policy statements and training documents to ensure graduate outcomes statements had clear relevance to community and primary care (condition 6). The College addressed this condition in 2012 by implementing a policy that requires registrars to complete at least six months' experience in community and primary care, and at least six months' experience living and practising in a rural/remote environment. Primary Rural and Remote Training (PRRT) teaching posts which do not offer experience in community primary care are given restricted accreditation for a maximum of 18 months. In addition, the College developed a consultation document providing guidance on the restrictions to be applied when accrediting PRRT posts.

The 2014 team found that the consistency of graduate outcomes via the different training pathways has been strengthened.

The revised Primary Curriculum clearly sets out the expected outcomes on completion of training, whatever pathway the registrar follows. It is a comprehensive and ambitious program, designed to ensure new fellows are safe, competent doctors, able to practise in the general practice context, independently and without supervision anywhere in Australia. It particularly aims to ensure this can occur in the often challenging and diverse environments of rural and remote general practice. The College clearly enunciates its commitment to high quality, sustainable health services in these challenging locations.

All curricula for Advanced Specialised Training (AST) are currently available, except for the new area of academic practice. The curricula have been undergoing a comprehensive review with stakeholder feedback due towards the end of 2014. Some curricula have already been updated, as indicated on the College's website. Unlike the Primary Curriculum, the edition date for some of the AST curricula are not clearly marked on the cover or title page of these documents. It is important that the dates of the revision are easily identifiable so there is no confusion about the currency of any version. The graduate outcomes required and the methods of assessment in each of the AST areas are clearly set out in the curricula documents.

The documented outcomes in the Primary Curriculum and Advanced Specialised Training curricula also serve as the basis for assessment of recognition of prior learning and for assessment of international medical graduates via the Specialist Pathway.

The College updated its *Fellowship Assessment Handbook* in March 2014 and provides a separately published list of changes available on the College's website to enable registrars, supervisors, health administrators and members of the public to see how meeting these outcomes are evidenced.

In 2010, the AMC recommended that the College provide evidence of processes for regularly reviewing the graduate outcomes for each training pathway in relation to community need (condition 7). The College has engaged in broad stakeholder consultations on its curriculum development, across the various communities which relate to the College including consumers, various medical specialties and allied health professionals. The reports of these consultations evidence respectful interactions and

the attempt by the College to be responsive to the views of its various stakeholders, even where views diverge and agreement is yet to be met. In 2014, the College introduced a consumer feedback and needs analysis survey which seeks comment on the Primary Curriculum and AST curricula and the overall College performance in terms of meeting community needs. Thirty two community organisations were included in the initial review process. This process is described in further detail under standard 6. The 2014 team considers that condition 7 from 2010 has been met.

It will be important for the College to report back to the consumers on the finding of these surveys, once the analysis is completed. The College should also refine and repeat the review process to ensure it is capturing current information on community need, especially during this time of significant change in the general practice training environment.

During the assessment visit, the team heard about the plans for the introduction of the College's new Customer Relationship Management (CRM) system. It appears that the CRM system will be able to provide increased support by recording the achievement of graduate outcomes across the professional life of the College's registrars and fellows. It will allow better integration of these outcomes across training and continuing professional development, as well as provide a consistent framework for the recognition of prior learning and the assessment of overseas trained general practitioners through the Specialist Pathway.

The team found that concerns remain about the impact of the variable relationships with RTPs and the College, which can impact negatively on graduate outcomes. The current environment of change from GPET and the new relationships with the RTPs provides the College with an opportunity to ensure more directly that its training requirements are being consistently applied across all RTPs. The College should continue its engagement with RTPs towards this end throughout the current period of change.

## 2010 Accreditation Conditions and Recommendations

*2010 Commendations*

Nil

*2010 Conditions to satisfy accreditation standards*

5  Consider its overall purpose and include in this a better definition of purpose in relation to the specialty of general practice. (Standard 2.1)

6  Review of ACRRM policy statements and training documents to ensure that statements concerning graduate outcomes have clear relevance to community and primary care as well as rural and remote contexts. (Standard 2.2)

7  Provide evidence of processes for regularly reviewing the graduate outcomes for each training pathway in relation to community need. (Standard 2.2)

*2010 Recommendations for improvement*

Nil

The 2014 team considers conditions 6 and 7 from 2010 have been met. Condition 5 from 2010 has been replaced by 2014 condition 3.

**2014 Accreditation Conditions and Recommendations**

*2014 Commendations*

E     The College's innovative use of publically available video, pamphlets, policies, curricula and handbooks which provide information for registrars, potential registrars, supervisors, training providers and the community on the expected graduate outcomes.

*2014 Conditions to satisfy accreditation standards*

3     Adopt the College's approved definition of general practice for use in all College documentation to provide clarity of purpose for the College. (Standard 2.1)

*2014 Recommendations for improvement*

CC    Increase direct engagement with training providers to ensure training requirements are being consistently applied across all training providers. (Standard 2.2)

# 3 The general practice education and training pathways

## 3.1 The curriculum framework

The accreditation standards are as follows:

- For each of its education and training programs, the education provider has a framework for the curriculum organised according to the overall graduate outcomes. The framework is publicly available.

### 3.1.1 The curriculum framework in 2010

*The ACRRM curriculum was established almost twenty years ago and was developed as one of the first to describe the expectations of competence and requirements for general practitioners who practised in rural and remote areas. This drove ACRRM's development of a structure of eleven principles to support educational initiatives, seven domains related to areas of practice and a strong experiential perspective to the curricula.*

*The domains are as follows:*

1 *Core clinical knowledge and skills: Primary care generalist knowledge and consulting skills extended to encompass the morbidity and mortality patterns of people in rural and remote areas, small communities, limited resources and teamwork.*

2 *Advanced clinical knowledge and skills: Diagnostic, therapeutic and clinical management skills of specialist areas adapted to suit the rural and remote environment.*

3 *Emergency care: Resuscitation, stabilisation and transfer skills, acute accident care.*

4 *Population health: Health education and promotion, public health issues of hygiene, sanitation, immunisation and health screening activities.*

5 *Aboriginal and Torres Strait Health: Aboriginal and Torres Strait history and culture, cross-cultural communication, community controlled health services and teamwork.*

6 *Professional and ethical practice: Use of information and telecommunication technology, practice management and personal work/life balance.*

7 *Rural and remote practice: Responsiveness to the social values and health needs of remote communities.*

*These domains have become increasingly important as the curriculum has evolved and, in particular, as assessment tools have been developed and progressively mapped to the curriculum. As an example, the third domain of emergency care now has nine learning outcomes:*

- *undertake initial assessment and triage of patients with acute or life threatening conditions*

- *stabilise critically-ill patients and provide primary and secondary care*

- *provide definitive emergency resuscitation and management across the lifespan in keeping with clinical need, own capabilities and available services*

- *perform required emergency procedures and courses*

- *arrange and/or perform emergency patient transport or evacuation when needed*

- *demonstrate resourcefulness in knowing how to access and use available resources*

- *communicate effectively at a distance with consulting or receiving clinical personnel*

- *participate in disaster planning and implementation of disaster plans, and post-incident analysis and debriefing*

- *provide inter-professional team leadership in emergency care that includes quality assurance and risk management assessment in the rural and remote setting.*

*Seventy-two broad learning outcomes are identified within the seven domains and assessment is mapped to these outcomes.*

*There are 22 largely discipline-based syllabus statements, which are structured as high level learning objectives, with the content expressed as general instructional objectives and required skills and abilities. The disciplines and/or topics covered by these statements are:*

1  *Aboriginal and Torres Strait Islander Health*

2  *Adult Internal Medicine*

3  *Aged Care*

4  *Anaesthetics*

5  *Child and Adolescent Health*

6  *Psychiatry/Mental Health*

7  *Emergency Medicine*

8  *Information Technology/Information Management*

9  *Management*

10  *Musculoskeletal Medicine*

11  *Obstetrics/Women's Health*

12  *Office based general practice*

13  *Ophthalmology*

14  *Oral Health*

15  *Palliative Medicine*

16  *Population Health*

17  *Dermatology*

18  *Radiology*

19  *Rehabilitation Medicine*

20  *Research and Evidence Based Medicine*

21  *Strategic Skills in Rural and Remote General Practice*

22  *Surgery.*

*The eleven principles that underpin the Primary Curriculum are as follows:*

*1    Grounding in professional standards*

*2    Responsiveness to community needs*

*3    Responsiveness to the rural and remote context*

*4    Outcomes focus*

*5    Focus on experiential learning*

*6    Applicability to practice*

*7    Validity, reliability and educational soundness*

*8    Appropriateness and acceptability of delivery and assessment methods*

*9    Utilisation of information technology*

*10   Articulation with advanced studies*

*11   Contribution to improving workforce capacity.*

*Advanced Specialised Training Curricula statements build on the basic knowledge and skills described in the ACRRM Primary Curriculum.*

### 3.1.2   2010 team findings

*The framework for the curriculum is in general well organised, although the role of the domains and the principles as organising structures is not clear. Although understandable as a means to emphasise a particular topic, having domains identical to curriculum areas (Aboriginal and Torres Strait Islander Health, Emergency Care/Medicine and Population Health) is a potential source of confusion. How the learning outcomes for the domains align with the learning objectives for the curriculum areas still need better articulation.*

## 3.2    Structure, content and duration of the training pathways

The accreditation standards are as follows:

- For each component or stage, the curriculum specifies the educational objectives and outcomes, details the nature and range of clinical experience required to meet these objectives, and outlines the syllabus of knowledge, skills and professional qualities to be acquired.

- Successful completion of the training program must be certified by a diploma or other formal award.

### 3.2.1   Structure, content and duration of the training pathways in 2010

*As indicated in Section 2, there are three vocational training pathways that lead to Fellowship of ACRRM. These are as follows:*

- *The Vocational Preparation Program. Training is through Australian General Practice Training, which is managed by GPET, and delivered through the RTPs. There are now 15 RTPs recognised by ACRRM to deliver training for registrars undertaking the Vocational Preparation Pathway.*

*When this pathway was introduced in 2003, 10 registrars enrolled. In 2005 there were 41 registrars enrolled in this pathway. In 2009, there were 140 registrars in this pathway.*

- *Remote Vocational Training Scheme. This Scheme is funded by the Australian Government and delivered by the Remote Vocational Training Scheme (RVTS) organisation, an independent company established in 2006 to manage and deliver training. The Scheme is accessible to trainees of both ACRRM and the Royal Australian College of General Practitioners (RACGP). It provides vocational training for isolated rural medical practitioners. It is delivered almost entirely through distance-based education and support. It involves ACRRM and RACGP accredited practice sites and supervisors/mentors. Successful completion qualifies participants for award of either or both the FACRRM and the FRACGP. The program has funded 15 registrars per year, and this will rise to 22 from 2011.*

- *Independent Training Pathway. This pathway is designed for experienced medical practitioners who are working in rural and remote communities. This is a flexible program for self-directed learners. Training is based on a learning plan, developed following assessment of the candidate's skills and experience against the ACRRM educational standards as defined in the ACRRM Curriculum. Candidates are directed to ACRRM-accredited practices within their region and develop their training portfolio in consultation with the ACRRM medical educator and an ACRRM mentor/supervisor. A majority of doctors training in this pathway are international medical graduates.*

  *Admission to the pathway is administered by ACRRM and the trainee funds their participation in the program. The program was closed in late 2007 to allow a review and reopened in early 2009 with enhanced teaching and learning supports. ACRRM has projected enrolments of up to 50 trainees per annum.*

*Training to fellowship of ACRRM is a minimum of four years of full-time (or part-time equivalent) post-internship training. This may be retrospectively accredited via recognition of prior learning (RPL).*

*The training comprises 36 months clinical training including hospital, core and advanced rural and remote medical training, with:*

- *one year of Core Clinical Training in an ACRRM-accredited metropolitan, regional or rural hospital*

- *two years of Primary Rural and Remote Training in ACRRM-accredited rural or remote posts and*

- *one year of advanced specialty training. Approved training areas for advanced posts include: surgery, obstetrics, anaesthetics, Aboriginal and Torres Strait Islander health, emergency medicine, mental health, adult internal medicine, population health, paediatrics, and remote medicine*

- *completion of a minimum of two approved emergency medicine courses*

- *four modules through Rural and Remote Medical Education Online*

- *satisfactory assessment for all training periods.*

### 3.2.2   2010 team findings on curriculum structure

*As noted above, despite the differences between the three pathways, the team considered they are converging both in education content and overall aims. Both the Vocational Preparation Pathway and the Remote Vocational Training Scheme are well established.*

*The Independent Pathway has provided a training pathway for experienced medical practitioners, most commonly international medical graduates. Those enrolled in this pathway have praised the learning support provided by ACRRM, which was increased in 2009 following the closure and review of the pathway. They have also praised the pathway's flexibility. Nevertheless, the AMC has some specific concerns about this pathway.*

*ACRRM data in 2011 show there are 149 registrars in the Independent Pathway, with 98 being international medical graduates. ACRRM considers that the pathway provides an important mechanism for the College to support medical practitioners with limited registration who wish to achieve specialist registration. Of the Independent Pathway registrars who interacted with the team during this assessment, a number worked in small communities and were supervised at a distance. The team had some concerns about the oversight of registrars in these circumstances, and their preparation for the Australian health care system, and the rural and remote context. The report raises concerns about the rigor of the process for recognition of prior learning, monitoring of participation in regular educational activities, progression through training, and performance in examinations. Now that the College has developed and had separately accredited processes for the assessment of international medical graduates, including a competent authority pathway for assessment of doctors seeking non-specialist registration and a pathway for doctors seeking specialist registration, the College needs to review the aims of the Independent Pathway, particularly its role as a structured learning pathway to fellowship for international medical graduates.*

*To comment on the ACRRM curriculum one needs to define the use of the word. Educationally, a curriculum is usually thought of as prescriptive and as encompassing all the planned learning opportunities the organisation offers to learners and the experiences that learners encounter when the curriculum is implemented. There is a comparison to a syllabus which is more descriptive and is usually an outline and summary of topics to be covered in an education or training course.*

*Within a curriculum one expects to see learning experiences, the intention being expressed by predetermined aims, goals and objectives that describe what should be learnt as well as how learners will find meaning through the activities. The definition of course objectives is crucial to the curriculum. They are usually expressed as learning outcomes and then include the strategy for assessment and standards required. The strategy for assessment must align closely to the curriculum and the requirements of the learning program.*

*The curriculum should describe the infrastructure and resources required and, importantly, the calibre of the educators and supervisors. In an apprentice-based system, role modelling and day-to-day educational opportunities are very important. Professional development and specific training of the front line clinicians in all educational roles is also critical to the specification for the fuller curriculum.*

*All these components are part of the activities of the College. At this stage there is a very strong focus on the syllabus and particularly the procedural subcomponents. At the time of the team's visit, a review of the Primary Curriculum was underway. As it indicated in the preliminary findings it presented to the College, the team regards the completion of the curriculum review as an important priority. In its update to the AMC of March 2011, the College outlined its plans for completion of the curriculum review which include convening a curriculum review steering committee, appointing appropriate educational and support staff, and the establishment of an international advisory panel to provide critical review.*

*The team regarded the current review as more a refinement focussed principally on the syllabus than substantial change. In this review, the listed texts within the curricula also need to be updated. The team considers it important that ACRRM also undertake an overall structural review, one aim of which must be a clearer outline of the interdependencies and broader experiences. A more accessible description of how the content and standards have been derived, how they take account of proposed new service delivery models and how they will be updated in the future should also be available.*

*The team makes the following observations regarding the curriculum structure.*

*The curriculum, and in particular the syllabus, is very broad as demonstrated by 22 curriculum statements that are all encompassing. The team understands that the process for developing the initial ACRRM Primary Curriculum gave significant weight to the contributions of experienced rural and remote medicine practitioners. The application and enthusiasm to achieve this is acknowledged and commended. In its desire to be all encompassing and to be ready for any emergency, the sense of common, important and core knowledge is not apparent. The need for this clarity is reinforced by the considerable variation in the practice of rural and remote primary care practitioners, depending on the environment in which they practise and whether or not they have developed extended skills in a particular procedural area.*

*It is important that ACRRM more clearly define core competencies and skills, and seek stakeholder input not only from the practitioners in the field but also from the consumers, that is, the members of the rural and remote community. More active engagement with consumers is necessary in the process of preparing and reviewing the curriculum statements.*

*The context of training and practice is important to the skills and competence required by the individual medical practitioner. However, the College needs to focus on how common, important and core are understood, defined and then communicated to trainees, supervisors and assessors. The team found it difficult to distinguish between the significant and core elements in the Primary Curriculum and the interesting but elective elements. The team's consultation with supervisors found that many relied on their own experience as a rural doctor to set learning objectives rather than basing them on a curriculum document. Discussions with registrars and RTPs indicate that greater clarity is required about the common and chronic clinical problems within the syllabus, and that learning objectives need to be specified for stages for training. While the structure of the training program aims to support progressively building the registrar's clinical and procedural skills, the curriculum document does not provide sufficient guidance on the level of understanding and experience which would be expected of a successful trainee at*

*successive training stages. This needs to be reflected in assessment tools such as the portfolio, logbooks and audit that are jointly reviewed by the trainee and supervisor as well as with the medical educator.*

*As registrars may be working in under-serviced areas and at a distance from supervision, the team considers teaching registrars how to recognise the limits of safe practice, and appropriate management of emergency presentations to be particularly important. In discussion, ACRRM senior officers indicated that this is presently addressed in the policy documents concerning teaching posts and supervisors. While ACRRM is reviewing these documents to provide greater direction to supervisors, it was not clear that registrars would look for curriculum direction in these standards. The curriculum document also requires review.*

*The development of the social context of medical practice education and training has been most significant over the last 15 years. Internationally, there are a number of broad curriculum frameworks that describe and define the roles of medical specialists in addition to their role as a medical expert. Although the domains as articulated by ACRRM do account for some of these roles and competencies, further analysis of frameworks such as CanMEDS with incorporation of this broader context would be important. These considerations should be accompanied by scrutiny of all relevant practice activity data and public health databases to ensure that redundancies, imbalances and gaps in the curriculum are identified and rectified at each planned review.*

### 3.2.3   2010 team findings on curriculum content

*The team identified the following areas of curriculum content for consideration by the College.*

*In setting the standards for its general practice training programs, the AMC does not require the College to adopt any specific definition of general practice, but its definition should align with international definitions of the discipline. Common to these definitions are the following: a generalist orientation with the general practitioner providing comprehensive health care for individuals regardless of age, sex or type of health problem based on a broad understanding of other specialist fields; coordinating care; engaging the resources available, including specialist resources; and providing continuity of care.*

*The team considers that the curriculum statement specifies relevant content to meet the objectives of training, which relate to the requirements of general practice. However, as ACRRM is one of two colleges setting standards for training in General Practice, the team was concerned that there did not appear to be a mandated period of time in community primary care. In discussions with the team, ACRRM officers indicated that its processes for accreditation of training posts was the mechanism by which it ensured that registrars do obtain this experience. As noted in section 8, this process is not robust.*

*It is important that registrars completing ACRRM training have completed a clearly identified period of experience in community and primary care, when they have the opportunity to experience the core skills of general practice, namely continuity of care, chronic disease management, prevention, and population health. The team recommends that ACRRM require a period of at least six months in community and primary care to*

*ensure all registrars graduate with an understanding of this practice, and are prepared to begin unsupervised practice.*

*In its update to the AMC in March 2011, ACRRM indicated that it had developed a Primary Rural and Remote Training Policy expanding on information from the Vocational Training Handbook. The policy includes the following:*

> *As a general guide, sufficient experience in unreferred, ambulatory primary care (initial, continuing, organised and comprehensive care for individuals, families and communities) requires no less than 6 months full-time or equivalent part-time experience over the Primary Rural and Remote Training period. The College recognises that such experience may be gained in a variety of practice models, including private community general practice, remote community clinics, small hospitals, Aboriginal Community Controlled Health Services, Royal Flying Doctor Service, the Australian Defence Force and other settings. Similarly, sufficient experience in outer regional and remote community context requires no less than six months living and practicing medicine in a rural or remote community.*

*The team was not convinced that all the practice models or all settings for some of the models listed in the ACRRM definition would meet the intention of the experience. It was also not clear when this policy would take effect. There must be very rigorous scrutiny of this component of the experience in Primary Rural and Remote Training to ensure that it does provide a minimum of six months in general practice.*

*The radiology curriculum was seen as too ambitious and inappropriate for vocational training. The learning objectives for radiology include:*

- *demonstrate the ability to provide a safe accurate diagnostic imaging service*

- *demonstrate confidence and skill in undertaking skull, spinal, abdominal, skeletal and chest radiology*

- *demonstrate basic experience and skill in ultrasonography.*

*The team's site visits confirmed that most registrars were not meeting these objectives. The curriculum statements should be revised to be clear about what is essential. In its update to the AMC of March 2011, the College indicated that the radiology curriculum requirement would be reviewed.*

*The team recommends that ACRRM review the mental health curriculum and how mental health is addressed in a primary care/general practice setting.*

*Comments by health departments recommended a stronger focus on safety and quality issues promulgated in the work of the Australian Commission for Safety and Quality in Health Care. Particular issues suggested included recognising and responding to the deteriorating patient, clinical governance, and incident reporting processes.*

*The ACRRM curriculum has a strong focus on Indigenous health. Aboriginal and Torres Strait Islander Health is a curriculum domain, one of the 22 curriculum statements, and the subject of an advanced specialist training curriculum statement. Despite this, it appeared that registrars had very variable relevant clinical experience in Aboriginal and Torres Strait Islander Health. Those in remote areas were more likely to have this experience than those in rural environments. The team encourages ACRRM to consider reviewing how the clinical experience available can better align with the focus given to*

*this topic in the written curriculum. In reviewing the curriculum and the clinical training possibilities, it is essential that appropriate community consultation occur.*

*The College indicated that the stakeholder response to the review of the Primary Curriculum had been limited but that, in general, had indicated that the curriculum was appropriate. The College's summary of areas identified by stakeholders for review and improvement included a number of the issues raised above by the team. Stakeholders consulted also suggested that the procedural logbook required updating; that some curriculum statements, such as Emergency Medicine, are too detailed and others, such as Surgery, lack detail and are not adequately reflected in the logbook requirements for mandatory skills or an ongoing assessment plan. In addition, feedback has indicated that the distinction between Domains 1 and 2 is ambiguous; and that there is overlap between Curriculum Statements 8 - Information Technology/Information Management; 9 - Management; 12 - Office Based General Practice; and 21 - Strategic Skills in Rural and Remote General Practice.*

*The AMC will expect regular reports on the progress of the review of the Primary Curriculum and that the College will make completion of the review a priority.*

*Since the AMC first assessed ACRRM's programs for initial accreditation in 2007, ACRRM has reviewed the curricula for advanced specialised training in a number of areas and developed additional curriculum statements in other areas.*

*The readiness of the advanced specialised training curricula was somewhat variable at the time of the team's assessment. Some had been developed through a joint consultative committee process, now usually tri-partite between the Royal Australian College of General Practitioners, the Australian College of Remote and Rural Medicine and the college that specialises in the relevant clinical area. The most developed structure is in the area of Obstetrics and Gynaecology where there is real engagement by all parties. A recent review of the curriculum has resulted in the development of three levels of training: a certificate in women's health, a diploma and an advanced diploma. To satisfy fellowship requirements, ACRRM requires advanced specialised training to include the completion of the certificate (or equivalent) and the diploma (or equivalent). The advanced diploma forms the basis of the advanced specialised training year.*

*The anaesthetic process was also well developed but appeared to be based more on goodwill and enthusiasm of individual participants rather than robust recognition of all the formal parties. This should be enhanced and include formal certification of completion.*

*The other processes were not as mature with curricula still under development or review and uncertain endorsement by various colleges. While ACRRM's accreditation submission indicated that enthusiastic individuals from the relevant specialty had contributed to the development of some of the specialised curricula, there had been insufficient formal engagement with many of the specialist medical colleges as the setters of standards for these discipline areas to ensure the learning objectives are appropriate and supported with appropriate clinical experience and supervision, and to provide a sustainable system for curriculum review and improvement. Specialist colleges saw this as an important area for their contributions. The team agrees.*

*In its March 2011 update to the AMC, ACRRM indicated that all the advanced specialised training curricula were complete, apart from Paediatric Health, which would be completed by August 2011. This progress is commended, but the concerns remain about how well ACRRM is engaging with other specialist medical colleges in the review and improvement of these statements. The AMC will require updates on the implementation of these curricula in the College's progress reports.*

*While not covered by this assessment, ACRRM contributes to a number of other formal education programs and pathways. Some of these demonstrate good practice in consultation and collaboration with the specialist medical college which sets the standards for the discipline. The Certificate in Primary Skin Cancer Management is such an example. This is a new dermatology course for general practitioners, developed by the Australasian College of Dermatologists, the RACGP and ACRRM. This is a largely online training program, available to fellows of both ACRRM and the RACGP. It consists of a number of online modules, submission of cases online, a workshop on dermatological surgery and clinical attachments with dermatologists. There are plans to extend this certificate course into a Diploma in Primary Care Dermatology in future years.*

*Of the registrars who responded to the AMC survey undertaken for this accreditation assessment, 38 per cent responded with neutral; disagree; or strongly disagree to the statement that ACRRM keeps registrars well informed about changes in program requirements. The team encourages ACRRM to consult registrars on how this information would best be communicated and to consider how it is engaging registrars in curriculum review.*

### 3.2.4 Framework, structure, content and duration of the training programs in 2014

The College's 4th Edition Primary Curriculum was introduced in August 2013. The curriculum specifies:

- 11 principles that form the conceptual and practical foundation for the curriculum
- 7 domains of rural and remote general practice
- 18 curriculum statements which describe the relevant content in the major medical disciplines or practice areas
- 73 generic abilities organised within the domains, covering essential skills and knowledge for rural and remote general practice.

The curriculum has maintained the 11 underpinning principles to support the generalist practice of medicine in rural and remote settings. The seven domains of practice have changed from the previous curriculum.

The revised domains are as follows:

1 Provide medical care in the ambulatory and community setting (previously called core clinical knowledge and skills).

2 Provide care in the hospital setting (previously advanced clinical knowledge and skills).

3 Respond to medical emergencies (previously emergency care).

4   Apply a population health approach (previously population health).

5   Address the health care needs of culturally diverse and disadvantaged groups (previously Aboriginal and Torres Strait Islander health).

6   Practise medicine with an ethical intellectual and professional framework (previously professional and ethical practice).

7   Practise medicine in rural and remote context (previously rural and remote practice).

Changes have been made to the curriculum statements reducing the number from 22 to 18. The curriculum statements describe the relevant content in the major medical disciplines or practice areas organised within the revised seven domains and with additional statements of essential knowledge and skills. The curriculum statement areas that have been removed are predominately covered within the domains of population health and emergency medicine.

The revised curriculum statements cover the following medical disciplines and practice areas:

1   Aboriginal and Torres Strait Islander Health

2   Adult Internal Medicine

3   Aged Care

4   Anaesthetics

5   Business and Professional Management

6   Child and Adolescent Health

7   Dermatology

8   Information Management and Information Technology

9   Mental Health

10  Musculoskeletal Medicine

11  Obstetrics and Women's Health

12  Ophthalmology

13  Oral Health

14  Palliative Medicine

15  Radiology

16  Rehabilitation Medicine

17  Research and Teaching

18  Surgery.

Procedural and clinical skills that are articulated in the curriculum are made explicit as required learning within the ACRRM Procedural Skills Logbook. All curriculum documentation is available on the College's website.

The Primary Curriculum will be formally reviewed on a five-yearly cycle; however a continuous process of feedback and feedback via multiple sources has been put in place to support the maintenance of a relevant and contemporary curriculum.

The Advanced Specialised Training (AST) curricula cover the 10 extended areas of advanced practice as follows:

1  Aboriginal Health

2  Adult Internal Medicine

3  Anaesthetics

4  Emergency Medicine

5  Mental Health

6  Obstetrics and Gynaecology

7  Paediatrics

8  Population Health

9  Remote Medicine

10 Rural Generalist Surgery.

Commencing in 2014, all 10 of the AST curricula are being reviewed sequentially to align with the format of the Primary Curriculum and to ensure currency. The College is also currently developing a new AST program in academic practice. The College has developed a draft curriculum and registrars are able to undertake posts in academic practice provided they have sought approval prospectively with the necessary documentation.

The AST curricula are being reviewed in consultation with relevant specialist colleges and the development committees have representations of both ACRRM and the relevant specialist college fellows. As discussed under standard 1, three specialist areas (obstetrics and gynaecology, anaesthetics and rural generalist surgery) have Joint Consultative Committees with members from the relevant specialist college, the Royal Australian College of General Practitioners and ACRRM. The process of review for an AST curriculum is consultative and includes feedback from multiple sources including the community, specialist colleges, registrars, supervisors and the fellowship.

ACRRM registrars are required to complete a minimum of four years of vocational training in accredited training posts. The structure of the three vocational training pathways that lead to fellowship are as previously described and include:

- Vocational Preparation Pathway. Up until 31 December 2014, training through AGPT has been managed by GPET. As discussed under standard 1, GPET's responsibilities will be transferred to the Australian Government Department of Health in 2015. There continue to be 15 RTPs recognised by ACRRM to deliver training for registrars undertaking this pathway. In 2009 there were 140 registrars in this pathway and currently (as at November 2014), 313 are enrolled.

- Remote Vocational Training Scheme Pathway. This scheme continues to be funded by the Australian Government and delivered by Remote Vocational Training Scheme

organisation. This program currently has a total of 89 registrars, increased by 22 from 2011.

- Independent Pathway. This training pathway continues to be delivered by ACRRM for experienced medical practitioners working in rural and remote communities. As of December 2013, there were 142 candidates on this pathway.

For all ACRRM registrars, the four-year training program must be completed in a maximum ten-year period (including any part-time training and leave allowances). This is clearly articulated in the ACRRM *Training Time Policy*.

### 3.2.5 2014 team findings

In its 2010 assessment, the AMC recommended that the College complete the review of the Primary Curriculum by September 2012 taking into account the recommendations made by the 2010 team regarding the framework and its content as well as other stakeholder feedback (condition 8). In May 2013, the College advised the AMC that the finalisation of the curriculum review would be delayed by a number of months. The College provided the final version of the Primary Curriculum to the AMC for review in August 2014. On the basis of this review, the AMC considered that condition 8 had been addressed. It was agreed that the 2014 team would review the implementation of the new curriculum during the assessment visit.

The Primary Curriculum is a comprehensive and user-friendly document, which can be accessed on the College's website. The curriculum is underpinned by principles and a philosophy that supports the delivery of generalist health care in a rural and remote setting. There is a clear separation of the Primary Curriculum (three years of training) and the Advanced Specialised Training (AST) curricula (one year). Registrars may complete the training requirements of either the Primary curriculum or their AST curricula in any order. The curriculum specifically includes a focus on issues that are relevant to the practice setting such as working with the Aboriginal and Torres Strait Islander population, business practice in general practice, and emergency medical management in a remote setting.

The College's comprehensive review of the Primary Curriculum in 2013 provided greater articulation between the revised seven domains and the revised eighteen curriculum statement areas. As discussed under standard 2, the College has put in place significant opportunity for all key stakeholders including the other specialist colleges to provide input and has developed a document that clearly sets out expectations of registrars, and guidance to supervisors, educators and the assessment process.

The curriculum reflects, within the domains, a more contemporary view of Australian society as it relates to rural and remote areas. In 2010, the place of Aboriginal and Torres Strait Islander health in the curriculum was confused (see 2010 team findings) and has since been clarified. Domain five has been extended from an exclusively Aboriginal and Torres Strait Islander focus to now encompass the wider disadvantaged and culturally diverse groups. The additional focus on Aboriginal and Torres Strait Islander remains as one of the 18 areas covered by the curriculum statements, as well as an Advanced Specialised Training area. However, there appears to be a need to ensure that the educational resources also reflect these changes. The Rural and Remote

Medical Education Online (RRMEO) module on cultural awareness still focuses heavily on Aboriginal and Torres Strait Islander healthcare delivery. This broader focus is not only important for rural and remote areas where other culturally and linguistically diverse groups, for example, refugees, have settled in significant numbers, but also for general practitioners working in all areas of Australia. Between 2009 and 2014, approximately 1 million migrants or refugees settled in Australia, of these approximately 11% (almost 108,000 people) settled in regional Australia and more than 800,000 migrants or refugees settled in metropolitan Australia. The College is encouraged to continue a strong focus on the many diverse communities that make up society in rural and remote areas and reflect these strongly in the Primary Curriculum and AST curricula.

As discussed under standard 2, the introduction of the minimum mandatory six-month placement in a community or primary care setting is an important development in the training program. This was recognised in the 2010 AMC review as an area that required further attention (condition 7). The team recommends that the College oversees the practical implementation of the minimum six-month placement by the training providers to ensure the integrity of the clinical experience in meeting the learning objectives that have been clearly set. Documentation to support the learning objectives of this placement are available, however there is a need to strengthen and review the process to support the implementation and expectations for this training experience, ensuring they are documented, publicised and understood in the training setting. The current process for the Bi-College accreditation of the regional training providers is an opportunity to provide closer oversight.

In 2010, the AMC recommended that the College engage with the standards setting bodies for the medical specialties to ensure the learning outcomes in relevant specialist discipline areas are appropriate (condition 9). The 2014 team considered condition 9 as part of this assessment.

The College office bearers are commended for the significant progress made towards enhancing the College's relationship with other specialist medical colleges. Specialist colleges have been well engaged in the development of all ACRRM curricula and are very supportive of the Primary Curriculum. During the assessment, the team heard positive feedback on the work achieved through the Joint Consultative Committees in anaesthesia, and obstetrics and gynaecology. Strong engagement in the content of the AST curricula has been generated by various specialist colleges. In many instances this has led to an enhancement of the proposed content in the revised documents. The 2014 team considers condition 9 from 2010 is satisfied. However, further progress is required to reach a common understanding about a safe scope of practice in a number of procedural and interventional areas. It is recommended that the College develop and document a process for considering the input of other relevant specialist medical colleges in the review of individual AST curricula.

### 3.3 Research in the training pathways

The accreditation standards are as follows:

- The training program includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, and encourages the trainee to participate in research.

- The training program allows appropriate candidates to enter research training during specialist education and to receive appropriate credit towards completion of specialist training.

#### 3.3.1 Research in the training pathways in 2010

*The ACRRM Primary Curriculum describes the skills and abilities required in research and evidence-based medicine. These relate to explaining the nature of research particularly in rural and remote general practice, accessing medical literature and other sources of information, critically appraising information, understanding basic concepts of clinical epidemiology and undertaking clinical audit.*

*In the Vocational Preparation Pathway and the Remote Vocational Training Scheme, RTPs are responsible for delivering learning activities to meet the curricula. Registrars in the Australian General Practice Training (AGPT) program may apply to undertake salaried training for a period of 12 months part-time, in an academic term as an extended skills post or as optional extra training. There are GPET/RACGP/ACRRM joint guidelines on supervision and learning outcomes for academic posts. At the time of the team's assessment, ACRRM indicated it was formulating policy on how academic posts would best fit in the training schedule. ACRRM's accreditation submission indicated that it accommodated registrars' research activities within an overall learning plan and that academic posts were typically accommodated as part of a Population Health or Aboriginal Health advanced specialised training. As the training provider for the Independent Pathway, ACRRM offers educational sessions on survey design and statistical analysis in its IP workshop series.*

*The inclusion of sections on research and evidence-based medicine in the Primary Curriculum is commended. ACRRM could strengthened this curriculum component by the following: setting requirements for formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice for all registrars; providing opportunities for registrars to participate in research; and putting in place mechanisms to monitor registrars' access to such opportunities. Registrar presentations should be formally assessed and the outcomes should to be recorded in the portfolio.*

*The College has reformed the research committee of the Board. The team commends this decision. It recommends that the priorities of the committee include identifying the scope of research already being undertaken in rural and remote practice and determining a plan for encouraging research that includes clinical audit, and promotion of research participation by registrars.*

#### 3.3.2 Research in the training pathways in 2014

In its 2010 assessment, the AMC recommended that the College establish requirements for formal learning about research, provide opportunities for registrars to participate in

research, and put in place mechanisms to monitor registrars' access to such opportunities (condition 10). The College addressed condition 10 in 2012 by reporting on the progress made in providing research opportunities for registrars, including the decision to establish Advanced Specialised Training (AST) in Academic Practice.

The strengthening in the Primary Curriculum of the importance of research and education is welcomed. The ACRRM Primary Curriculum describes the abilities, knowledge and skills required in research and evidence-based medicine. The ACRRM assessment process also ensures that registrars are assessed on their research and evidence-based medicine competencies. The team acknowledges that the RTPs teach the critical appraisal and research skills to the registrars in the vocational training pathways. The College is encouraged to ensure that through the Bi-College Regional Training Provider Accreditation Program, the training providers are able to demonstrate their commitment to these educational objectives.

The College has a very active Research Committee that pursues all opportunities to advance research activities in the delivery of health care in rural and remote settings. The College continues to have active representation on the Registrar Research Committee (currently governed by GPET) and also hosts the annual Research Week. Research Week is undertaken as an online conference open to all Australian General Practice Training (AGPT) program registrars as well as all ACRRM members, and utilises the Rural and Remote Medical Education Online (RRMEO) platform as its vehicle. The registrar scholarship and research fund to support registrars to undertake a twelve-month part-time academic position to complete a specific project, has been an important development in the past. This is currently being reviewed due to the Commonwealth Government changes relating to the closure of GPET.

As previously discussed, the College is currently developing an AST program in Academic Practice which will include research and teaching. The team strongly encourages this development.

## 3.4  Flexible training

The accreditation standards are as follows:

- The program structure and training requirements recognise part-time, interrupted and other flexible forms of training.
- There are opportunities for trainees to pursue studies of choice, consistent with training program outcomes, which are underpinned by policies on the recognition of prior learning. These policies recognise demonstrated competencies achieved in other relevant training programs both here and overseas, and give trainees appropriate credit towards the requirements of the training program.

### 3.4.1  Flexible training in 2010

*The College's accreditation submission outlines in detail the features of its vocational training pathways that provide flexibility to suit differing registrar circumstances, profiles and lifestyle choices. As noted earlier, the three training pathways target the different needs and situations of registrars.*

*There is also flexibility in how clinical training requirements are met within the structure of each of the training pathways, which is facilitated by a learning and assessment plan. This is discussed in Section 4 of this report.*

*ACRRM's policy on leave from training reflects that of the Australian General Practice Training (AGPT) program and the Remote Vocational Training Scheme. Independent Pathway registrars apply directly to ACRRM. Applications for continuous leave of up to 12 months may be made to the training provider and/or the College; longer periods of time may be considered in extenuating circumstances. Applications for extended leave must be supported and recommended by the ACRRM medical advisor. ACRRM policy requires training providers to have procedures to manage leave requirements taking into consideration the potential effect on the registrar's progress.*

*Training time with ACRRM is accumulated pro-rata. The main contingents are that part-time training must be prospectively approved and that training time may not exceed ten years in total.*

*ACRRM has provision for recognition of prior learning and experience (RPL). The College will assess applications for RPL in the following circumstances:*

- *on entry to or during the training program, to ascertain the total amount of training time needed to attain fellowship*

- *when changing from one fellowship pathway to another, e.g. changing from Royal Australian College of General Practitioners to ACRRM training*

- *when changing training pathways*

- *on the completion of the FRACGP and the RACGP's Fellowship of Advanced Rural General Practice or Grad Dip Rural, where a candidate is not eligible to apply for Fellowship through the Advanced Standing Process.*

*Generally the College will grant no more than two years of RPL to a candidate. There may be exceptional circumstances where the Censor will grant in excess of two years.*

*Under its policy, ACRRM will consider the following experience and skills for RPL:*

- *prior hospital, general practice or advanced skills/specialist practice, which has been supervised or unsupervised, occurring in metropolitan or rural and remote settings in Australia or overseas*

- *prior experience gained in overseas postings as part of defence force deployment or voluntary/paid medical aid work*

- *prior courses of study, excluding primary undergraduate or graduate medical school training, but including course work completed at a university, medical college or other appropriate institution (deemed by the Censor).*

*The process involves the registrar submitting an application identifying previous training which may fulfil the criteria of one or more of Core Clinical Training, Primary Rural and Remote Training and Advanced Specialised Training. Sufficient certified information must be supplied to enable this to be verified. The registrar must map their experience against the College's curriculum areas and educational domains. References are sought from*

*previous supervisors. This information is then assessed by the College Censor and a decision made as to the amount or type of RPL which will be granted.*

*The College's data on the number of applicants for RPL in the three training pathways between 2007 and 2009 showed that 57 applications were received from Independent Pathway registrars and 56 were approved; three for the Remote Vocational Training Scheme with two approved; and 28 for the Vocational Preparation Pathway, all of which were approved.*

### 3.4.2   2010 team findings

*The team commends ACRRM's approach to flexible training.*

*The team spoke to a number of registrars who had undertaken part-time training. All of them were happy with the system and the flexibility of the College in this regard.*

*The team found the recognition of prior learning process was onerous and cumbersome for both the applicant and the College. It warrants review to ensure increased capacity and veracity; this might include outsourcing the verification of qualifications. Furthermore, the team considered that the information ACRRM required of referees was not sufficient to confirm the nature and level of training undertaken in previous positions.*

*At this point, consideration of applications is dependent on substantial commitment by a few ACRRM officers, such as the Censor. The ability to delegate an increased number of requests within clear policy guidelines will be most important.*

*The team also had concerns about the framework for making decisions about the recognition of registrars' prior learning as appropriate for general practice. College decisions should be clearly linked to curriculum requirements.*

### 3.4.3   2014 team findings

The College continues to demonstrate a strong commitment to flexible training. Registrars can interrupt training for a total of two years. The team recommends that the College develop a statement to reflect expectations regarding re-entry requirements for registrars who take an extended period of leave in line with the Medical Board of Australia's requirements.

According to the ACRRM *Training Time Policy*, the College requires registrars to complete all their training within a ten-year period.

The numbers of registrars applying for and granted recognition of prior learning (RPL) from January 2011 to July 2014 were as follows.

| Pathway | Applied for RPL | Granted RPL |
|---|---|---|
| Vocational Preparation Pathway | 87 | 87 |
| Remote Vocational Training Scheme Pathway | 17 | 17 |
| Independent Pathway | 252 | 197 |
| **Total** | **356** | **301** |

The policies related to RPL are well-documented on the College website. As recommended by the AMC in 2010, the scrutiny of prior learning experiences has been tightened and the College is able to demonstrate a thorough process of assessment. The process for recognition of prior learning for the candidates on the Vocational Preparation Pathway and the Remote Vocational Training Scheme Pathway is through a submission via the registered training provider to the College. The College maintains all oversight and approval of RPL. The College responded to the 2010 AMC findings regarding the substantial commitment required of the College Censor in considering RPL applications. RPL applications are now prepared by College staff and considered by the Director of Education, with final approval made by the College Censor. For prospective registrars in the Independent Pathway, the RPL is initially reviewed as a paper-based exercise and then confirmed following further discussion at the selection interview. The team recommends that the College conduct a review of the link between the selection and RPL processes for candidates entering the Independent Pathway. This is discussed further under standard 7 of this report.

At this point, consideration of applications is dependent on the substantial commitment by a few ACRRM officers, such as the Censor. The ability to delegate an increased number of requests within clear policy guidelines will be most important.

During the assessment visit, registrars and supervisors described problems where the advice from the training providers differed from the expectation of the College. This was reported as being confusing and misleading to registrars who were entering through the Vocational Preparation Pathway or the Remote Vocational Training Scheme Pathway. The team recommends the College review the process to ensure that there is alignment between advice given by the training providers and the College's RPL policy. It was discussed during the visit, that an opportunity to implement the process of alignment is currently available and beginning to progress through the Bi-College Regional Training Provider Accreditation Program.

## 3.5    The continuum of learning

The accreditation standards are as follows:

- The education provider contributes to articulation between the specialist training program and prevocational and undergraduate stages of the medical training continuum.

### 3.5.1   The continuum of learning in 2010

*ACRRM shows leadership in contributing to articulation between its vocational training pathways and the prevocational and undergraduate stages of medical education. This is evidenced by its support of John Flynn scholarship students and rural bonded medical students. In an environment in which the continuum of learning assumes increasing importance, ACRRM's links with rural clinical schools will be vital to enable it to identify and support medical students and junior doctors with an interest in rural and remote training. Links with postgraduate medical councils need to be enhanced as these are also essential.*

### 3.5.2 The continuum of learning in 2014

The College has continued to show leadership in contributing to the vertical integration of the undergraduate and graduate medical curricula, and of pre-vocational and vocational training pathways, all the way through to workforce supply and development in rural and remote settings. The College is strongly supported by many stakeholders met during the assessment visit, including rural clinical schools and the jurisdictions in promoting this vertical integration. Stakeholders throughout this review described the College as being a leader in the field of supporting generalist medical practice in rural and remote Australia.

## 2010 Accreditation Conditions and Recommendations

*2010 Commendations*

D     The application and enthusiasm shown by rural and remote medicine practitioners in the development of the ACRRM Primary Curriculum.

E     The inclusion of sections on research and evidence-based medicine in the Primary Curriculum.

F     ACRRM's support of flexible training.

G     ACRRM's leadership in contributing to articulation between its vocational training pathways and the prevocational and undergraduate stages of medical education.

*2010 Conditions to satisfy accreditation standards*

8     Complete the review of the Primary Curriculum, taking account of the recommendations in this report regarding the framework and content as well as other stakeholder feedback. In particular, the following are required:

o     clearly identify learning outcomes for the various stages of training

o     nominate the common and important conditions which must be addressed in the curriculum and learning outcomes, and which apply to all the settings in which ACRRM fellows work

o     put in place mechanisms to ensure that registrars completing ACRRM training have a clearly identified and extended period of experience in community and primary care, when they have the opportunity to experience the core skills of general practice, namely continuity of care, chronic disease management, prevention, and population health. The team recommends at least six months in community and primary care. (Standard 3.1)

9     For ACRRM curriculum statements for specialist discipline areas, engage with the standards setting bodies for the medical specialties to ensure that learning objectives are appropriate and supported with appropriate clinical experience and supervision, and to provide a sustainable system for curriculum review. (Standard 3.2)

10    Set requirements for formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice for all registrars, provide opportunities for registrars to participate in research, and put

in place mechanisms to monitor registrars' access to such opportunities. (Standard 3.3)

*2010 Recommendations for improvement*

FF    Consult registrars on how information about curriculum change would best be communicated to them and consider how ACRRM is engaging registrars in curriculum review. (Standard 3.1)

HH    Enhance the links with postgraduate medical councils. (Standard 3.5)

GG    In relation to Recognition of Prior Learning policies:

    o    review the framework to ensure that it is recognising registrars' prior learning as appropriate for general practice

    o    review the application process with the aim of streamlining and providing clearer policy guidelines for applicants and the College. (Standard 3.4)

The 2014 team considers that conditions 8, 9 and 10 from 2010 have been met.

## 2014 Accreditation Conditions and Recommendations

*2014 Commendations*

F    The 4th Edition Primary Curriculum, completed in 2013, supports the strong underlining principles and philosophy of the delivery of generalist health care in a rural and remote setting.

G    The College's formal engagement and consultation with key stakeholders in the review of the Primary Curriculum and Advanced Specialised Training curricula.

H    The strengthening in the Primary Curriculum of the importance of research and education and the inclusion of an opportunity to pursue Advanced Specialised Training in Academic Practice.

I    The strong commitment to and promotion of the vertical integration of all aspects of training and workforce development to support the practice of generalist medicine in rural and remote settings.

*2014 Conditions to satisfy accreditation standards*

4    Complete and report on the review of the Advanced Specialised Training curricula and the development and introduction of the Academic Practice curricula. (Standard 3.1 and 3.2)

5    Review the documentation and oversight to support the learning objectives of the clinical experience in the minimum six-month mandatory placement in a community or primary care setting. This review is to include the expectations of the training providers to support the placement and provide greater clarity to the registrars regarding the placement requirements. (Standard 3.2)

6    Develop and document a process for considering the input of other relevant specialist medical colleges in the review of individual Advanced Specialised Training curricula. (Standard 3.2)

*2014 Recommendations for improvement*

DD    Develop an engagement and stakeholder strategy to increase the regional training provider's understanding of the ACRRM curriculum and training requirements. (Standard 3.1 and 3.2)

EE    The Joint Consultative Committee on General Practice Procedural Surgery clearly defines the agreed scope of practice of procedures in the Advanced Rural Generalist Surgery curriculum. Current areas of disagreement need to be defined and agreement reached as to how the training experience in those areas will progress. (Standard 3.2)

FF    Review and develop a process to ensure there is policy and procedural alignment in the advice given by the training providers in relation to recognition of prior learning and ACRRM's clearly articulated policy. (Standard 3.4)

GG    Develop a statement of expectations regarding re-entry requirements for registrars who take an extended period of interrupted leave. (Standard 3.4)

# 4 Teaching and learning methods

## 4.1 Practice-based teaching and learning

The accreditation standard is as follows:

- The training is practice-based involving the trainees' personal participation in relevant aspects of the health services and, for clinical specialties, direct patient care.

### 4.1.1 Spheres of learning in ACRRM training pathways in 2010

*As outlined in the previous section, there are currently three training pathways to fellowship of ACRRM. Training encompasses three spheres of learning:*

- *one year of Core Clinical Training*

- *two years of Primary Rural and Remote Training*

- *one year of Advanced Specialised Training.*

*There is significant flexibility in the manner in which these years may be undertaken, including the use of 'hybrid' posts.*

***Core Clinical Training*** *may be commenced as early as Postgraduate Year 2. This year is hospital-based and aims to provide a foundation of clinical competence in areas related to rural/remote and urban hospital-based practice. Registrars are required to have completed a ten-week term in paediatrics, as well as terms in emergency medicine; general surgery; general internal medicine; obstetrics and gynaecology; and anaesthetics, preferably prior to completion of Core Clinical Training. There is an expectation that most of the teaching and learning needs of the trainee will be met by the hospital during this period.*

***Primary Rural and Remote Training*** *can be completed in a variety of accredited positions, including those based in metropolitan, regional and rural hospitals, general practice, community-based and other posts. During Primary Rural and Remote Training, the College expects the registrar will progressively build their clinical and procedural skills, especially in the context of rural and remote medicine. On completion, the registrar would be expected to be able independently to provide comprehensive and continuing care for individuals, families and communities.*

***Advanced Specialised Training*** *provides the registrar with the opportunity to extend skills beyond the ACRRM Primary Curriculum in one specialised discipline relevant to general practice in the rural and remote context. Twelve months of training in one of ten specified disciplines must be undertaken in order to complete Advanced Specialised Training. At the time of the Team's assessment, ACRRM had confirmed the curricula for the Advanced Specialised Training in Obstetrics & Gynaecology and Anaesthetics. In these two areas, specific qualifications accompany successful completion of Advanced Specialised Training. Curricula for other areas were at varying stages of development. As noted earlier, all but Paediatric Health had been completed by the time of the College's update to the AMC in March 2011.*

### 4.1.2   Spheres of learning in ACRRM training pathways in 2014

The three training pathways and spheres of learning remain similar to those in 2010, although there have been some significant developments, centring on the revision and completion of the Primary Curriculum. The 2013 revision of the Primary Curriculum sets out 11 principles which shape the teaching and learning across the training program. The principles are consistent with, and reinforce accreditation standards 4.1 and 4.2. The principles have not changed since the 2010 review as described under standard 3 of this report.

## Core Clinical Training

There is a greater interconnection now between the prevocational training of doctors and the College's training pathways. For example, in the 2011 *Core Clinical Training Standards for Supervisors and Teaching Posts*, it is noted that while fellowship training cannot commence before postgraduate year 2 (PGY2), experiences in postgraduate year 1 (PGY1), the intern year and PGY2 all count towards the compulsory experiences required to complete core clinical training. The College relies on the accreditation of terms by state and territory Postgraduate Medical Councils, or separate accreditation of posts by the College directly, or by the regional training provider acting on the College's behalf for these core terms.

The required components of core clinical training remain unchanged since 2010, even though the curriculum has been redesigned. The abovementioned College standards set out the requirements for supervisors and training posts in the core clinical training areas. In these standards, criterion 6.2 includes requirements for a hospital's training program, which are consistent with the *Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs 2010*, standards 4.1 and 4.2. Criterion 6.3 includes requirements for the hospital term or discipline itself, and these are also consistent with the requirements of accreditation standards 4.1 and 4.2.

## Primary Rural and Remote Training

The *Primary Rural and Remote Training Standards for Supervisors and Teaching Posts* were completed in 2013. This requires that a registrar must complete the remainder of the training requirements of the Primary Curriculum (not completed in Core Clinical Training), over a 24-month period. This period must include: a minimum of six months in community primary care and population health; a minimum of six months of hospital and emergency care; and at least 12 months of training in a rural and remote context.

## Advanced Specialised Training (AST)

As discussed under standard 3, the College offers eleven AST disciplines. All disciplines continue to require a minimum of 12 months' experience except Surgery which requires a minimum of 24 months. The College introduced Academic Practice as the eleventh AST in 2012 and the curriculum is currently under development. All the AST curricula are undergoing a review in 2015 and the College is seeking feedback from key stakeholders.

### 4.1.3  ACRRM teaching and learning approaches in 2010

*The designated supervisors, clinical teachers and medical educators are central to the delivery of the training. A short description of these roles follows, and the selection, support and evaluation of the clinicians who fill these roles is discussed in Standard 8 of this report.*

*ACRRM policy requires that each registrar is linked to an ACRRM-accredited supervisor who provides supervision, clinical skills training, monitoring, guidance and feedback on professional and educational development.*

*The term 'clinical teachers' applies to the variety of teachers, experts in particular content areas, and specialists who contribute to activities and workshops during training time.*

*Medical educators are senior clinicians, with experience in teaching and medical education, who are selected and employed by their RTP. Their roles include providing advice regarding the key components of the training pathway; providing information to the registrar cohort on opportunities to train towards Fellowship of ACRRM; participating in the development of learning plans for ACRRM registrars and monitoring the registrar's achievement of their broad goals through learning plans; participating in, and advising on, placement allocation for ACRRM registrars; and facilitating and encouraging ACRRM accreditation of posts. ACRRM also employs medical educators for the Independent Pathway registrars.*

*Teaching and learning approaches differ somewhat across the three training pathways.*

*The Vocational Preparation Pathway, designed with new graduates in mind, aims to deliver training based on an enhanced apprenticeship model supplemented by a structured education program delivered in part by supervisors and in part by the RTP.*

*The RVTS has been designed for doctors currently practising or wishing to train in remote areas where access to on-site supervision may be difficult. The program sees doctors supported remotely by a supervisor experienced in remote practice located in the same geographic region who has a decreasing level of planned involvement with the registrar as they progress through training (one hour per week in the first six months; one hour per fortnight in the following six months and one hour per month thereafter). In addition, registrars have access to weekly group tele-tutorials and attend twice yearly face-to-face workshops with financial support from the RVTS.*

*The Independent Pathway has been designed for trainees with significant previous experience and/or a strong focus on self-directed learning. The revised program, introduced in 2009, includes the requirement for a registrar-specific learning plan created with the assistance of the ACRRM Censor and/or medical educator(s). A structured education program involving 32 tutorials a year is delivered via Elluminate Live™ which is a real-time virtual classroom environment. Two, five-day face-to-face workshops occur each year. These involve theory-based teaching, interactive skills training and simulated psychomotor skills training. Formative assessments are available both directly as delivered by ACRRM medical educators and via the Rural and Remote Medical Education Online (RRMEO) website.*

### 4.1.4   ACRRM teaching and learning approaches in 2014

The three pathways now share a common set of abilities, set out in the curricula and common assessment pathways, as well as the establishment of learning plans under each pathway. The advantage of these common elements in the training pathways is that, from a community and health system perspective, the expected skills and abilities of an ACRRM fellow should be consistent whatever pathway has been followed.

The range of teaching and learning approaches, which are detailed further below, involve many different tools, designed to fit with the needs of rural and remote practitioners. There is varying supervision, described under standard 4.3, depending upon the experience and specific needs of registrars. Most registrars interviewed by the team expressed satisfaction with the variety of ways that their learning objectives could be met to fit in with their location. Registrars commented that ACRRM training was challenging, but well-matched to the responsibilities of a doctor in a non-urban setting.

### 4.1.5   Practice-based teaching and learning in 2010

*Given ACRRM's stated aim of providing an apprenticeship method of teaching to deliver training in General Practice in the context of rural and remote Australia, it is imperative that supervisors are aware of the aims, syllabus and assessment processes involved in training towards fellowship of ACRRM.*

*The team found that many of the supervisors it met did not know the specifics of the ACRRM curriculum. In many cases, they were unaware of their registrar's College affiliation and could not name specific learning objectives the registrar should be addressing. Most offered similar training strategies for all registrars regardless of their final qualification intention. While some had a copy of the ACRRM curriculum from the College, there were others who did not know it and/or who in the College to contact for further information. Some were not aware of whether or not they were accredited to train ACRRM registrars, while others had been told that being accredited to supervise Royal Australian College of General Practitioners' (RACGP) registrars implied 'cross-accreditation' with ACRRM.*

*In addition, a number of registrars undertaking training on the Vocational Preparation Pathway felt that neither they nor their supervisors were adequately apprised of the learning objectives of their term with respect to ACRRM training. Most registrars on the Vocational Preparation Pathway or the Remote Vocational Training Scheme would approach the RTP in the first instance for further information regarding their teaching and learning needs.*

*In contrast, registrars undertaking training via the Independent Pathway indicated that they were well supported by the College and that information available direct from the College and via the College website was both useful and usable. In addition, they indicated that their queries generally were dealt with promptly and efficiently by College staff and office-bearers. This appears to reflect issues concerning communication between registrars, GPET, the RTPs and ACRRM raised in Standard 1 of this report.*

*Registrars on the Remote Vocational Training Scheme reported that they valued their interactions with their remote supervisors to assist in their practice-based learning. These*

*mostly occurred as planned and the registrar also had the ability to access their supervisor at other times of need.*

*The requirement for completion of 'core' terms before or during Core Clinical Training could be difficult in some jurisdictions particularly as this expectation could lead to competition between ACRRM registrars and trainees from other disciplines. It was noted that the College was quite flexible in its arrangements for completion of terms. This has led to some confusion between registrars, RTPs and the College. It is important for the College to clarify the requirements, particularly as the number of registrars increases, and work with RTPs to ensure these are well known.*

*As noted above, a great range of clinical experience satisfies ACRRM's training requirements. Issues of communication between training providers and the College need to be addressed to ensure that appropriate training posts continue to be accredited and unsuitable posts are removed from ACRRM's training program.*

*Some registrars reported feeling distressed at being left unsupervised and/or without local back-up when on call.*

*As indicated in Section 2 and 3 of this report, the ACRRM Primary Curriculum and the policy on accreditation of posts makes it theoretically possible for a registrar to complete training towards fellowship of ACRRM without having undertaken any training in community and primary care. In the team's discussions with registrars, supervisors and College office-bearers on this topic, some put the view that emergency department Australasian Triage Scale (ATS) 4 and 5 patients were similar to general practice. There is a large body of literature which refutes this supposition. The team was pleased to note that in its response to the draft report, the College indicated that this is not part of ACRRM's training post accreditation considerations.*

### 4.1.6 *Practice-based teaching and learning in 2014*

The AMC recommended in 2010 that the College engage with regional training providers (RTPs) to ensure the ACRRM curriculum is understood by the regional training provider, training supervisors and medical educators and delivered to College standards (condition 11). In 2012, the AMC agreed that the College was undertaking a number of measures to communicate its training requirements with RTPs but further work was required. The College was asked to report on mechanisms for ensuring the curriculum is delivered to College standards by RTPs under condition 23 from 2010. This is discussed in further detail under standard 8.1 of this report.

During the 2014 site visits, registrars in the Independent Pathway reported that there has been an increase in contact from the College's Medical Educators and that supervision had improved. This was generally also the case with registrars in the Vocational Preparation Pathway, although in some cases, they have not been able to get assistance from their RTP and this gap has been filled by the College. Registrars have particularly appreciated the opportunity to communicate with other registrars over social media, using it both as an informal educational environment and also as social support. Registrars generally viewed the College as providing more individualised assistance and as better understanding their needs in rural and remote practice.

The Remote Vocational Training Scheme Pathway arrangements remain positive and well-suited to the training cohort for which it is intended. Evaluation of the remote supervision approach indicates that this provides equivalent support for practice-based teaching and learning, when combined with the various other educational supports available such as those on the Rural and Remote Medical Education Online (RRMEO) platform.

Since the 2010 AMC assessment, the environment for ACRRM program delivery in the Vocational Preparation Pathway has changed, and its future shape still remains unclear. There are continued issues with some RTPs and their level of understanding of the differences between the ACRRM curriculum and training expectations, and those of the Royal Australian College of General Practitioners. The Bi-College RTP Accreditation Program has started to influence this, as detailed below. However, there has been a hiatus in its progress, as RTPs are uncertain about their own futures. The Bi-College RTP Accreditation Program may stall pending the Government's decision on the number of providers that will be tendered in 2015.

There remains considerable criticism by some registrars about some RTPs' lack of knowledge of the ACRRM curricula and expectations and, in some cases, the apparent disinterest of the training provider, in recognising and working with these differences to ensure registrars meet the outcomes required for ACRRM fellowship. The need for the College to advocate for its registrars in these circumstances has led to tense relationships between the College and some RTPs. The College will need to examine how to effectively influence RTPs in relation to their knowledge about, and their implementation of, the ACRRM curricula, as well as their use of the College's learning platform, RRMEO. The College will need to ensure that its supervisors are adequately supported either through contractual or other requirements in the RTP or through the College directly, to ensure the registrar's program of training and learning is fully supported in the practice, the hospital and in other training posts.

## 4.2    Practical and theoretical instruction

The accreditation standards are as follows:

- The training program includes appropriately integrated practical and theoretical instruction.

### 4.2.1  Practical and theoretical instruction in 2010

#### Electronic tools

*Rural and Remote Medical Education Online (RRMEO) is a web-based teaching and learning resource which has been designed for use by registrars, members and fellows of the College as well as Medical Educators from RTPs, and providers of continuing professional development courses. The system has been arranged to allow creation of a learning plan, identification of both online and external educational opportunities, and recording of education undertaken. This is automatic in the case of online activities and approved CPD events.*

*Registrars reported they mostly found the site useful and easy to use. They felt that access to online modules had improved the consistency of their learning. Resources, such as*

*TeleDerm, were widely used and applauded. However, some registrars on the Vocational Preparation Pathway reported that there was significant lag time between registering as a trainee and being allowed access to RRMEO. It was noted that the problem might be caused by delays in ACRRM receiving data about registrars from the RTPs. This issue should be addressed as a matter of urgency, and points to a need for further streamlining of information exchange between the training providers and the College.*

*Elluminate Live™ is a real-time virtual classroom environment being delivered via RRMEO. The platform allows interactive tutorial style teaching to be delivered simultaneously to multiple sites. Utilising voice, text, video, interactive whiteboard, software sharing and online polling, it allows a near equivalent experience to face-to-face education without extensive travel. It also allows central recording of attendance, a level of interaction of 'class-members' as well as delayed viewing by those whose commitments preclude their attendance in real time. It does require significant support from ACRRM IT personnel.*

*Elluminate Live™ is used to facilitate 32 tutorials per year for Independent Pathway registrars. It has also been used to deliver other specific learning modules for members and fellows of the College.*

*The team found that users of Elluminate Live™ were mostly enthusiastic. They found it relatively easy to use and valued the IT support which was provided to facilitate its use. In addition, the content delivered was relevant to their learning needs.*

### Learning plans

*It is the intention of ACRRM that each registrar has a personalised learning plan which identifies desired areas of learning as well as the means by which these will be addressed both in the short term (six months) and over the period of training. Registrars can access and update the learning plan through the RRMEO website, developing with their educator a learning plan specific to the registrar's needs. Once a learning task is completed, this can also be recorded via the website.*

*The learning plan may include proposed clinical placements, placement specific learning goals, online modules, workshops and self-directed learning. On completion, it will outline:*

- *accredited posts completed*
- *supervisors' reviews*
- *satisfactory completion of the required Emergency Medicine courses*
- *completed and validated procedural skills logbook*
- *completion of online learning modules, including a minimum of four RRMEO online modules*
- *ACRRM recognition of prior-learning statements (if relevant); and*
- *formative assessment reports.*

*For Independent Pathway registrars, the learning plan is developed in conjunction with the ACRRM Censor or Medical Educator. As ACRRM believes the numbers of Independent Pathway registrars may expand, the College must increase its capacity to support registrars to develop learning plans, perhaps at the local level. Independent Pathway*

*registrars indicated that they found the development and completion of a learning plan useful to their training. Most felt that the website was adequate for delivering the service; however, some commented that the platform could be designed better for ease of use for this application. The College's own formal feedback from registrars on the RRMEO system, which has been limited to the Independent Pathway registrars, supported these findings. The team recommends the College IT team increase the liaison with registrars in all pathways to continue improvement in this area.*

*Candidates in the Remote Vocational Training Scheme complete their learning plan with the assistance of their training advisor and supervisor. It is a requirement for the completion of training that participants can demonstrate their learning plan activities throughout their training time.*

*Vocational Preparation Pathway registrars develop and monitor their learning plan in conjunction with their RTP medical educator. In practice, the team found that not all registrars had utilised this resource. Some, most commonly in the first six to twelve months of ACRRM membership, had not been able to access RRMEO.*

### Workshops

*To be eligible for fellowship, all registrars must complete a minimum of two Emergency Medicine courses. These must be approved by ACRRM as meeting specified criteria to deliver learning outcomes relevant to emergency medicine in a rural and remote setting. For those on the Vocational Preparation Pathway and Remote Vocational Training Scheme, the RTP covers some of the costs related to attendance at these courses.*

*Remote Vocational Training Scheme registrars are expected to attend intensive five-day education workshops covering a range of areas including procedural skills development, fellowship examination preparation, emergency medicine and other specific topics best learnt in a face-to-face environment. Registrars attend these workshops twice a year. These workshops are developed and run by the Remote Vocational Training Scheme with the cost being covered by the RVTS.*

*Independent Pathway registrars are also expected to attend face-to-face workshops run by ACRRM twice a year. These workshops include teaching on theory, interactive skills training; simulated psychomotor skills training and opportunities for formative assessment. Registrars reported that these workshops were generally well run, relevant to their learning needs and easy to access.*

### 4.2.2   Practical and theoretical instruction in 2014

The information detailed in 2010 under practical and theoretical instruction remains current, and according to registrars there has been further expansion and improved access to resources since the last review.

### Electronic Tools

The Rural and Remote Medical Education Online (RRMEO) platform continues to be the central means of delivering a large range of training modules (currently more than 100). Some of which are developed by the College and some of which can be accessed through other expert bodies, such as Parkinson's Australia, the Royal Flying Doctor

Service or other medical colleges, such as the Royal Australian and New Zealand College of Psychiatrists. Users reported to the 2014 team that they were satisfied with the modules and found that they provided highly useful information in an easy to use format.

In addition, the virtual, real time tutorials were praised by registrars, as was the capacity to return to an incomplete sessions at a later date, for example if the registrar was called away to an emergency during the tutorial session.

The Customer Relationship Management (CRM) system, due to be introduced in February 2015, also appears to be a positive development. The system will provide improved access for both supervisors and registrars to individualised registrar learning plans as well as up-to-date information on registrar progress. It will also allow a validated record of the registrar's experience and achievements against the abilities they are required to demonstrate under the curricula. The CRM system will include the current RRMEO functionality and the professional development program documentation and tracking.

Some training providers have developed or are in the process of developing online education materials for their general practice registrars. Given the financial and intellectual investment in the development of the RRMEO resources and its high rate of acceptability to registrars, it is unclear why the Remote Vocational Training Scheme Pathway and the Vocational Preparation Pathway do not promote these tools in training ACRRM registrars. Given that the same system is also used for delivery of some of the College's professional development programs, it is important that all ACRRM registrars understand and use this system prior to completion of training.

**Learning Plans**

The use of learning plans across all training pathways and the Specialist Pathway for international medical graduates is a positive development. The 73 expected abilities in the Primary Curriculum and the specific additional requirements detailed in the Advanced Specialised Training curricula are able to be recorded. If recognition of prior learning has been granted, this can also be documented on the learning plan. The capacity and requirement for evidence of registrar completion/attainment of requirements on the learning plan, and its central recording in the College's system is seen as a real advantage by both registrars and supervisors. It is also considered as a reliable, validated record for future employers.

**Workshops**

The various workshops continue to be considered positively by registrars both from a learning perspective and also for the opportunity to meet with other doctors practising in similar environments. Greater consistency across the training pathways is also reflected in this area.

**4.3    Increasing degree of independence**

The accreditation standard is as follows:

- The training process ensures an increasing degree of independent responsibility as skills, knowledge and experience grow.

### 4.3.1  Increasing degree of independence in 2010

*The basic structure of ACRRM training, involving Core Clinical Training, Primary Rural and Remote Training and Advanced Specialised Training, aims to facilitate increasing levels of responsibility in General Practice. However, due to the flexibility of the program, there is the potential for an individual registrar to be left without appropriate supervision during a particular portion of their training.*

*For example, a registrar's only experience in community and primary care may be as the final clinical experience in their training. Indeed, the team interviewed a number of registrars for whom this was the case and for whom this experience was limited. Some felt that they had been left inadequately supervised during this period.*

*In general, however, registrars considered their supervisors responsive to their needs, often providing a greater level of supervision than expected or necessary. The College may need to be more explicit in detailing the level of supervision required of registrars dependent on the specific training which they are undertaking.*

*For registrars on the Remote Vocational Training Scheme, supervision is remote. However, minimum supervisor contact during training is clearly laid out as one hour per week in the first six months, one hour per fortnight in the second six months, and one hour per month thereafter. The team's discussions with supervisors and registrars, and the AMC surveys of both groups indicated that this commitment was mostly being fulfilled.*

*The team saw much more limited guidance for supervisors of registrars on the Independent Pathway or the Vocational Preparation Pathway, although changes proposed to ACRRM's Standards for Teaching Posts and Teachers in Primary Rural and Remote Training provide greater clarity. The College's 2010 revisions introduce a requirement for supervisors of registrars on both these pathways to provide three hours per week in the first six months, then 1.5 hours in the next six months and thereafter according to the individual registrar's need.*

*Notwithstanding the more limited written guidance, the general practice supervisors interviewed by the team were comfortable with a graded approach to supervision, and most registrars felt their requirements for supervision were being met. Supervisors in hospital settings had varying expectations of the degree of supervision which was required at different levels of training. Most tailored their supervisory regime to the experience and skills of the individual registrar.*

### 4.3.2  Increasing degree of independence in 2014

The three training pathways continue to provide great flexibility in accommodating registrars of vastly different experiences and skills. The level of supervision provided to registrars on each of the different pathways recognises their differing experience levels. The role of supervisors for each pathway is clearly documented in the *Standards for Supervisors and Teaching Posts*. This is described in further detail under standard 8.1 of this report.

There is also material available to assist supervisors in understanding the graded needs of registrars. For example, the *Guide for Supervisors – Primary Rural and Remote*

*Training (November 2010)*, which was produced for supervisors of the Vocational Preparation Pathway, sets out teaching/learning guidance for supervisors, as registrars progress along the 'novice to expert scale'. In addition, the College's requirements of levels of direct supervision varies over the duration of the Vocational Preparation Pathway, with an expectation that supervisors will be on site 80% in the first six months, 50% in the second six months and 25% thereafter. It is noted that in the *Primary Rural and Remote Training Standards for Supervisors and Teaching Posts (July 2013)*, supervision is required to be onsite, except in the case of Remote Vocational Training Scheme (RVTS) registrars as the pathway has been specifically designed for remote supervision. The College allows remote supervision in the other pathways, but only under exceptional circumstances. These requests must be approved by the College in advance. In all cases, where there is remote supervision (including RVTS) a remote supervision plan needs to be submitted to the College for approval before the registrar commences in the post.

The requirements for supervisors to provide structured educational activities in each of the training pathways differ, but all recognise the changing needs of registrars over the duration of their training. For example, supervisors of the Vocational Preparation Pathway are required to provide three hours per week of structured educational activity in the first six months of Primary Rural and Remote Training (PRRT), 1.5 hours per week in the second six months of PRRT and then on an individual needs basis.

Under the RVTS, the supervisor is required to have one hour per week direct contact with the registrar for the first six months, one hour per fortnight in the second six months, and one hour per month for the remainder of the program. In addition to teleconferences between the registrar, supervisor and the medical educator, the supervisor will visit the registrar once a year as part of a clinical teaching visit, and join at least two tele-tutorials per year.

The requirements of the Independent Pathway are similar to those of the Vocational Preparation Pathway, however if a registrar receives recognition of prior learning of 12 months or more, the education and training requirements will be matched to the specific training needs of the registrar.

Since the 2010 AMC assessment, the College has become more proactive in ensuring that registrars' teaching and learning needs over their training program is understood and met. This has been facilitated by the development of individual learning plans.

## 4.4    Flexibility in ACRRM training

### 4.4.1   Flexibility in 2010

*One of the features of ACRRM training is its flexibility. Indeed this was one of the more common reasons registrars gave for choosing to train with ACRRM. This flexibility is reflected not just in its provisions for part-time and interrupted training but also in ACRRM's approach to recognition of prior learning, the flexible order in which training components may be undertaken and the ability to undertake 'hybrid' posts to fulfil training requirements.*

*While registrars are encouraged to complete Core Clinical Training prior to Primary Rural and Remote Training, it is possible to complete Advanced Specialised Training (AST) immediately following Core Clinical Training. Indeed, the team spoke with a number of registrars who had taken this opportunity. As long as AST curricula are developed and modified with this in mind, the team sees no issue with this approach.*

*Many ACRRM registrars reported they had completed or were intending to complete 'hybrid' posts. In essence, these posts may involve time spent in two or three separate and contrasting clinical settings during a term in order to provide the registrar with appropriate exposure to clinical settings which may not otherwise be possible and/or to provide increased breadth of training. The latter is particularly relevant in the rural and remote setting. Examples include posts organised in Aboriginal Medical Services where segregation occurs by gender, whereby the registrar spent three days a week in the male area and one in the female area; and posts where registrars spent part of their week working in a regional emergency department and part in general practice. These posts were predominantly available to Independent Pathway candidates and had often been specifically created for them. The team considered this to be an innovative approach by the College to fulfilling the training requirements of its registrars. As registrar numbers grow, the College needs to ensure registrars continue to complete appropriate training in conditions which are common and important in General Practice in rural and remote environments.*

*While swapping between training pathways is not recommended, regulations are available regarding the situations under which this can be done. This predominantly involves changes between the Remote Vocational Training Scheme and the Vocational Preparation Pathway.*

### 4.4.2 Flexibility in 2014

The College continues to offer a flexible program of teaching and learning to accommodate not only different learning needs and styles of registrars, but also to recognise the practical complexity of those training in rural and remote locations. The College's processes for the recognition of prior learning, as well as the range of methods available for registrars to access teaching and learning, is to be commended. The Primary Curriculum and the Advanced Specialised Training curricula, combined with the uniform assessment processes across all training pathways, provide a clear framework of graduate outcomes, enabling the College to certify that registrars have met a consistent standard of performance, wherever and however the training and education has been provided.

## 2010 Accreditation Conditions and Recommendations

*2010 Commendations*

H      The focus on, and achievements in, the development and utilisation of remote learning tools to reach its dispersed and diverse membership, including:

      o   the impressive Rural and Remote Medical Education Online Learning Management system which is an excellent tool for managing and supporting registrar learning

      o   the level of support and structure for Independent Pathway registrars, including the use of Elluminate Live™ to facilitate teaching and learning.

I      The use of registrar-specific learning plans to assist in guiding registrars through their training.

J      The creation of 'hybrid' posts, which aid registrars, particularly Independent Pathway registrars, in gaining breadth and depth in their clinical experience.

K      The workshops facilitated by ACRRM and the Remote Vocational Training Scheme which are well run and integral to registrar learning.

*2010 Conditions to satisfy accreditation standards*

11      Engage with regional training providers in order to ensure the ACRRM curriculum and any changes to it are understood by the regional training provider, training supervisors and medical educators and delivered to College standards including the level of supervision required. (Standard 4.1.1)

*2010 Recommendations for improvement*

II      Address the issue of registrar access to Rural and Remote Medical Education Online. (Standard 4.1.2)

JJ      Increase capacity for the College to support formulation of registrar-specific learning plans as registrar numbers grow. (Standard 4.1.2)

KK      Through the College IT team increase the liaison with registrars to continue improvement in the website's capacity to support registrars' learning plans. (Standard 4.1.2)

The 2014 team considers that condition 11 from 2010 has been met. Further work is required by the College which is reflected in 2014 condition 14 under standard 8.1 of this report.

## 2014 Accreditation Conditions and Recommendations

*2014 Commendations*

J      The College's continued expansion of both the Rural and Remote Medical Education Online (RRMEO) education modules and its virtual classroom which provides registrars with up-to-date education in the rural and remote environment.

K      The introduction of learning plans for registrars on all training pathways, and the College's plans for the introduction of the Customer Relationship Management system which will provide improved access for supervisors and registrars to individualised learning plans as well as up-to-date information on registrar progress.

*2014 Conditions to satisfy accreditation standards*

Nil

*2014 Recommendations for improvement*

HH    Develop and implement strategies to promote to training providers, knowledge about, and implementation of the Rural and Remote Medical Education Online (RRMEO) platform for ACRRM registrars' learning with its specific focus on the rural and remote practice. (Standard 4.1.2)

II      Develop and implement processes to ensure that supervisors are adequately supported through their training provider or through the College directly, to ensure the programs of training and learning are fully supported in the practice, the hospital and in other training posts. (Standard 4.1.2)

# 5 Assessment of learning

## 5.1 Assessment approach

The accreditation standards are as follows:

- The assessment program, which includes both summative and formative assessments, reflects comprehensively the educational objectives of the training program.

- The education provider uses a range of assessment formats that are appropriately aligned to the components of the training program.

- The education provider has policies relating to disadvantage and special consideration in assessment, including making reasonable adjustments for trainees with a disability.

### 5.1.1 Assessment approach and alignment of assessment to educational goals in 2010

*The ACRRM program of assessment incorporates a variety of assessment modes.*

*Formative assessment methods are Mini Clinical Evaluation Exercise (Mini-CEX) and Multi-Source Feedback.*

*Summative methods are:*

- *Multiple Choice Question examination*

- *Mini Clinical Evaluation Exercise*

- *Multi-Source Feedback*

- *Structured Assessment Using Multiple Patient Scenarios (StAMPS)*

- *Procedural Skills Logbook*

- *a portfolio of supervisor appraisals and specific educational modules.*

*Each Advanced Specialised Training (AST) discipline has a distinct and separate summative assessment. ACRRM's accreditation submission indicates that the assessment modalities vary across the different AST disciplines, but they are drawn from the assessment modalities used in the ACRRM Primary Curriculum.*

*Formative assessments are conducted in each of the four years of the training program. The summative Multi-Source Feedback and Mini Clinical Evaluation Exercise can be undertaken any time after 24 months of training. The summative Multiple Choice Question examination can be undertaken any time after 12 months of training. At the time of the team's assessment, StAMPS could only be attempted after all other summative modalities, including the Procedural Skills Logbook, had been successfully completed. This changed after the team's assessment to permit registrars to undertake StAMPS after two years of training.*

*Each of the summative assessment modalities are graded on a pass/fail basis and registrars must achieve a pass grade in each of these. For each modality, registrars may also access feedback on their performance.*

*At the time of the team's assessment, ACRRM had offered the Multiple Choice Question examination four times and StAMPS and the Mini Clinical Evaluation Exercise twice.*

### *5.1.2   2010 team findings*

*ACRRM has developed its formative and summative assessment processes significantly, using appropriate expertise, since the AMC granted the College initial accreditation in 2007.*

*The team commends the approach to the design of the assessment program. ACRRM has set the standard expected at that of a safe, confident and independent general practitioner able to work across a full and diverse range of healthcare settings in Australia, including rural and remote settings.*

*ACRRM has stated the fundamental requirement is that the curriculum be experiential. This is well supported by the design adopted. Internationally, modern assessment approaches embrace a variety of assessment methods, including well-made knowledge tests, clinical and practical skills examinations and workplace assessments which together provide a comprehensive and coherent picture of clinical performance. The ACRRM program is a good example and is well placed to support the curriculum and provide evidence of progress while also enabling the registrar to receive appropriate feedback.*

*The unusual curriculum structure which emphasises the context of practice is amenable to this approach.*

*The team was pleased to see the assessment blueprint which demonstrates the relevance of each assessment modality to the learning outcomes. In particular the level of detail that was provided in the advance diploma (obstetrics) was impressive.*

*For the Primary Curriculum, the assessment blueprint maps to the 72 learning outcomes defined under ACRRM's seven domains. While this is an excellent blueprint, it lacks connection to the detailed content of the curriculum statements. The team recognises the problems of working with a three-dimensional matrix, but there is a wide research base in assessment which shows that performance in one clinical area does not predict performance in another. For example, excellence in the management of diabetic coma does not necessarily predict ability to manage a fitting child. While this may seem self-evident, this research finding is crucial in designing tests and workplace assessments that sample detail widely and enough.*

*A principal purpose for the assessment program is to assure that the registrar has reached the standard for FACRRM, which as noted above, is that of a safe, confident and independent general practitioner able to work across a full and diverse range of healthcare settings in Australia, including rural and remote settings. The team urges the College to play close attention to the performance of the individual components and to recognise the strength of the design in considering and judging the entire range of evidence generated by the different methods. Undue reliance on one method in determining the outcome could lead to weakness in the face of challenge. All new programs face this difficulty and meticulous data collection, as well as robust policies and procedures are crucial. The team was particularly pleased to note that matters of progress*

*are discussed in the examination board where all of the evidence is given careful consideration before final decisions are made.*

*Formative assessment of registrars by supervisors occurs within the RTPs for registrars on the Vocational Preparation Pathway, and RTP processes and GPET policies also apply. It was of concern that 52 per cent of the registrars who responded to the AMC survey either disagreed, strongly disagreed or responded neutral to the statement that ACRRM supervisors provided regular feedback on their progress, with a higher proportion of registrars in the Vocational Preparation Pathway making these responses. This was supported by the team's discussions with registrars.*

*ACRRM needs to receive regular communication concerning these assessments, in order to be assured that its processes are being implemented appropriately. The organisation of formative assessment appeared to be undermined by the inadequate understanding within the RTPs of the need for the College to have assessment records returned to them. Inadequate data sets place the entire assessment process at risk.*

*The team noted that GPET has established policies concerning registrar assessment, monitoring and intervention, which include a structured remediation process. It was not clear how these policies aligned with those of ACRRM.*

*There appeared to be less structured monitoring of Independent Pathway registrars' participation in regular educational activities to support their progression through training. These are busy practitioners, whose learning has a significant self-directed component and it is important that the College actively monitor their progress. In its update to the AMC in March 2011, the College indicated that it had implemented an 'Independent Pathway Active Training Policy' in July 2010 in response to concerns that a significant number of registrars were not participating to a sufficient level in the education program. The policy applied to registrars joining the Pathway from 2010. It requires that in each six-month period registrars attend at least 13 out of the 16 tutorials and at least four of the five days of workshop each, or that they negotiate an alternative with the Medical Educator. They must also participate in education sessions with the Medical Educator, and be in an accredited post within three months of receiving the outcome of the Recognition of Prior Learning process. Subject to eligibility requirements they must also enrol in and attempt at least one ACRRM summative assessment each year. ACRRM indicated that three registrars had failed to satisfy the attendance requirements and would be required to make these up in the next six months. ACRRM plans to further revise this policy in August 2011. The AMC expects to be informed of the development of this policy, the progress of Independent Pathway registrars through training, and the number of registrars who have had their status reviewed and/or changed as a result of the policy in annual progress reports.*

### 5.1.3 Assessment approach and alignment of assessment to educational goals in 2014

The College has continued its significant work to develop its assessment practices. It is adopting a programmatic approach to assessment and is using this strategy to guide assessment changes and development that should provide the foundation for a comprehensive assessment system into the future. The College's adaptability and responsiveness to AMC feedback from the 2010 review is commended.

The suite of assessment tools has not changed since the 2010 review but a number of internal changes have been made, and some assessment tools are due to be reviewed. This includes a plan to consider the introduction of case-based discussion and an associated removal of mini clinical evaluation exercise from the summative assessment program. The College has commenced the review process but no decision has been reached as yet.

All components of the curriculum are mapped to the assessment tools to achieve comprehensive coverage of ACRRM's curriculum. The College asserts that all curriculum areas will be tested at least once during a registrar's progression through the training program. The operational management of assessments has been restructured to allow for clear assessment responsibilities. The College also presents this as a means to help it achieve alignment of assessment to the educational objectives of the training program.

The College adheres to its three core assessment principles as follows:
- The content of assessment reflects the curriculum.
- Assessment has been developed by clinically active fellows and other medical practitioners.
- Registrars are given the option to participate in the assessments within the locality where they live and work.

Adhering to the last of these principles in particular provides challenges that are unique to the rural and remote context of the College. These are actively being addressed. The College has continued to engage with experts to assist it with assessment work and has maintained an ongoing debate to achieve improvement. One example has been to convene a coordinated assessment review workshop in 2014. This workshop brought together major stakeholders from across assessment areas of the College to discuss and debate current challenges.

The detailed and comprehensive review of the ACRRM Primary Curriculum has led to greater articulation between the seven domains and 18 areas of specific focus. The College put in place significant opportunities for key stakeholders to provide input and has maintained a document that clearly sets out expectations of registrars. The assessment process is clearly aligned to the curriculum and appears to be well understood by registrars and examiners. The Advanced Specialised Training assessments are due for review in 2015 and the outcomes of this review in terms of balance and equivalence across disciplines should be reported to the AMC in future progress reports.

There has also been a recent extensive review of assessment outcomes overall including analysis by training pathway and annual trends. The College is continuing to refine and revise its workplace-based assessment systems.

In 2013, the College developed the *Special Considerations for Assessment Policy* that has replaced the former *Disability Policy*. The policy outlines the criteria and process by which candidates undertaking ACRRM assessment may apply for special consideration. Special consideration may be granted to accommodate a disadvantage suffered by a

candidate which is beyond the candidate's control and which is likely to affect, or has affected, performance in assessment.

### 5.1.4   2014 team findings

The team acknowledges the ongoing nature of the work being conducted by the College to improve its assessment system overall. The team was impressed by the College's willingness to revise assessment practices to achieve improvements in the quality and comprehensiveness of its assessment overall. The team found all those interviewed during the assessment visit, spoke convincingly and coherently about the case for change and improvement and the means to do so.

Developments have been well considered and appropriate for the current practice of postgraduate medical education. Such developments have naturally brought about challenges and the College has been willing to grapple with these. The team found that the College is striving to provide a contemporary and comprehensive assessment program, while balancing important issues such as retaining flexibility for registrars and ensuring feasibility in delivery with available resources.

Since 2010, there have been a number of developments in the assessment strategies which have maintained the focus on the alignment of assessment to the curriculum. The team commends the College's work in this area.

The team acknowledged that there are logistical challenges in meeting the needs of registrars who are practising in rural and remote contexts. The College has adhered to the principle of allowing registrars to perform their training and assessment in their own locality. In particular, this has brought challenges in maintaining the delivery of high-quality summative assessments in the workplace.

There are two major areas which need to be the focus of future assessment changes. In making these recommendations, the team acknowledges the significant practical and logistical burden involved with training in rural and remote locations.

Firstly, as ACRRM continues to grow, the College should review the assessment program overall to consider how comprehensive and sustainable the assessment suite is. The need for this has become evident with the introduction of summative workplace-based assessments which are currently conducted by a designated group of trained assessors. As part of this, the process for the provision of feedback on assessments should be reviewed and revised. This is referred to under standard 5.2.

The other area which the College should consider is the balance in its assessment portfolio between simulated/theoretical assessment and more authentic competency-based or performance-based assessment modalities. This can involve a review of whether the Structured Assessment using Multiple Patient Scenarios (StAMPS) examination can feasibly be expanded to routinely include some competency testing. The College should continue to use external expertise to provide objective guidance on the development of its assessment practices. An integrated approach to assessment blueprinting across all modalities should assist in creating an assessment suite that is well balanced and comprehensive. Continuing review and monitoring of cross-

disciplinary appropriateness and equivalence should also be performed as part of the 2015 review of all Advanced Specialised Training assessments.

The AMC will require updates on these developments in forthcoming progress reports.

### 5.1.5 Components of the assessment program in 2010

*The Multiple Choice Questions (MCQ) examination is conducted through a secure website with the registrar located in or near their home community. It is a three-hour examination and consists of 125 questions of the 'type A' style. Questions mostly consist of a clinical case presentation, a brief targeted lead-in question with four or five options, from which registrars are required to choose the single best option. There are no negative marks for incorrect answers.*

*The Structured Assessment using Multiple Patient Scenarios (StAMPS) examination aims to test higher order functions in a highly contextualised framework, where registrars have the opportunity to explain what they do and demonstrate their clinical reasoning. The examiners also ask the registrars how they would deal with system or patient factors that prevented the 'standard' approach from being applied.*

*On the day before the examination, each registrar can access the 'appointment book' through a secure internet portal. This lists the 15 or more patients who have made an 'appointment' for a consultation with the registrar, details key logistical issues about the location where the examination is set, and an indicator of other relevant community factors that would suggest other more possible emergent presentations.*

*The examination is conducted by videoconference with each registrar in his/her home region and all examiners at the one examination centre. The registrars have one continuous videoconference connection, with examiners rotating between registrars so each registrar has a range of examiners. The registrars are provided with written documentation detailing the background information for each station at the start of the ten minutes of reading time, which precedes the first station. Each examination comprises eight, 10-minute stations, with another five minutes reading time between stations. Each registrar's performance is digitally recorded.*

*Each station is framed around an assessment target or goal. The scenario and questions are unfolding in nature, allowing information to be progressively revealed. Some involve a simulated patient, parent, colleague, nurse, etc. The remainder of the stations require the registrar to discuss the scenario directly with the examiner.*

*The tools to be used within practice are Mini Clinical Evaluation Exercise and Multi-source Feedback, both of which are recognised as excellent for the purpose of formative assessment.*

*For the **Mini Clinical Evaluation Exercise**, an assessor visits the clinical environment of the registrar and observes the clinical interactions between the registrar and their patients. The Mini Clinical Evaluation Exercise can be conducted in any clinical setting where the registrar sees patients including office-based practice, inpatient and outpatient hospital departments, home visits, as well as aged care and other settings.*

*Registrars arrange and complete the formative Mini Clinical Evaluation Exercise at a time of their choosing, and in accordance with the rules and regulations of their training provider. The registrar can complete the formative exercise when their medical educator visits or may choose another medical practitioner to complete the assessment. If the latter, the practitioner must be a fully trained general practitioner, or hospital-based senior registrar or consultant. Each Mini Clinical Evaluation Exercise can be completed as a single episode or consecutively as a series of exercises in a session. In each consultation, the assessor provides written and oral feedback using a standardised format.*

*For the summative Mini Clinical Evaluation Exercise the registrar selects a six-month period during which they would like to be examined after successful completion of 24 months of training. ACRRM selects a trained examiner for the process and negotiates a mutually convenient time and day to hold the three to four hour examination. At the start of the examination, the registrar provides the examiner with information on potential patients, with a set number of options for each examination location. The examiner selects the patients from this list. Until 2010, the examination consisted of five non-emergency interactions with five different patients and possibly up to three locations that have been previously agreed between the examiner and registrar. From 2010, the examination consists of nine cases. If there are insufficient patients, then the registrar is required to perform well person checks on any available staff members to ensure the required number of cases.*

*The* **Multi-Source Feedback** *is conducted for ACRRM under licence by Client Focused Evaluations Program. The examination consists of two key components, a colleague assessment tool and a patient assessment tool. The former involves a questionnaire sent out to 15 people (including doctors, other health care professionals, other work colleagues such as managerial or administrative staff), while the latter requires 50 patients to complete an anonymous questionnaire.*

*On the registrar's enrolment, Client Focused Evaluations Program contacts the registrar and requests the names and contact details of 15 or more colleagues. It sends the participating colleagues a questionnaire which asks them to score the registrar in 18 different areas. Client Focused Evaluations Program sends the registrar 50 patient questionnaires with detailed instructions on how best to arrange patient participation in an anonymous and ethical fashion. Each patient is asked to score the registrar in 12 different areas. All results are processed by Client Focused Evaluations Program. The registrar receives a detailed report, including a comparison of results against international benchmarks.*

*Registrars can take the formative MSFs at a time of their choosing in accordance with the rules and regulations of their training provider. Registrars can enrol in the summative MSF after successfully completing 24 months of training.*

*The College emphasises the importance of procedural skills acquisition for registrars completing training leading to Fellowship of ACRRM. Registrars' performances of skills is observed and recorded in the* **Procedural Skills Logbook**. *The Logbook lists procedural items identified as mandatory skills in the ACRRM Primary Curriculum which are required of all fellows of ACRRM regardless of their areas of special interest. Certification of*

*additional procedural skills, if mandatory for an advanced skills discipline, will be documented in course-specific logbooks.*

*Each registrar is provided with a printed logbook on enrolment, although they may request this up to 12 months before enrolment. The doctor who certifies the registrar has completed an item must be a FACRRM, general practitioner, registered specialist or a senior registrar in specialty training. Each of the specified items has a minimum level of competency that must be met before sign off. The four levels of competency are:*

- *performed to the standard of an independent general practitioner on a real patient, not just in a simulated environment*

- *performed to a pass standard in a certified course in a simulated environment*

- *performed under supervision to the standard of a general practitioner working under supervision*

- *assisted an experienced practitioner performing the task.*

### 5.1.6   2010 team findings

*The team congratulates ACRRM on the energy and rigour that has gone into the creation of the test bank for the Multiple Choice Question (MCQ) examination and approaches to data collection that will enable scrutiny of item performance and reporting of overall test performance. The team recognises the importance of this test as an anchor as other tests mature.*

*The team commends the approach to the development of the novel Structured Assessment using Multiple Patient Scenarios (StAMPS) examination. It looks forward to the College formally presenting this development in medical education research. The team acknowledges that the College will be able to increase the capacity of the examination as required into the future.*

*While it recognises that the rural and remote context can make the delivery of the Mini Clinical Evaluation Exercise difficult, the team recommends that ACRRM set a longer term goal to train local supervisors and other professionals to conduct the assessment within the normal working day.*

*Summative use of the Mini Clinical Evaluation Exercise is a relatively new departure and ACRRM will need to give careful consideration to the necessary range of assessors and wide sample of different clinical conditions to achieve reliability.*

*The team applauds the incorporation of multi-source feedback in the assessment of registrars' performance. Multi-source feedback will be a new experience for registrars and trainers alike, and ACRRM will need to give high priority to training for giving feedback if it is to avoid unintended harm to registrars or clinical teams. This will particularly be the case when the College is assessing more candidates by this tool and when senior fellows are providing the feedback. Supervisors need to be trained for the possibility of both highly performing registrars being destabilised by a negative comment, and registrars' demonstrating resistance or failure to hear and act on feedback. Best practice requires that difficult feedback is never sent directly to the registrar but that the registrar is able to discuss the feedback with a trained supervisor in supportive circumstances.*

*The team is concerned that it is possible to 'fail' the multi-source feedback and recommends the College change the marking from pass/fail to satisfactory/raises concerns. This would align with the College's stated view that these assessments are intended to flag concerns and to lead to their being addressed. Concerns raised in a multi-source feedback usually are in the areas of clinical competence or professionalism. ACRRM's assessment framework should include policy on how concerns in these areas are addressed. Performance in other components may support the multi-source feedback data, and decisions about progress will best be discussed at Assessment Committee level.*

*The team found that registrars were confused about the logbook, including whether the appropriate version is the paper or online version. Many supervisors were unaware of this tool. In its March 2011 update to the AMC, ACRRM outlined changes to improve the online version of the logbook and to provide a new logbook guide.*

*The team was surprised by the emphasis given to the logbook record, as currently structured, in the assessment of practical and procedural skills. While the logbook is a useful tool, it does not provide the capacity to analyse all components of undertaking a procedure. The team would expect the College to develop appropriate tools as a priority. Recognised tools are utilised in other specialty training programs in Australia such as surgery and emergency medicine.*

### 5.1.7  Components of the assessment program in 2014

The assessment system is maturing and, along with it, all policies and processes are being developed to a sophisticated level. A relatively small cohort of fellows is building considerable expertise in the creation and management of assessment tools and is steadily building assessment items that can be banked. The new operational structure for assessments provides a clear framework and outline of discrete areas of responsibility.

A small group is focussed on creating high quality multiple choice question (MCQ) items and is building expertise in this process. All MCQs now have four options and this is considered to have improved the overall quality of the items used. In general the College follows the principle that the number of options should be appropriate for each question. The team recommends that the evidence for the improvement in item quality should be gathered and presented in future progress reports.

Mock examinations have been introduced to assist with examination preparation providing feedback and focus opportunities for registrars.

The Structured Assessment using Multiple Patient Scenarios (StAMPs) examination is now run face-to-face as well as in online format. The experience of the online format has been used as the basis of the face-to-face examination and is managed effectively. Examiner recruitment and training remains a focus, and the College is actively recruiting more junior fellows to become engaged in assessment practices to assist with issues of system sustainability.

The mini clinical evaluation exercise (mini-CEX) assessments have been developed in form and structure and have been run as summative assessments for training. While the logistics are challenging for a geographically dispersed group of registrars, the mini-CEX

has been positively received as an assessment modality and appears to be having a positive impact on learning.

The multi-source feedback (MSF) assessment is now well embedded in the College's processes with a revised assessment grading implemented. The administration and conduct of this assessment has been working well for registrars and assessors and benchmark data helps to provide meaning and context to the assessment and the follow-up plans for development made subsequently. The Procedural Skills Logbook has also received attention and the College's considerable work in this area, including online monitoring to improve user satisfaction, is noted.

### 5.1.8   2014 team findings

As the assessment systems mature, the College has continued to invest a considerable amount of development energy into creating high-quality assessment materials.

The College's online record and content management system has been rebuilt and the new Customer Relationship Management (CRM) system is due for launch in February 2015. This is a fully integrated system that will allow all registrars to access their training records, learning materials and all online assessments. The College should consider prioritising its examination management processes in subsequent phases of online CRM system development. The College will be required to report to the AMC on the implementation of this system and its impact on program efficiency and user satisfaction.

Equally, now that the College has improved both access to and content of assessment orientation materials, it should be able to focus on completing its online supervisor training modules. These will assist further to provide consistent assessment and feedback experiences for registrars, particularly in the workplace.

Mock examinations have proved to be popular with registrars in all pathways. From the mock examinations, study groups are formed using the results as the basis for educational planning. This is a sensible approach and a practical means to breach any perceived divide between training and assessment. The AMC looks forward to learning how this develops over time including further review of any impact this has on assessment outcomes.

The multiple choice question system is developing effectively under the stewardship of a small committed group of fellows. This appears to be promoting best-practice with appropriate quality assurance systems in place using examination and item performance data. The College is positive about including less senior fellows in the assessment item generation process and this is commendable, along with the other appropriate quality assurance and monitoring processes that have been put in place to cultivate an increasingly robust set of processes into the future.

The low pass rates for the Structured Assessment using Multiple Patient Scenarios (StAMPs) examination (particularly for Independent Pathway and Emergency Medicine candidates) has been investigated thoughtfully by the College. In particular, a thorough review of the quality and standard of the Emergency Medicine StAMPS was conducted and the College was satisfied that the standard is appropriately set. The College has

subsequently focussed its efforts on adequate preparation and preparedness of the candidates including a review of recognition of prior learning (RPL) requirements. The 2013 *Recognition of Prior Learning Policy* indicates that RPL may be reviewed by the College if progress in training and assessment is not satisfactory.

The team commends the professionalism with which the StAMPs examinations are administered. Running these examinations in online and face-to-face formats has been developed to accommodate candidate demand. This adheres to the principle that registrars should be able to complete all areas of their program from their site of choice. The team observed exemplary examiner behaviour and conduct in examinations and this reflects well on the examiner preparation process. The College is encouraged to maintain its examiner recruitment and training strategies to ensure longer term sustainability of the formal examinations.

The College has begun work to review the outcomes of its examinations and to use this information to plan the development of targeted learning materials. This approach is considered, creative and designed to improve learning. The College is encouraged to monitor and evaluate the effectiveness of this approach.

The College is to be commended on the clarity of material to support registrars and members. Examples include online support including material on the College's website, guidelines available for mobile devices and online education modules. The College is also commended on its early work to review the outcomes from assessments and match these to curriculum enhancement activities (current examples include dermatology and women's health).

In terms of progress with the College's workplace-based assessments, multi-source feedback (MSF) now requires a 'satisfactory completion' grading as a course completion requirement which addresses the AMC's previous concerns about assessment outcomes (condition 12). Completing the summative mini clinical evaluation exercise (mini-CEX) is considered by the College to be difficult to sustain in the longer term due to the need to provide external assessors to conduct the assessments. Various logistical variants have been trialled including the performance of the assessments on healthy colleagues. The number of times that this option has had to be taken is minimal to meet the assessment requirements for any particular registrar. The College has also run a trial of videotaping mini-CEX encounters but problems were experienced around understanding relevant clinical context and associated reasoning and also observing clinical examination and obtaining patient consent were issues. The ability to sample a relevant range of patient presentations was also considered to be problematic.

In 2015, case-based discussion (CbD) will be run as a trial in workplace-based assessment with a view to replacing the summative mini-CEX. The CbD assessments will be performed by telephone and will sample a range of cases. It is proposed that three one-hour discussions will occur in which the assessor will explore in depth two (of four) clinical cases. The genuine and considerable disadvantage of this proposal is that it would result in there being no direct observation of a registrar's clinical interactions across the College's assessment program.

The team was pleased to see that the Procedural Skills Logbook has been reviewed and augmented to include physical examination and a reviewed set of procedures. The mini-CEX assessment form has also been reviewed and expanded to include more components of physical examination. It is considered that this may, to some extent, mitigate against issues caused by removing direct observation of clinical practice in the formal assessments.

Other supporting materials were reviewed and found to be of high quality such as the online module on mini-CEX which includes a range of calibration and orientation video material. The preparation of all assessors is comprehensive and professional and examiner conduct at the examinations observed by the team was considered to be exemplary.

Assessor training and ongoing review across all College assessments is both comprehensive and appropriate. The hierarchy or progression from being a StAMPS assessor to a workplace-based assessor is working to maintain a skilled and growing assessor pool. Undoubtedly this approach has also assisted in gaining acceptance for formal workplace-based assessment. Now that the assessments are becoming more firmly established it may be possible to consider alternative entry points to College assessor roles. This would assist with sustainability, feasibility and succession planning without necessarily impacting on either quality or reliability. In 2010, the AMC recommended that the College consider training local assessors to conduct mini-CEX within the normal working day rather than relying on external assessors, which the College now does. It introduced compulsory formative mini-CEX of at least six consultations in 2012. The College indicated that if it introduced case-based discussion, it would require additional mini-CEXs conducted by local assessors with a focus on physical examinations.

## 5.2    Performance feedback

The accreditation standards are as follows:

- The education provider has processes for early identification of trainees who are under performing and for determining programs of remedial work for them.
- The education provider facilitates regular feedback to trainees on performance to guide learning.
- The education provider provides feedback to supervisors of training on trainee performance, where appropriate.

### 5.2.1  Feedback and performance in 2010

*Registrars appear to receive good feedback, particularly on the summative assessments.*

*This capacity appears to depend on the skills and enthusiasm of a small number of assessors. As the numbers of registrars grows, it will be important that supervisors and other clinical teachers receive training in providing feedback to ensure consistency and the ability to maximise the educational opportunities.*

### 5.2.2 *Feedback and performance in 2014*

In its 2010 review, the AMC recommended that the College set in place processes to ensure that its supervisors provide regular feedback to registrars on their progress and provide training to supervisors in giving feedback (condition 14). The College satisfied condition 14 in 2012. The College's Accreditation Management Agreement clearly describes the responsibilities of regional training providers (RTPs) in the accreditation of teaching posts and supervisors. Each RTP sends the College an annual report detailing the relevant accreditation activities undertaken and the collated feedback from supervisors and registrars in all accredited posts.

The College was asked to report on the implementation of the *Independent Pathway Active Training Policy* and other mechanisms to monitor the progress of registrars on the Independent Pathway (condition 13). In 2012, the College commenced a review to identify those registrars with outstanding training and assessment requirements. The review identified that the majority of registrars had completed their training requirements but were finding the assessments a barrier to completion. In its 2013 progress report to the AMC, the College reported on a range of initiatives to assist registrars including implementing study groups, the Structured Assessment using Multiple Patient Scenarios (StAMPS) examination coaching, assessment preparation and remediation programs. In addition, a Registrar Review Panel was established to monitor registrars considered to be not progressing in accordance with the *Active Training Policy*. The 2014 team reviewed the implementation of these initiatives and considered condition 14 from 2010 as satisfied.

The College's commitment to providing individualised feedback to registrars at all points in the assessment process is acknowledged. The College has clearly given considerable balanced thought to the means by which it provides feedback to registrars. It is expected that all examination candidates receive feedback via their medical educator. Previously candidates who did not achieve a pass grade could request teleconference feedback from one of the principal examiners.

While these systems are comprehensive, the College is, quite rightly, reviewing feedback as a whole to consider sustainability and how to derive the most overall benefit for candidates. There are components of the current feedback processes that are very labour intensive but probably of limited value to individual registrars.

As an example of where a revision is being considered, a trial has been run in 2014 in which standardised written feedback is provided for an examination. In this feedback, general issues are highlighted to all candidates in the first instance. After this has been supplied, candidates can request an individual teleconference to review their own performance. To date there have been relatively few requests for teleconference follow-up. This general written feedback has also been provided to the training providers. Candidates who fail at the examination and request a feedback session are asked to complete a reflection and self-assessment. This encourages self-direction and clear identification of strategies to prepare more effectively for future examination attempts.

Such reviews and modifications to feedback are considered very appropriate. Subsequent progress reports to the AMC should include information on the revised processes developed.

### 5.3 Assessment quality

The accreditation standards are as follows:

- The education provider has a policy on the evaluation of the reliability and validity of assessment methods, the educational impact of the assessment on trainee learning, and the feasibility of the assessment items. It introduces new assessment methods where required.

#### 5.3.1 Assessment quality in 2010

*The team acknowledges the College's substantial efforts in developing the program of summative assessment. The College already has in place an approach that will generate good data about the quality of the program and its components. As the College's experience develops, the team expects the College will be able to make a substantial contribution to the research base in the assessment of clinical competence and performance.*

#### 5.3.2 Assessment quality in 2014

The team noted the ongoing developmental work on all components of assessment planning, delivery and links to learning for registrars. The College continues to engage with experts in the field and also to develop its own in-house expertise. The College should continue to involve educational expertise in the decision-making around major changes to the assessment suite and to provide a coherent rationale for doing so. The College should also be encouraged to continue and grow the endeavours to publish current findings in assessment. In doing so it should seek to engage fully in the academic community of practice across Australia and internationally.

The College is considering the way in which increasing numbers of registrars are being dealt with and planned for. Ongoing attention will need to be paid to this. Staff workloads and succession planning in relation to assessment changes and developments will need to be considered, supported and proactively monitored.

The development of integrated systems to administer, manage and monitor all assessments including the formal examinations should be considered a priority in the next phase of the Customer Relationship Management (CRM) system development for the College.

Major changes are planned for the College's formative and summative workplace-based assessment requirements. These will need to be monitored during implementation for factors such as impact on learning, reliability (for summative components) and feasibility. The College's proposal to remove summative mini clinical evaluation exercise should be re-examined, given its relevance to the registrar's actual clinical practice. There is merit in determining whether this could be retained without the current onerous burden on a limited group of assessors and the resources to get these assessors into the candidate's workplace. Cognitive alignment of scales and an expanded pool of local assessors are both worthy of exploration. These would need to encompass all aspects of the workplace-based assessment system including multi-source feedback.

## 2010 Accreditation Conditions and Recommendations

*2010 Commendations*

L        The approach to the design of the assessment program.

M       The assessment blueprint which demonstrates the relevance of each assessment modality to the domain learning outcomes.

N        The novel Structured Assessment using Multiple Patient Scenarios examination.

*2010 Conditions to satisfy accreditation standards*

12       Change the way the College grades the multi-source feedback assessment from a grade of pass or fail to a grade of satisfactory or raises concerns. (Standard 5.1.2)

13       Report on the implementation of the *Independent Pathway Active Training Policy* and other mechanisms to monitor the progress of registrars on the Independent Pathway. (Standard 5.2)

14       Set in place processes to assure the College that supervisors are providing registrars with regular feedback on their progress and offer ACRRM-accredited supervisors training in providing feedback to ensure consistency and to maximise the educational opportunities. (Standard 5.2)

*2010 Recommendations for improvement*

LL       Make stronger connection between the assessment blueprint and the detailed content of the curriculum statements, not just the blueprint and the 72 learning outcomes defined under the domains. (Standard 5.1)

MM     In the longer term, train local supervisors and other professionals to be able to conduct the Mini Clinical Evaluation Exercise within the normal working day rather than rely on an assessor brought in for the purpose. (Standard 5.1)

NN      In recognition that the summative use of Mini Clinical Evaluation Exercise is relatively new, consider the appropriate range of assessors and the breadth of the sample of clinical conditions necessary in order to achieve reliability. (Standard 5.1)

OO      Enhance capacity to assess registrars' practical and procedural skills. (Standard 5.1.2)

The 2014 team considers conditions 12, 13 and 14 from 2010 have been met.

## 2014 Accreditation Conditions and Recommendations

*2014 Commendations*

L        The College's ongoing commitment and development activity to build a comprehensive set of professionally managed and administered assessments that cover all curriculum components and the implementation of a revised operational structure which provides clear areas of responsibility and transparency in process.

| M | The extensive revisions to the Procedural Skills Logbook in terms of both format (online) and content (inclusion of physical examination and a revised set of procedures). |
|---|---|
| N | The College's extensive work to prepare candidates effectively for examinations including the provision of mock examinations and tailored study group activity. |
| O | The review of assessment outcomes for both the suitability of the standard being applied and the availability of suitable examination preparation resources and processes should benefit the College and its registrars. |
| P | The Structured Assessment using Multiple Patient Scenarios (StAMPS) examination, run in both face-to-face and online formats to provide registrars with maximum choice in terms of location and format of examination. Both formats are run with notable professionalism and consistency from all involved including College staff and examiners. |

*2014 Conditions to satisfy accreditation standards*

| 7 | Review the balance in the assessment portfolio between simulated/theoretical assessment versus more authentic competency-based or performance-based assessment modalities and as part of the review of all Advanced Specialised Training disciplines. (Standard 5.1.2) |
|---|---|
| 8 | Progress and report on outcomes of the effectiveness of the case-based discussion assessment trial and decision whether to remove the summative mini clinical evaluation exercise (mini-CEX). (Standard 5.3) |

*2014 Recommendations for improvement*

| JJ | Develop an integrated online module in the next phase of the Customer Relationship Management (CRM) system development to better support examination management and data integrity. (Standard 5.1) |
|---|---|
| KK | Delay the development of selection tests into training until the assessment suite has reached a steady and stable state and the necessary reviews (of feedback, balance and clinical performance) have been completed. (Standard 5.1) |
| LL | Develop the systems by which blueprinting at the test level occurs. (Standard 5.1) |
| MM | Complete the planned review of assessment feedback processes overall with a view to streamlining and ensuring long-term sustainability. (Standard 5.2) |
| NN | Train local assessors to conduct the mini clinical evaluation exercise within the normal working day rather than relying on external assessors. (Standard 5.3) |
| OO | Complete the planned online supervisor/assessor module maintaining a focus on providing feedback on assessments and strategies to enable registrars to effectively plan their own learning using the College's learning plan approach. (Standard 5.3) |
| PP | Review and present evidence for the improvement in item quality for the Multiple Choice Question Examination. (Standard 5.3) |

### 5.4 Assessment of specialists trained overseas

The accreditation standard is as follows:

- The processes for assessing specialists trained overseas are in accordance with the principles outlined by the AMC and the Committee of Presidents of Medical Colleges Joint Standing Committee on Overseas Trained Specialists (for Australia) or by the Medical Council of New Zealand (for New Zealand).

#### 5.4.1 Overview of assessment pathways for International Medical Graduates in 2010

*The AMC assesses or oversees the assessment of the knowledge, clinical skills and professional attributes of international medical graduates (IMGs) who are seeking registration in medicine in Australia. The Council of Australian Governments agreed on a consistent national approach to the assessment of international medical graduates with effect from 1 July 2007. Under this approach, international medical graduates may be assessed under the following four pathways:*

- *Competent Authority Pathway: The Competent Authority Pathway is for international medical graduates applying for non-specialist positions, or, for those international medical graduates working in general practice area of need positions (as deemed by the relevant state office of the Australian Health Practitioners Regulatory Association) and who have completed specified training and assessment through approved overseas 'competent authorities'.*

- *Standard Pathway (AMC Examination): The AMC administers national examinations of overseas-trained medical practitioners who want to practise medicine in Australia, but whose basic medical qualifications are not recognised by the Medical Board of Australia.*

- *The Standard Pathway (workplace-based assessment) is intended for international medical graduates who are not eligible for the Competent Authority or Specialist Pathways, who are seeking general registration in Australia and who have obtained the appropriate category of limited registration from the Medical Board of Australia to be employed in the approved clinical position for workplace-based assessment.*

- *Specialist Assessment Pathway and Area of Need: Applicants for specialist assessment are expected to have satisfied all the training and examination requirements to practise in their field of specialty in their country of training. The standard applied to the assessment of overseas-trained specialists is the standard required for admission as a fellow to the relevant Australian specialist medical college. The documentation requirements and arrangements for processing Area of Need Specialist Pathway applications are broadly similar to those for applications through the Standard AMC/Specialist Pathway for overseas-trained specialists, with some differences because of the need to process Area of Need Specialist Pathway applications rapidly and in parallel with the assessing college.*

#### 5.4.2 The College's assessment role in 2010

*ACRRM has recently established an international medical graduate assessment program and, in September 2009, gained provisional accreditation from the AMC for a pathway for accreditation of specialist general practitioners trained overseas. As such, the processes*

*are in accordance with the principles outlined by the AMC and the Committee of Presidents of Specialists Colleges Joint Standing Committee on Overseas Trained Specialists.*

*Medical practitioners with qualifications in General Practice gained outside Australia apply through the AMC for recognition as a specialist General Practitioner. They may choose to be assessed for recognition by either ACRRM or RACGP. If the candidate chooses ACRRM, they submit evidence of their previous training and experience to the AMC, including a structured application form for ACRRM. This application form addresses five domains relevant to rural general practice.*

*The AMC checks that the doctor is eligible for the pathway, including that the applicant holds a specialist qualification in general practice. It then verifies the doctor's qualifications. Concurrently, the ACRRM censor or their nominee investigates and assesses the quality of their experience based on the evidence presented.*

*If the College determines the documentation does not represent appropriate qualifications and/or experience, the application is rejected and the AMC is notified. The candidate may seek registration via one of the other relevant pathways of the AMC.*

*ACRRM invites doctors whose experience and qualifications are thought acceptable for potential fellowship to an interview with a panel comprising three fellows of ACRRM. A rating guide for interview panel members clearly articulates the skills, knowledge and attitudes (aligned with ACRRM domains of practice) by which the applicant will be rated. During the interview, a refined mapping process is undertaken to assess the level of the candidate's functioning as a potential rural general practitioner including identifying areas of concern and establishing a recommended learning plan.*

*If deemed substantially comparable, candidates must complete the following: undertake twelve months of supervised practice, which may have remote supervision; implement their learning plan; and undertake the College's multi-source feedback, reported at three, six and 12 months*

*If deemed partially comparable, the candidate must undertake up to two years of supervised practice; implement a learning plan which will include an higher number of identified learning objectives in comparison with those deemed substantially comparable and undertake a variable, but specified range of College assessments.*

*At the end of either period, if the candidate is deemed successful, ACRRM reports concurrently to the AMC and the Board of ACRRM. Fellowship of the Australian College of Rural and Remote Medicine may then be conferred.*

*Mechanisms for remediation are currently being addressed by the College. This may include being offered training with ACRRM on an alternative training pathway.*

*At the time of the Team's assessment in March 2010, ACRRM had not developed a Competent Authority Pathway for international medical graduates seeking non-specialist registration. In August 2010 the AMC granted initial accreditation to the College to conduct assessment for international medical graduates wishing to work in General Practice under the Competent Authority Pathway. International medical graduates who*

*are eligible for the Competent Authority Pathway in General Practice are not required to pass the components of the AMC Examination to be registered for area of need, but must satisfactorily complete a period of workplace-based performance assessment with an accredited authority.*

### 5.4.3   2010 team findings

*In March 2010, the ACRRM process for assessment of overseas-trained specialist general practitioners was untested. As such, the team was unable to discuss the process with any candidates, supervisors, RTPs or consumers.*

*Of note, however, prior to the introduction of this pathway, a number of international medical graduates gained entry to the Independent Pathway of ACRRM training, often with significant recognition of prior learning. The registrars in this situation who gave feedback to the team expressed the view that the College had given them significant levels of support and recognition in their goal to attain an Australian fellowship. With the development of the College's specialist assessment pathway and the competent authority pathway, and in keeping with the nationally agreed approach to the assessment of international medical graduates, the College will need to review the place of the Independent Pathway as a pathway for training and assessment of international medical graduates. The AMC's recommendations on this pathway are given in Standard 3 of this report.*

*The new process for assessment of overseas-trained specialist general practitioners appears to be robust. With implementation, further information will allow this to be judged further.*

*The team considered it important that ACRRM address the issues of appeal and remediation to allow adequate feedback to the practitioners involved in the process. This should be possible at three points in the pathway:*

- *at the point of rejection of initial application*

- *following the panel interview*

- *during the supervised period; potentially via existing mechanisms within the College.*

*This should allow the practitioner to be aware of areas of weakness or concern and the means by which they may address these.*

*The AMC will require further feedback from the College regarding the implementation of the process in periodic reports, including feedback information from all stakeholder groups.*

### 5.4.4   The College's assessment role in 2014

The College reported that one of its biggest challenges has been the development of a comprehensive system for assessment of international medical graduates over the last few years. The team determined that the systems are now comprehensive and effectively administered. The amount of assessment activity in this area is still relatively small and is therefore manageable. The College has shifted its focus from development to governance and impact and this is considered appropriate. Ongoing sustainability

should also be considered to avoid growth exceeding capacity at any stage although this is not considered to be a current risk.

From an operational perspective, the College considers it is well equipped to respond to AMC requirements and that this is attributable in part to having effective lines of communication with both the AMC and the Australian Health Practitioner Regulation Agency.

International medical graduates applying for registration to practise in Australia via the College's Standard Pathway must attain a satisfactory outcome in a pre-employment structured clinical interview (PESCI). The PESCI is a fitness for task assessment/interview where the panel assesses the candidate's skills, knowledge and experience for the position for which they are seeking registration to practise in Australia. The interview panel comprises three people (three ACRRM fellows or two ACRRM fellows and one community representative). Each interview takes approximately 90 minutes and includes questions-and-answers and discussions based on three to four different clinical scenarios.

The College has introduced changes to supervisor reports, moving away from the PESCI 'tick box' approach in an attempt to obtain better feedback. Learning plans require evidence of participation and outcomes and this same learning plan populates the supervision report. While there are a key set of activities that form the basis of the learning plan for many international medical graduates (most notably the online Indigenous Health modules, Rural Emergency Obstetrics, Rural Emergency Skills Training and Advanced Life Support courses) there is a clear rationale for their choice. The College has approval to provide pre-employment structured clinical interviews through a separate AMC accreditation process.

Follow-up with international medical graduates occurs through their learning plan and individuals have clear contact points and follow-up with the College. International medical graduates participate in the same assessment program as all other ACRRM registrars, including joining the wider cohort in study groups, mock examinations and examinations. Prior to enrolling in assessment, candidates must have completed a portion of their peer review period specified in their requirements.

In July 2013, the College was approved by the AMC to undertake ad eundum gradum assessment for general practice. The Ad Eundum Gradum Pathway enables experienced general practitioners from New Zealand and family physicians from Canada to be recognised as specialists without assessment or examination.

This pathway is for holders of the:

- Fellowship of the Royal New Zealand College of General Practitioners (FRNZCGP); or
- Certificate in Family Practice from the College of Family Physicians Canada awarded post 1992 (CCFP).

The College also submitted a proposal for an ad eundum gradum pathway for Fellowship of the Division of Rural Hospital Medicine, Royal New Zealand College of

General Practitioners. The AMC determined that this fellowship was not equivalent to ACRRM fellowship.

The approved Ad Eundum Gradum Pathway for New Zealand and Canada is reported to be working well and is considered to be a rigorous process which includes referee reports and interviews. Reciprocal arrangements are not of necessity but are in place. The College plans to negotiate around qualifications from other countries in the future. The College maintains a contemporary 'codified list' of international qualifications in family medicine and has communicated with each of the specialist colleges about this list. The codified list is routinely reviewed and has undergone two review cycles since its inception. The plan is to continue to do so to maintain its contemporary focus. Current work is being conducted as a result of an invitation from the Norwegian Parliament for example. Qualifications from other jurisdictions (for example, Ireland) are currently under investigation for their suitability for recognition.

The College adheres to the ethical requirements outlined in the Melbourne Manifesto of 2002[3], adopting the principle that medical organisations in the developed world should not recruit from the developing world and that if they do there should be some reciprocal contribution. For example, international medical graduates from South Africa can return to their own country and undertake a service placement. This option is available but has not been taken up as yet.

The AMC recommends that the College update the AMC about the outcomes of all this work including the uptake of options such as that described for South African doctors.

The team found that there was strong support from the clinical sector for the College process with employers satisfied that they can accept international medical graduates from this process into their hospitals.

### 5.4.5 2014 team findings

The College's international medical graduate process has reached a stage of maturity and stability. It is nested neatly into the overall system of assessment across the College and is being managed effectively.

Participants in the international medical graduate assessment process should continue to benefit from enhancements that are underway in the College – particularly the increasing data available to benchmark local multi-source feedback data and assessment preparatory materials and processes.

**2010 Accreditation Conditions and Recommendations**

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*2010 Commendations*

O    The work to begin to implement a robust process for the assessment of overseas-trained specialist General Practitioners.

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[3] World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA). *A Code of Practice for the International Recruitment of Health Care Professionals: The Melbourne Manifesto*. WONCA, 2002.

*2010 Conditions to satisfy accreditation standards*

Nil

*2010 Recommendations for improvement*

PP    Continue to develop mechanisms for feedback to overseas-trained general practitioners at key points in the assessment process. (Standard 5.4)

There were no conditions from 2010 in relation to Standard 5.4.

## 2014 Accreditation Conditions and Recommendations

*2014 Commendations*

Q    The College's effort to create individualised learning plans for international medical graduates, and the resources and support provided to assist candidates meet their learning needs and assessment goals.

*2014 Conditions to satisfy accreditation standards*

Nil

*2014 Recommendations for improvement*

QQ    Monitor the use and effectiveness of the individualised learning plan for international medical graduates. (Standard 5.4)

# 6 Monitoring and evaluation

## 6.1 Monitoring and evaluation

The accreditation standards are as follows:

- The education provider regularly evaluates and reviews its training programs. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.

- Supervisors and trainers contribute to monitoring and to program development. Their feedback is systematically sought, analysed and used as part of the monitoring process.

- Trainees contribute to monitoring and to program development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training program to ensure that existing trainees are not unfairly disadvantaged by such changes.

- The education provider maintains records on the outputs of its training program, is developing methods to measure outcomes of training and is collecting qualitative information on outcomes.

- Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.

### 6.1.1 Monitoring and evaluation of the training programs in 2010

*ACRRM's accreditation submission described a number of recent reviews of components of the training pathways leading to fellowship of ACRRM.*

*The ACRRM Primary Curriculum, published in 1998, was reviewed in 2003 and was again being reviewed at the time of the team's assessment. According to the College's timeline for completion of this review, wide ranging stakeholder consultation and comparison with comparable curricula was to be completed by August 2010, with a decision at that stage on whether further rewriting is required. The College had completed minor editing of the Primary Curriculum to ensure consistent language and terminology when the team completed its assessment. The Advanced Specialised Training Curricula were also under review.*

*ACRRM has also reviewed its training program requirements against those of other comparable general practice vocational training programs to compare curriculum, training program content, accreditation, assessment, evaluation and outcomes.*

*The College completed a review of the Independent Pathway in 2008, and closed the pathway to applications during the review. This review resulted in enhanced support and structured learning activities for registrars on this pathway.*

*The ACRRM Professional Development Program Committee reviewed the Professional Development Program in 2007 with stakeholder input.*

*The College's Vocational Training Committee undertook a review of the Standards for Teaching Posts and Teachers in Rural and Remote Medicine prior to the team's assessment.*

*In addition, the College has a number of more routine evaluation processes:*

- *There is a regular process for seeking registrar, examiner, invigilator, item writer and editor feedback through an online survey after assessments are completed. For multi-source feedback (MSF), ACRRM conducts evaluations in partnership with the organisation that has licensed ACRRM as an MSF provider.*

- *There is a regular cycle of review of assessment items.*

- *ACRRM Standards for Teaching Posts and Teachers in Primary Rural and Remote Training indicate that posts and supervisors should be accredited on a three-year cycle although, as noted elsewhere in the report, a three-year review had not been achieved for many posts and supervisors.*

- *The Professional Development Program includes a participant survey in its review cycle, with the most recent survey in September 2008.*

*ACRRM also provides for stakeholders to submit feedback on ACRRM activities anonymously via its website.*

*While the College is undertaking much of this review and development work internally, it has also employed external consultants and medical educators to assist as necessary.*

### 6.1.2   2010 team findings

*In its accreditation submission, ACRRM recognises that there is a need to establish a more systematic approach to monitoring and evaluating the training pathways. This is particularly so as ACRRM's approach to training continues to evolve. During the accreditation assessment, the College presented a draft ACRRM Evaluation Plan 2009–2011 which was to set a framework for regular, systematic monitoring and evaluation of ACRRM programs. The draft plan covers the following programs and processes:*

- *Vocational Training Program.*

- *Vocational Training Program Assessment processes.*

- *Overseas Trained General Practitioner Specialist Assessment Pathway.*

- *Professional Development Program.*

*As noted in Standard 1 of this report, ACRRM has invested substantial resources in other education and training activities which are not directly part of this accreditation assessment. In an organisation with limited resources, the focus on these areas of activity has the potential to impact on the availability of resources to monitor, evaluate and improve the training programs. For this reason, the AMC suggests that ACRRM report on these developments as well.*

*The draft plan proposes review of the goals of the training program and the curriculum every five years, and reviews of the following every three years: assessment approaches; recognition of prior learning policy; and standards for training providers, posts and*

*supervisors; the criteria for selection to the Independent Pathway; and the Professional Development Program. Data collection methods and frequency of collection are described. The team considers that, if implemented, this has the potential to provide an appropriate framework for regular formal evaluation and improvement of the pathways to fellowship of ACRRM.*

*It is important that ACRRM prioritise resources to support implementation of the plan and ensure that evaluation drives changes. The AMC will wish to be informed in progress report of the implementation of the plan, and the outcomes of ACRRM's evaluation of its programs.*

*The draft plan rightly focuses on collecting feedback from registrars and supervisors, RTPs and General Practice Education and Training Ltd (GPET). Many of ACRRM's processes for seeking feedback from registrars, supervisors, and medical educators in regional training providers have been informal and ad hoc. Formalising these processes and reporting back to these stakeholders on the feedback and the College's response are important steps. As ACRRM's draft evaluation plan acknowledges, it will be important to establish efficient mechanism for communicating with stakeholders about how their program evaluations influence future changes. Web-based methods provide obvious opportunities for efficient and easy communication and ACRRM is well placed to communicate in this way.*

*Delivery of learning resources and management of registrars' progress relies heavily on the web-based Rural and Remote Medical Education Online (RRMEO) resource. The team was pleased that the College is proposing an annual review of RRMEO users to determine if it continues to meet training program needs.*

*The AMC requires colleges to provide opportunities for health care administrators, other health care professionals and consumers to contribute to evaluation processes. The team encourages ACRRM to develop more specific plans for engaging these stakeholders.*

*As noted elsewhere in this report, the general practice training environment is complex. GPET and the RTPs, as well as the two Colleges – ACRRM and the Royal Australian College of General Practitioners (RACGP) – set standards and requirements, and have roles in monitoring performance. In this environment it is essential that ACRRM work with GPET, regional training providers, RACGP, registrars and other key stakeholders.*

*GPET and the RTPs monitor and evaluate the delivery of training. GPET, as the organisation which funds and manages general practice vocational training, has a considerable role in the evaluation and quality improvement of general practice education and training. The Australian General Practice Training performance management system draws on a wide range of GPET and external data (such as Medicare and Department of Health and Ageing data) to assess the performance of the program and individual providers. GPET also runs annually a registrar satisfaction survey. GPET's Quality Framework guides the accreditation of training providers, as well as evaluation, improvement and reporting on general practice vocational education and training. This accreditation process and how it relates to ACRRM's role is discussed in Standard 8.2 of this report.*

*The team notes that ACRRM's Standards for Regional Training Providers Recognition requires training providers to have an evaluation framework which includes a supervisor survey. ACRRM indicated that the results of these surveys would be reviewed during the process of training provider reaccreditation.*

*There are some commendable evaluation processes within Australian General Practice Training (AGPT), and the AMC would encourage appropriate collaboration between AGPT and ACRRM to enable sharing of relevant data. Nevertheless, ACRRM needs to articulate its responsibilities for evaluation, monitoring, and addressing concerns about the training delivery. While much of the training is delivered via RTPs, and GPET evaluates their performance, ACRRM must have processes to assure itself that RTPs are delivering education and training to ACRRM standards, and that registrars are able to meet ACRRM curriculum and training experience requirements. It was not clear to the team what role ACRRM would play when registrars in any of the three pathways raised concerns that training standards, including supervision and teaching requirements, were not being met. How the College would address issues that require more immediate attention than is possible in the cyclical review of posts, supervisors and RTP performance also was not clear.*

*Registrars can provide feedback via the Registrar Committee and registrar representatives on the Vocational Training and the Assessment Committees. As noted in Standard 7 of the report these mechanisms require more support.*

*The College maintains records on the outputs of its training program. The College's accreditation submission included detailed data concerning the number of registrars entering the training program over the past few years by training pathway. Total numbers of registrars and numbers of graduating fellows for each year over the past three years were also provided.*

*The College keeps detailed records on examination success rates. It monitors the pass rates in annual assessments by training pathway. The data in the accreditation submission showed the pass rate for Independent Pathway registrars in some assessments, and particularly the College MCQ examination, to be low (9 of 23 sitting passed in 2008 and 12 of 19 passed in 2009). The AMC will be interested in the College's analysis of, and response to this data.*

*No formal qualitative information is collected on the outcomes of training, although ACRRM indicated that it was establishing processes that would enable measurement of the medium to long-term outcomes of training.*

### 6.1.3   Monitoring and evaluation of the training programs in 2014

The College's 2014 accreditation submission describes the various forms of monitoring and evaluation of its training programs. Essentially, the College provides three training pathways to fellowship, either directly via the Independent Pathway or indirectly via the Australian General Practice Training (AGPT) program (Vocational Preparation Pathway) and the Remote Vocational Training Scheme (RVTS) Pathway.

The College's ability to evaluate and monitor these programs depends on the specific pathway. The AGPT program is subcontracted to the RTPs through GPET and similarly

the RVTS is a separate Government-funded program. The Independent Pathway is delivered specifically by the College. The AGPT and RVTS programs are accredited by the Bi-College Regional Training Provider Accreditation Program involving the Royal Australian College of General Practitioners (RACGP) and ACRRM. A number of RTPs have recently been reaccredited by this program and it appears to be working well.

GPET surveys the satisfaction of registrars in its program and these survey results have been available to the College for the last 12–24 months. While this is a comprehensive survey run by a third party, it does not specifically identify the responses from ACRRM registrars, as opposed to RACGP registrars and thus is of limited value to ACRRM.

The College's own Independent Pathway which includes about 20% of all ACRRM registrars is accredited by the College using a standards framework. The College has had an Evaluation Coordinator in place since 2011 and has developed a range of monitoring and evaluation tools. The College compiled a comprehensive *Evaluation Report* (June 2014) for the period 2010–12, which not only provided information on the training pathway but also on the contribution of ACRRM fellows' qualifications to rural and remote areas, and how both programs and services could be improved. This evaluation used a mixed method and multisource evaluation design incorporating both qualitative and quantitative data and included feedback from participants in the program and other stakeholders using evaluation surveys and questionnaires. The 2014 *Evaluation Report* was compiled with direct reference to the *ACRRM Evaluation Plan 2012–2014*.

The College's *Evaluation Report* is structured around eight questions and includes the blueprint for the *Evaluation Plan* as well as a description of the evaluation activities undertaken between 2012 and 2014.

The questions addressed in the *2014 Evaluation Report* are:

- How is ACRRM contributing to the healthcare needs of rural and remote Australians and specifically in relation to its approach to the specialty of general practice?

- What are the professional characteristics of an ACRRM registrar and what do registrars do differently as a result of ACRRM training?

- What is the skill mix of an ACRRM fellow to improve and sustain the health care of rural and remote Australian communities?

- How does a FACRRM qualification in rural and remote areas benefit the Australian health system in terms of cost, efficiency and time?

- What is the career path of a rural doctor?

- Is ACRRM positioned as an authority/leader in rural and remote health nationally and internationally?

- How is ACRRM leading the way in innovative medical education?

- How efficiently are staff and resources being used?

- How can ACRRM programs and services be improved?

The activity reported in the 2012–2014 period describes a wide range of surveys in regard to placement, training activities and examination reliability analysis. Audits of

personal development plans, course evaluations, online services as well as staff and membership surveys are all part of the recorded activity.

In June 2014, the College introduced a Consumer Feedback and Needs Analysis Survey to seek comment on the College's Primary Curriculum and Advanced Specialised Training (AST) curricula as they relate to graduate and medical workforce outcomes and the overall performance of the College in terms of meeting community needs. The survey was distributed to key rural organisations with a role in allied health provision or as representatives of health consumers and available on the College's website for any interested persons. In November 2014, the College had received one hundred responses from healthcare consumers and providers from over 20 organisations. A formal report will be completed in April 2015.

An extensive review of the ACRRM Primary Curriculum involving all stakeholders concluded in 2013. The review process involved a comprehensive program of stakeholder engagement with:

- ACRRM membership
- teams drawn from the membership with relevant qualifications
- supervisors including representatives of regional training providers
- relevant community groups
- related medical colleges
- representatives of health and other related services.

In 2014, the College commenced its review of AST curricula. The review of the ASTs in obstetrics, surgery and anaesthesia will be undertaken in collaboration with the relevant Joint Consultative Committees. Further information is provided under standard 3 of this report.

The College has a cycle of review in place for all documentation relating to teaching standards. During the period 2011–13, the College completed the following activities in relation to the standards for supervisors and teaching posts:

- revision of standards for Primary Rural and Remote Training (PRRT)
- development of guidance for off-site supervision
- development of standards for Core Clinical Training (CCT)
- development of standards for supervisors and teaching posts for AST posts in the disciplines of emergency medicine, Aboriginal and Torres Strait Islander health, adult internal medicine, mental health, population health, remote medicine and surgery and paediatrics.

The College's assessment processes are developed and reviewed using continuous quality improvement principles. After each assessment the writers of multiple choice questions (MCQ) and/or Structured Assessment using Multiple Patient Scenarios (StAMPS) items examine how the items perform in order to improve the individual item if required and more generally improve skills in developing items. All StAMPS scenarios are tested prior to the assessment.

Following each assessment, registrars, examiners, invigilators, writers and editors are given the opportunity to provide anonymous feedback through an online survey. The process for ongoing evaluation of assessment modalities includes consideration of the educational impact of the assessment on registrar learning.

### 6.1.4   2014 team findings

In 2010, the AMC set four conditions on accreditation relating to the College's evaluation and monitoring processes, including to: implement a system framework for program evaluation (condition 15); articulate the College's role in addressing concerns about training standards across the three pathways (condition 16); implement processes for obtaining regular feedback from registrars and supervisors (condition 17); and implement processes for regularly obtaining comment from consumers, supervisors and non-medical professional on the curriculum (condition 18).

The College satisfied condition 16 in 2012 by reporting on processes for resolving accreditation issues raised by the training providers. The College satisfied condition 17 in 2013 by implementing both registrar and supervisor feedback surveys as part of its annual evaluation plan.

The 2014 team was impressed with the comprehensiveness of the evaluation and monitoring processes instituted by the College. The various reviews of the College since the 2010 AMC review have led to an iterative development and improvement in its processes in this area and it is now able to address a wide range of program outcomes.

While the *Evaluation Report* was complete in many respects, the team considers that having data regarding the number of registrars who complete the program in the defined minimum time, versus those who ultimately complete the program, would be useful, both from a horizontal perspective to compare with other similar programs and from a vertical perspective over time.

The team also recommends that where survey feedback or related indicators have identified issues, the College needs to implement processes to ensure a clearly articulated set of actions are put in place and connected to further evaluate and assess the desired outcomes.

In 2010, the AMC recommended that the College implement a systematic framework for program evaluation, with a particular focus on the use of evaluation information for program improvement (condition 15). It is the view of the 2014 team that this condition has been met and the evaluation framework provided addresses the issues raised in the 2010 assessment. Specifically the *Evaluation Report* demonstrates a thorough program evaluation and provides feedback on the learning platforms for registrars and the value of ACRRM registrars to rural and remote communities.

The College was also required to implement processes for regularly obtaining feedback on the curriculum from consumers, supervisors and non-medical health professionals and involving them in more formal program review (condition 18). The team notes the feedback on the ACRRM curriculum provided in the *2014 Evaluation Report* from the community, registrars and supervisors. Support for the Primary Curriculum is evident and the process appropriate. The 2014 team regards this condition as satisfied.

The team commends the College on the introduction of the Consumer Feedback and Needs Analysis Survey to seek comment on outcomes and the overall performance of the College in terms of meeting community needs. The formal report will be available in April 2015 and the AMC will be interested in the College's analysis and response to this data.

The team notes that despite the present Bi-College RTP Accreditation Program, the inevitable change of governance which is going to occur with the closure of GPET will mean additional effort is required by the College to develop and maintain an effective accreditation process which is able to ensure the consistent application of ACRRM standards.

## 2010 Accreditation Conditions and Recommendations

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*2010 Commendations*

P      ACRRM's periodic reviews of its training pathways.

*2010 Conditions to satisfy accreditation standards*

15      Implement a systematic framework for program evaluation, with a particular focus on the use of evaluation information for program improvement. (Standard 6.1)

16      Articulate clearly ACRRM's role in addressing concerns about training standards across the three pathways to fellowship. This should include ACRRM's role when supervision and teaching requirements are not being met. (Standard 6.1)

17      Implement processes for obtaining regular feedback data from registrars and supervisors in relation to all aspects of the training pathways to fellowship of ACRRM. (Standard 6.1)

18      Implement processes for regularly obtaining comment on the curriculum from consumers, supervisors and non-medical health professionals and involving them in more formal program review. (Standard 6.2)

*2010 Recommendations for improvement*

Nil

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The 2014 team considers that conditions 15, 16, 17, 18 from 2010 have been met.

## 2014 Accreditation Conditions and Recommendations

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*2014 Commendations*

R      The College's evaluation framework which provides a comprehensive overview of the processes undertaken to monitor and improve the quality of the training program.

*2014 Conditions to satisfy accreditation standards*

9      Where survey feedback or related indicators have identified issues, implement

processes to ensure a clearly articulated set of actions are put in place and connected to further evaluate and assess the desired outcomes. (Standard 6.1)

*2014 Recommendations for improvement*

RR    Collect data regarding the number of registrars who complete the program in the defined minimum time versus those who ultimately complete the program and compare with other similar programs. (Standard 6.2.1)

# 7 Issues relating to trainees

## 7.1 Admission policy and selection

The accreditation standards are as follows:

- A clear statement of principles underpins the selection process, including the principle of merit-based selection.

- The processes for selection into the training program:

  o are based on the published criteria and the principles of the education provider concerned

  o are evaluated with respect to validity, reliability and feasibility

  o are transparent, rigorous and fair

  o are capable of standing up to external scrutiny

  o include a formal process for review of decisions in relation to selection, and information on this process is outlined to candidates prior to the selection process.

- The education provider documents and publishes its selection criteria. Its recommended weighting for various elements of the selection process, including previous experience in the discipline, is described. The marking system for the elements of the process is also described.

- The education provider publishes its requirements for mandatory experience, such as periods of rural training, and/or rotation through a range of training sites. The criteria and process for seeking exemption from such requirements are made clear.

- The education provider monitors the consistent application of selection policies across training sites and/or regions.

### 7.1.1 Admission and selection into training pathways leading to FACRRM in 2010

*The ACRRM accreditation submission provided the following information on the numbers of registrars entering the three pathways to fellowship.*

| Pathway | 2007 | 2008 | 2009 | Total by pathway |
|---|---|---|---|---|
| Independent Pathway | 18 | 0 | 30 | 48 |
| Vocational Preparation Pathway | 34 | 61 | 45 | 140 |
| Remote Vocational Training Scheme | 12 | 15 | 16 | 43 |
| **Total by year** | **64** | **76** | **91** | **231** |

*Apart from those for the Independent Pathway, these figures include registrars who are also training for fellowship of the Royal Australian College of General Practitioners (RACGP). More than 80 per cent of registrars enrolled in ACRRM pathways were also training towards fellowship of the RACGP.*

*The process for selection of registrars depends on the training pathway.*

*To qualify for entry into the Remote Vocational Training Scheme (RVTS), applicants must be Australian or New Zealand citizens or Australian permanent residents, with Australian or New Zealand qualifications or AMC certificate (awarded to international medical graduates). The RVTS application guide outlines other categories of applicants who may be considered depending on the availability of places. There are additional requirements concerning the applicant's location (remote and single doctor town or town with limited medical services); interest in a career in rural and remote medical practice; and intention to continue to live and work in a rural/remote community for the majority of their training.*

*Applicants complete an RVTS application form and provide supporting documentation. A panel of RVTS representatives interviews selected applicants by telephone.*

*Applicants are assessed against the eligibility criteria and additional criteria related to:*

- *their demonstrated commitment to rural/remote practice*

- *their experience in and/or suitability for rural/remote practice*

- *their capacity for self-directed learning and suitability for the RVTS program.*

*Vocational Preparation Pathway applicants apply to General Practice Education and Training (GPET) for selection to the Australian General Practice Training (AGPT) program. There are eligibility requirements in relation to citizenship, medical qualification, current medical registration, and training program qualifications. GPET assesses candidates for eligibility for entry. They are then ranked on the basis of referees' reports, and interviewed by their preferred RTPs. Applicants apply to train in either the rural pathway or the general pathway.*

*For the Independent Pathway, applicants apply directly to ACRRM. In addition to meeting citizenship/residency requirements, to qualify for entry applicants must:*

- *be a graduate from an accredited Australian or New Zealand medical school; or an international medical graduate who has gained medical registration*

- *have at least one year of hospital experience as an intern or equivalent to an Australian internship year*

- *be working, or prepared to work, in a general practice role in an environment capable of being accredited as an ACRRM training post.*

*ACRRM opens applications for the Independent Pathway once per year, with an occasional second round depending on availability of places.*

*The application process entails two phases: an ACRRM selection panel assesses applications against the selection criteria; it then invites shortlisted applicants to a telephone interview with a selection panel.*

### 7.1.2  2010 team findings

*Since the establishment of the Remote Vocational Training Scheme (RVTS) and the Australian General Practice Training (AGPT) program, selection processes have developed and matured. These processes are now well established.*

*These remain complex processes because of the number of parties engaged in the selection. ACRRM does contribute to the development and review of the Australian General Practice Training and the Remote Vocational Training Scheme policies and processes. ACRRM, RACGP and GPET are working collaboratively to ensure the AGPT selection process can manage the expected growth in applications as medical graduate numbers increase.*

*As one of the two professional bodies for the specialty of general practice, ACRRM needs to be assured that the selection processes result in registrars with the appropriate qualities, knowledge and skills to be successful in the Vocational Training Pathway. The AMC considers that all colleges need to engage formally with selection and appointment process to meet the accreditation standards.*

*At the time of the team's assessment, new registrars intending to train towards fellowship of ACRRM were not required to identify their intentions on first enrolment. This has caused some problems for ACRRM in contacting and communicating with its registrars. The team was pleased to note that this concern is being addressed, and looks forward to those issues being resolved.*

*ACRRM's 2011 data on the qualifications and experience of doctors selected to the Independent Pathway indicate that 98 of the 149 current registrants are international medical graduates. These hold medical registration in a range of categories. Registration standards in Australia have changed as a result of Council of Australian Government policy (implemented July 2007) and the introduction of the National Registration and Accreditation Scheme (July 2010). ACRRM needs to review the criteria for selection to this Pathway to ensure they align with the National Law.*

*A majority of registrars in all three pathways who met the team and who responded to the AMC surveys felt that the criteria for selection into their training pathway were clear and followed the documented processes.*

### 7.1.3  Admission and selection into training pathways leading to FACRRM in 2014

The College's accreditation submission provided the following information on the numbers of ACRRM registrars entering the three pathways to fellowship from 2011–13.

| Pathway | 2011 | | 2012 | | 2013 | |
|---|---|---|---|---|---|---|
| | **Enrol** | **Total** | **Enrol** | **Total** | **Enrol** | **Total** |
| Independent Pathway | 49 | 104 | 45 | 120 | 45 | 142 |
| Vocational Preparation Pathway | 73 | 225 | 102 | 276 | 115 | 309 |
| Remote Vocational Training Scheme Pathway | 22 | 65 | 23 | 80 | 21 | 82 |
| **Total by Year** | **144** | **394** | **170** | **476** | **181** | **533** |

The requirements and the process for selection remain largely unchanged since 2010 in all three pathways. However, given the closure of GPET on 31 December 2014, and the transfer of its functions to the Australian Government Department of Health, there will be changes. The exact nature of these changes was unknown at the time of the accreditation visit.

The future selection processes for AGPT are unknown although ACRRM has submitted a proposal co-signed with the Royal Australasian College of General Practitioners outlining a possible governance structure to administer the selection process, and including a process for registrar selection.

In 2013, GPET commissioned a general practice job analysis project to evaluate the effectiveness of the current selection processes. The research compared the selection outcomes to fellowship assessment outcomes. The final report will be considered by the GPET Board in December 2014. The AMC will be interested in updates on the outcome of these findings in future progress reports.

### 7.1.4   2014 team findings

In feedback to the College on its progress reports, the AMC considers that condition 19 from 2010, has been addressed. This includes the concerns regarding the selection criteria for the Independent Pathway to ensure its alignment with the National Law. The AMC first considered the College's response to condition 19 in 2011. While the College's changes to the selection processes seemed appropriate, the AMC did not have sufficient information on the specific changes to determine if these would satisfy the condition. The College provided additional information in its January 2012 and September 2012 progress reports. The AMC also met with key College representatives in November 2012. On the basis of this meeting the AMC determined condition 19 was met.

The title of the Independent Pathway continues to cause problems in understanding the nature of the pathway for external stakeholders. Other than the self-funded nature of the pathway it offers the same structure as the other two programs, although all candidates for the Independent Pathway are required to have some recognition of prior learning (RPL) as a prerequisite. While the combination of a selection interview with the verification of RPL undertaken in one interview provides efficiencies, it may unduly bias either process. The team recommends that the College conduct a review of the link between the selection process and the RPL for candidates entering the Independent Pathway.

The team considers that the AGPT, RVTS and Independent Pathway selection processes appear to be valid, reliable, fair and consistently applied across all applicants. The College website provides information regarding the Independent Pathway and there are links to the RVTS and AGPT websites to access relevant information.

There is a clearly defined and documented complaints and appeals procedure for all pathways.

Neither the Royal Australian College of General Practitioners (RACGP) nor the College are actively involved in the selection of candidates to the AGPT program and to training providers.

Following the AMC's recommendation in 2010, the College now contributes to the development and review of the AGPT and the RVTS policies and processes. This contribution to selection processes is guided by the College's Selection Framework.

The closure of GPET and transfer of its functions to the Australian Government Department of Health provides a significant opportunity for ACRRM to become more involved in the selection process and a current proposal from ACRRM and RACGP highlights these opportunities.

At the time of the team's assessment, new registrars intending to train towards fellowship of ACRRM were not required to identify their intentions on first enrolment. This has caused some problems for the College in contacting and communicating with its registrars. The team was pleased to note that the proposal to be considered by the Australian Government Department of Health provides a solution to these problems.

## 7.2    Registrar participation in education provider governance

The accreditation standards are as follows:

- The education provider has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

### 7.2.1  Registrar participation in governance of their training in 2010

*ACRRM governance structures support the involvement of registrars through the appointment of a Registrar Director elected by registrar members on the ACRRM Board, and on Program/Standards Committees of the College.*

*ACRRM has established a Registrar Committee to provide an avenue for registrar representatives to communicate with and to provide feedback and advice to the ACRRM Board, as well as to provide direction regarding ACRRM information and communication strategies directed at the registrars.*

*The Committee is expected to meet at least six times per year, primarily by teleconference or email, and to report to the ACRRM Board through the Registrar Director after every meeting.*

*The Committee, which is chaired by the Registrar Director, consists of at least six registrars, including at least one from each training pathway. Membership gives consideration to balance gender, geography and age.*

*All committee positions (including the Registrar Committee) are filled by calling for applications from the College membership. The ACRRM Board reviews the applications and makes a decision about inclusion on the committees. Registrars are full members of the committees and hold the same rights as other members. ACRRM pays the cost of travel and accommodation for registrars to attend committee or board-related activities.*

*ACRRM registrar representatives participate in meetings with the General Practice Registrars Association. They also attend functions on behalf of ACRRM and act as guest speakers.*

### 7.2.2   2010 team findings

*It is critically important that registrars are fully engaged in the governance structures of the College. The team commends the College's initial steps towards incorporating registrars at a range of levels, including the ACRRM Board.*

*The Registrar Committee is new and is still developing its role. The members of the Committee who met the team outlined a range of plans to improve communication with registrars about their activities and those of ACRRM and to use the College's excellent remote learning platforms to do this. While enthusiastic, they will require considerable ACRRM support to extend registrars' input. Responses from registrars who responded to the AMC survey for this assessment were equally divided between those who felt there were good opportunities for registrars collectively to discuss issues concerning training and those who did not.*

*The process for selection of registrar representatives, outlined above, was of concern to the team. Registrars are most likely to engage with the Committee if the selection process is open, and involves the registrars in the selection of their representatives.*

*The team notes that the Committee liaises with other trainee bodies, including General Practice Registrars Association and the AMA Council of Doctors in Training.*

### 7.2.3   Registrar participation in governance of their training in 2014

The involvement of registrars within College governance structures has remained essentially unchanged since 2010. The Registrar Committee is well established and the election and appointment of the Registrar Director to the Board is working well.

The Committee, which is chaired by the Registrar Director, consists of at least six registrars, including at least one from each training pathway. Membership gives consideration to balance gender, geography and age, although this is done informally.

All committee positions (including the Registrar Committee) are filled by calling for applications from the College membership. The ACRRM Board reviews the applications and makes a decision about inclusion on the committees. In this respect, representatives are not elected by the registrar body; although this is the mechanism to ensure that the Registrar Committee is representative.

The Registrar Committee provides an avenue for registrar representatives to communicate with and to provide feedback and advice to the ACRRM Board, as well as to provide direction regarding ACRRM information and communication strategies directed at registrars. Again, this takes place in a complex environment and a variety of other organisations and representatives also provide advocacy within the training system for ACRRM registrars.

In addition to this, each of the training providers has mechanisms for registrar participation in the governance of the training program, and has Registrar Liaison Officers (RLOs) to support registrar participation and resolutions of issues. Often, however these RLOs are RACGP registrars and have little knowledge of the ACRRM training program or ACRRM related training problems.

Nationally, General Practice Registrars Australia (GPRA) is the peak independent body representing general practice registrars on a range of issues. GPRA provides feedback on registrar issues to relevant stakeholders. The GPRA Advisory Council is largely made up of RLOs. ACRRM registrars have one, and have just had a second position added to this large council of approximately 60 members. Given the RACGP focus of this organisation there are concerns that ACRRM registrars are not adequately represented by this body.

### 7.2.4   2014 team findings

It is critically important that registrars are fully engaged in the governance structures of the College. The team commends the College on incorporating registrars at a range of levels, including the ACRRM Board.

The Registrar Committee has matured and has an effective communication strategy via social media for communicating with registrars. The College supports the committee effectively and it appears that it brings value to the organisation.

The process for selection of registrar representatives, outlined above, was of concern to the team. Registrars are most likely to engage with the Registrar Committee if the selection process is open, and involves the registrars in the selection of their representatives. Given that some training issues seem to be regional in nature, it is important that all registrars have representatives that can understand their issues and advocate on their behalf.

The team noted that the committee liaises with other trainee bodies, including General Practice Registrars Australia (GPRA) and the Australian Medical Association (AMA) Council of Doctors in Training.

The team noted that registrars are involved in the relevant College governance processes and are included in the core committees.

The team heard from both College and GPRA representatives that the relationship between GPRA and the College is not strong. The registrars feel that GPRA does not adequately represent ACRRM registrars and that their advocacy is largely limited to issues concerning RACGP registrars.

The team notes that each training provider has a Registrar Liaison Officer (RLO) however the relationship between RLOs and the College is not formalised and often the RLO is not an ACRRM registrar. In contrast to the Royal Australian College of General Practitioners (RACGP), the majority of ACRRM registrars appear to align with the College rather than their RTP. This may reflect the lack of ACRRM-specific advocacy occurring at the RTP level.

### 7.3    Communication with registrars

The accreditation standards are as follows:

- The education provider has mechanisms to inform trainees about the activities of its decision-making committees, in addition to communication by the trainee organisation or trainee representatives.

- The education provider provides clear and easily accessible information about the training program, costs and requirements, and any proposed changes.
- The education provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

### 7.3.1  Communication with registrars in 2010

*The ACRRM accreditation submission indicated that the College publishes decisions that affect all registrars on the ACRRM website, Rural and Remote Medical Education Online (RRMEO) and also emails them directly to training providers, supervisors and registrars. The quarterly newsletter, FACRRM Fundamentals, reiterates changes in policy.*

*The College considers that communication with registrars and other stakeholders is a challenge due to the delivery environment for general practice training, with multiple stakeholders. This is supported by the feedback to the team from registrars, many of whom did not feel well informed about developments in the training program. Many also indicated that they would first approach their supervisor, then the staff of the regional training provider to clarify requirements rather than approach ACRRM directly. Registrars in the Remote Vocational Training Scheme feel very well supported by that Scheme and would approach staff in that Scheme. Independent Pathway registrars who met the team overall had a closer relationship with the College and its staff and felt well supported. The team noted that for the small number of Independent Pathway registrars who had had difficulties in receiving information from the College or in receiving advice in response to enquiries, unlike those training within the AGPT program, other avenues for advice were not available.*

*ACRRM has indicated that it is refining its communication strategy. As a first step it had reviewed its website and begun a re-development project to improve interactivity and two-way communication facilities. In seeking to improve its communication strategies, the College needs to seek feedback from registrars in all training pathways.*

*The team considers that the College has an important role in supporting registrars during training but, as noted above, there have been some structural impediments to its success.*

### 7.3.2  Communication with registrars in 2014

The AMC recommended in 2010 that the College improve mechanisms to communicate with its registrars about training requirements and on any developments in training (condition 20). The College satisfied condition 20 in 2013 by reporting on the range of mechanisms introduced to communicate with registrars and the opportunities available for registrars to provide feedback on the training experience.

The College communicates with registrars about training issues via:
- the College website which publishes decisions affecting registrars
- the bi-monthly FACRRM Fundamentals newsletter, which includes Registrar Committee input
- the weekly Country Watch e-newsletter
- direct email

- the Rural and Remote Medical Education Online (RRMEO) platform

- workshops at the annual Rural Medicine Australia conference and other relevant conferences and activities

- orientation sessions for registrars on all pathways via a virtual classroom.

The College set up two Facebook groups in 2014, one group specifically for Independent Pathway registrars and the other group for all ACRRM registrars. The College monitors the content of the Facebook pages. The College has also established Twitter forums and YouTube videos to encourage registrar interaction. Registrars also have access to all-of-College Facebook and Twitter pages which are also used to send information to them.

Both the RTPs and the RVTS have processes in place to communicate with registrars. The College has established accreditation standards relating to expectations concerning communication with registrars. Monitoring of the standards is assessed via the Bi-College RTP accreditation process. In 2012, the College held monthly information sessions for training providers via a virtual classroom. In 2013 and 2014, the College changed the format to face-to-face workshops every six months to increase attendance. The College visits training providers and attends RTP events to provide information and answer questions.

The College considers that communication with registrars and other stakeholders is a challenge due to the multi-stakeholder environment in which general practice training is delivered. This is reflected by the variation in feedback heard during the assessment visit. Some registrars indicated that they would first approach their supervisor, then the staff of the regional training provider to clarify requirements rather than approach the College directly. Overall, Independent Pathway registrars who met the 2014 team had a closer relationship with the College and its staff and feel well supported.

ACRRM's communication strategy has matured and now seems well established and has been widely adopted by its registrars. The College is commended on the adoption of social media strategies and a variety of electronic mediums to communicate with, and to educate registrars. Registrar feedback indicated that the online environment is a valued source of interaction, especially in isolated practices.

The RRMEO platform provides a Learning Planner/Portfolio to document Logbook requirements, module completion and formative assessment outcomes. Both registrars and supervisors use this platform to track training progress. This process works well for Independent Pathway registrars. RTPs and the RVTS use alternative systems to track and record training status for those registrars training with them.

GPET has a separate data collection and management system for reporting purposes. A memorandum of understanding (MOU) is in place between the College and GPET and defines what information is shared between the two organisations. Currently the shared data only includes details of enrolments, withdrawals and completion of training in the Australian General Practice Training program. The College indicates that it is uncertain about the progress of the MOU given the closure of GPET.

The team commends the College on the plans for the redevelopment of its website and the implementation of the new Customer Relationship Management (CRM) system which will improve communication channels for registrars, supervisors and training providers alike.

Training requirements and costs of training are documented for all pathways.

The team acknowledges that the College works hard to ensure its documentation is available to registrars and all other relevant stakeholders. The team accessed the College's documentation including the website, RRMEO platform and a preview of the forthcoming CRM system.

In this context, the importance of version control for documents accessible via the website was highlighted. The team noted a number of examples where the date and currency of documents on the website was unclear and this needs to be remedied quickly to reduce confusion and the risk of registrars and supervisors working with outdated requirements. For example, there are two versions of the *Standards for Supervisors and Teaching Posts* (2010 version and 2013 version) currently accessible on the College's website. The associated *Primary Rural and Remote Training Policy* is also past its review date and does not seem to have been reviewed since the changes to the Primary Curriculum.

It is important that linked documents are updated simultaneously and that their version dates are clearly displayed on the cover or header/footer on each page. There should also be a clear indicator whether the document is superseded or current; so that users can be sure that they are using the correct version. Where small changes have been made, the College may consider providing a list of changes so that users can easily view the new information.

## 7.4    Resolution of training problems and disputes

The accreditation standards are as follows:

- The education provider has processes to address confidentially problems with training supervision and requirements.
- The education provider has clear impartial pathways for timely resolution of training-related disputes between trainees and supervisors or trainees and the organisation.
- The education provider has reconsideration, review and appeals processes that allow trainees to seek impartial review of training-related decisions, and makes its appeals policies publicly available.
- The education provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

### 7.4.1  Resolution of training problems and disputes in 2010

*The College's accreditation submission indicates that GPET and RVTS are responsible for resolving training issues for their registrar cohort. ACRRM encourages medical educators and registrars to seek clarification from ACRRM when required.*

*The College has developed a formal appeals process, together with processes for review and reconsideration of decisions. GPET has a separate appeals policy as does the RVTS. ACRRM indicated that it had received two formal appeals, which related to a component of the College's assessment.*

*The team found that most registrars felt able to raise and address concerns without recourse to the formal appeals process, but frequently used processes other than those of ACRRM to do so.*

*Because of the multiple organisations involved in general practice training, each with review and appeals procedures, the processes for dealing with disputes can be confusing for registrars. The accreditation standards require ACRRM, as the accredited education provider, to have processes for addressing training related disputes. ACRRM needs to clarify its own processes and ensure these are known to its registrars.*

*Of concern was the lack of a clear ACRRM policy and process on how a registrar seeks the College's assistance when they have difficulties with their supervisor. The team's discussions with ACRRM suggested a clear view that the responsibility for designing and documenting a process for registrar assistance when they have difficulty with their supervisor sits with the training provider. The team considers that the absence of an ACRRM policy means the College will potentially fail to gather important information about the way its training requirements are being delivered, and that it is limiting its capacity to advocate for and support its registrars.*

### 7.4.2 Resolution of training problems and disputes in 2014

In 2010, the AMC recommended that the College develop and disseminate policy and procedures on how registrars seek assistance when they have difficulties with their supervisor, with registrar and regional training provider input (condition 21). The College satisfied condition 21 in 2012, by implementing the *Grievance Policy* which provides guidance to registrars and supervisors on how to resolve grievances in training.

The College's accreditation submission indicates that the RTPs and the Remote Vocational Training Scheme (RVTS) continue to be responsible for resolving training issues for their registrar cohorts. The College encourages medical educators and registrars to seek clarification from the College when required. The team found that often ACRRM registrars approach the College directly if their training provider has not adequately addressed their concerns.

The College has a formal appeals process, together with processes for review and reconsideration of decisions which are all available on the College's website. This includes policy and procedures for seeking assistance when a registrar has difficulties with a supervisor. GPET has a separate appeals policy for registrars in AGPT as does the RVTS. Where a GPET appeal relates to an ACRRM registrar an ACRRM College representative is included in the appeal panel.

The processes for resolving training problems and disputes are monitored through the Bi-College RTP Accreditation Program.

Because of the multiple organisations involved in general practice training, each with their own review and appeals procedures, the processes for dealing with disputes can occur with, or involve, multiple organisations, essentially at the discretion of the registrar. ACRRM's processes are appropriate although more integration and further communication with RTPs could be beneficial.

The College has an independent appeals process that is used when the appeal directly involves a College decision.

All formal appeals are registered and the management process tracked. Details on appeals are included in the monthly reports to the ACRRM Board to help identify any systemic issues. In 2013, eight applications for appeal were received and of these, only two lead to the original decision being overturned. In 2014, three applications for appeal were received, one was withdrawn and two did not demonstrate grounds for proceeding.

## 2010 Accreditation Conditions and Recommendations

*2010 Commendations*

Q        The establishment of the Registrar Committee and the members' plans for the Committee.

*2010 Conditions to satisfy accreditation standards*

19        Review the criteria for selection to the Independent Pathway to ensure they align with the National Law. (Standard 7.1)

20        Review and improve the mechanisms to communicate with registrars about training requirements and developments, and actively engage registrars in the review. This should include direct communication as well as improved mechanisms for registrar representation (See area for improvement SS). This should aim to address issues related to both training requirements as well as feedback regarding the training experience. (Standard 7.3)

21        Develop and disseminate policy and procedures on how registrars seek assistance when they have difficulties with their supervisor, with registrar and regional training provider input. (Standard 7.4)

*2010 Recommendations for improvement*

QQ        Extend the support for the Registrar Committee to facilitate and support the involvement of trainees in the governance of their training. (Standard 7.2)

RR        Review the processes for appointment of registrar representatives to ensure registrars' views are considered in making appointments. (Standard 7.2)

The 2014 team considers that conditions 19, 20 and 21 from 2010 have been met.

## 2014 Accreditation Conditions and Recommendations

*2014 Commendations*

S    The inclusion of registrar representatives at all levels of ACRRM's governance structure, including the ACRRM Board, and the College's responsiveness to registrar needs and issues during their training.

T    The College's extensive, widely adopted communication strategies using technology including the Rural and Remote Medical Education Online (RRMEO) platform and the upcoming Customer Relationship Management (CRM) system. Social media is used as an effective means of communication, especially by the Registrar's Committee, and also by the College more generally, both to distribute information to, and to receive feedback from registrars.

*2014 Conditions to satisfy accreditation standards*

10    Monitor and report on changes to the selection processes for the Australian General Practice Training (AGPT) program in response to the changes to the structure of general practice training. (Standard 7.1)

11    Work actively to obtain the cooperation of the regional training providers and the Remote Vocational Training Scheme in implementing the College's selection criteria and standards for selection. (Standard 7.1)

12    Review and implement processes for the appointment of registrar representatives to the Registrar Committee to ensure registrars' views are considered in making appointments. (Standard 7.2)

*2014 Recommendations for improvement*

SS    Revise the process for verifying the candidate's recognition of prior learning and applying for selection to the Independent Pathway. (Standard 7.1)

TT    Build on existing work with General Practice Registrars Australia and regional training providers to improve advocacy for ACRRM registrars within these organisations and ensure their understanding of their shared responsibility. (Standard 7.2)

UU    Develop and implement a system of dating and version control on all curricula, handbooks, policies and online resources so version applicability and tracking is easily possible for these key documents. (Standard 7.3)

# 8 Implementing the training program – educational resources

## 8.1 Supervisors, assessors, trainers and mentors

The accreditation standards are as follows:

- The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the training program and the responsibilities of the education provider to these practitioners.

- The education provider has processes for selecting supervisors who have demonstrated appropriate capability for this role. It facilitates the training of supervisors and trainers.

- The education provider routinely evaluates supervisor and trainer effectiveness including feedback from trainees and offers guidance in their professional development in these roles.

- The education provider has processes for selecting assessors in written, oral and performance-based assessments who have demonstrated relevant capabilities.

- The education provider has processes to evaluate the effectiveness of its assessors/examiners including feedback from trainees, and to assist them in their professional development in this role.

### 8.1.1 ACRRM roles of supervisors, clinical teachers, medical educators in 2010

*ACRRM policy concerning supervision of training is articulated in a number of policy documents. The central document is the College's Standards for Teaching Posts and Teachers in Primary Rural and Remote Training. The document includes: Standards for Teaching Posts and Teachers of Rural and Remote Medicine and Standards for Teaching Posts and Teachers in Remote Contexts. These two sections include a small number of criteria and indictors. The document also outlines the accreditation procedures. This document was under review at the time of the Team's assessment.*

*As noted in Section 4 of this report, ACRRM policy requires that each registrar is linked to an ACRRM-accredited supervisor who provides supervision, clinical skills training, monitoring, guidance and feedback on professional and educational development. Independent Pathway registrars are responsible for choosing their own supervisor.*

*Medical educators are clinicians employed by their training provider. They provide advice and support to registrars, contribute to the development and review of learning plans for ACRRM registrars, participate in placement allocation for ACRRM registrars, and facilitate ACRRM accreditation of posts. This role is well established in general practice education.*

### 8.1.2 2010 team findings

*The quality of supervision is a key issue for all practice and apprentice-based training programs, and all specialist medical colleges. Like all colleges, ACRRM relies on the commitment and dedication of clinicians to deliver important elements of the training and to act as role models and mentors for, as well as assessors of, the registrars. In its site visits, the team met a large number of supervisors who were very committed to providing high quality teaching.*

*The AMC survey of registrars indicated that the majority of respondents felt that they were adequately supervised.*

*The structure of general practice training in the AGPT program and the RVTS programs means that ACRRM could be perceived as being one step removed from its supervisors. Earlier sections of the report, particularly sections 3 and 4, raise a number of concerns about the supervisors' level of knowledge of ACRRM curriculum requirements, and the need for the ACRRM Primary Curriculum to provide greater guidance for registrars and supervisors on detailed learning objectives for particular stages of training.*

*The team has also suggested earlier in the report that ACRRM review the extent of the guidance available to Independent Pathway and Vocational Preparation Pathway supervisors on the structured educational activity time requirements. Earlier in the report, concerns are also raised about the amount of formative feedback that registrars receive from their supervisors.*

*Registrars indicated there were poor processes for them to feedback to the College concerning the quality of their supervision, and they did not believe their feedback influenced decisions on these matters.*

*A number of registrars felt their medical educator was not well prepared to advise on learning activities relevant to the ACRRM curriculum because they did not know the ACRRM Primary Curriculum and/or the aims of ACRRM training. This was thought, in part, to be related to relative recent inclusion of ACRRM in the AGPT program, and the much smaller numbers of ACRRM registrars resulting in the medical educators' more frequent need to work with and advise on training to the fellowship of the RACGP.*

*The team considers this to be an area of vulnerability in the ACRRM training arrangements. ACRRM must continue to work with GPET to ensure that ACRRM's education requirements and standards are known, and that supervisors' and RTPs' implementation is reviewed and evaluated.*

*The College's accreditation submission and its progress reports to the AMC describe a range of mechanisms to inform stakeholders about ACRRM vocational training requirements, including visits to training providers, regular teleconferences with training providers, medical advisors and other training staff, and facilitating medical educator training workshops on the ACRRM vocational training program. This communication needs to be ongoing.*

*The accreditation standards require the College to have defined the responsibilities of hospital and community practitioners who contribute to the delivery of the training program and the responsibilities of the College to these practitioners, and to have processes to evaluate their effectiveness in these roles. Discussions with ACRRM office-bearers suggested that a range of issues concerning the quality of supervision and its appropriateness for the ACRRM pathways were seen as matters to be addressed by the RTPs and GPET. Despite the difficulties inherent in the environment, ACRRM does have responsibilities for ensuring that the supervisors accredited to deliver its training have the resources and the support necessary, and access to appropriate professional development and training. The challenge for ACRRM is to work with the RTPs and their medical*

*educators to clarify ACRRM requirements and standards, to identify training needs and to build opportunities for training delivery.*

*ACRRM was reviewing the standards for teaching posts and supervisors at the time of the team's visit and the team was pleased to see that the revised version provided more detailed guidance for accredited supervisors and training providers. ACRRM had also received short term funding from GPET to employ a medical educator to provide support, education and training for supervisors to improve understanding of the ACRRM curriculum. The team considers these to be important developments.*

*In its March 2011 update to the AMC, ACRRM outlined a number of GPET-funded developments that have begun since the team's assessment visit to enhance supervisors' and RTPs' understanding of ACRRM training requirements. These include a new Guide for Supervisors, and a web-based Training Providers Tool Kit which collates all the information training providers need in one place.*

*The College has also held four workshops with training providers on the revised ACRRM post and supervisor standards to provide RTPs with a greater understanding of the standards, to assist training providers with designing policies and procedures around accreditation and conducting accreditation visits. Regular online workshops with Regional Training Providers were to commence in April.*

*The team commends these developments.*

### 8.1.3 ACRRM roles of supervisors, clinical teachers, medical educators in 2014

Since 2010, ACRRM has consolidated earlier work on the roles and responsibilities of supervisors, clinical teachers, medical educators and mentors, which are reflected in the various *Standards for Supervisors and Teaching Posts* documents, applicable to each component of the training program (Core Clinical Training, Primary Rural and Remote Training and each Advanced Specialised Training discipline). The standards relating to supervisors outline the qualifications, experience and abilities required and require evidence of a commitment to teaching and providing support to registrars.

The College works with training providers, state health departments and other specialist colleges to identify suitable supervisors and teaching posts.

The recruitment, orientation, training and accreditation of supervisors occurs through different processes in three different training pathways. For the Vocational Preparation Pathway and RVTS, these functions are delegated to training providers. The College monitors these processes through the Bi-College RTP Accreditation Program. Supervisors of Independent Pathway registrars are accredited directly by the College following application from the prospective registrar and supervisor.

Since 2010, the College has developed a Guide for Supervisors and offers supervisor workshops at the annual Rural Medicine Australia conference. The College is developing an online module for supervisors and it is expected to be completed in 2015. On the AGPT and the RVTS Pathways, training providers are required to provide training for supervisors.

The communication of goals and objectives of ACRRM training to supervisors is complicated by the indirect nature of the relationship between the College and its supervisors within RTPs and the RVTS. As a result, a significant proportion of supervisors are not adequately aware of the components and requirements of ACRRM training and assessment.

During the assessment visit, the College indicated it intends to explore the role of mentoring within the education and training programs in 2015.

The processes for appointment of assessors include opportunities for expression of interest from interested College fellows. Prospective assessors are required to be several years post successful completion of ACRRM training, although no specific criteria have been enunciated. New assessors receive extensive training and support.

The training providers are primarily responsible for evaluating supervisor and training effectiveness for the AGPT and the RVTS. The College is responsible for monitoring supervisor effectiveness for the Independent Pathway.

The *Standards for Supervisors and Teaching Posts* stipulate that registrars must provide feedback to their training provider and the College on the training environment provided by the post and their supervisors. Training providers are required to have processes to collect information on supervisor performance. Registrars provide feedback to the training provider at the end of each training placement.

The College requires an annual report from each training provider against a set of key performance indicators. A summary of feedback from registrars on their supervision is required, plus any issues that have been identified and how they have been dealt with. Matters arising are primarily dealt with by the training provider; however, in some cases the College and the training provider may discuss and agree on how to deal with the issue and how to provide feedback. The evaluation information feeds into supervisor accreditation and reaccreditation cycles.

Where the College is notified about an issue with a registrar's progress or the quality of their supervision on the Independent Pathway, the College will contact the supervisor to discuss in further detail. During the assessment visit, the College reported this process has worked well to date, without causing any issues for the registrar. If there are repeated complaints, the College will seek to review the accreditation of the training post and if remediation is not possible, will withdraw accreditation for the post. This has only been necessary on rare occasions.

The College uses a number of processes to evaluate effectiveness of its assessors. Post examination feedback is gathered from registrars, assessors, invigilators and other key stakeholders after each multiple choice question (MCQ) examination, the Structured Assessment using Multiple Patient Scenarios (StAMPS) examination, mini clinical evaluation exercises (mini-CEX) and multisource feedback (MSF) assessment. This information is reviewed by the Principal Examiner and if relevant fed back to the assessors.

### 8.1.4   2014 team findings

The AMC set three conditions on accreditation in 2010, including that the College ensure supervisors have the necessary resources and support, and access to appropriate professional development and training (condition 22); communicate actively with regional training providers and supervisors to ensure they are informed about training requirements, standards of supervision, and expectations (condition 23); and work collaboratively with other stakeholders to implement processes for regular evaluation of supervisor effectiveness, with feedback from registrars (condition 24).

The College has done an excellent job in clearly defining the roles and responsibilities of practitioners involved in the delivery of the training program. Evaluation of supervisor performance is effective. The team considers that condition 24 from the 2010 review has been met. Despite developments and the fact that efforts to improve communication with regional training providers are progressing, the team does not consider that conditions 22 and 23 from 2010 have been fully met. The need for ongoing work on the relationship between the College and training providers, particularly in the context of changes in the general practice training environment that are anticipated in 2015.

While supervisors interviewed by the team were generally positive about the assistance provided by the College, there continues to be some issues about the availability of information for supervisors regarding their role provided by regional training providers. This has also been aggravated due to the variable knowledge and understanding of ACRRM requirements by regional training providers. In the Independent Pathway, the College's new practice of contacting each new supervisor after forwarding a supervisor orientation pack, appears to be addressing this issue and ensuring the College has a direct relationship with the supervisor. Once new arrangements for the Australian General Practice Training (AGPT) program are established, the team considers the need for more informed relationships with regional training providers will be an area of work for the College.

The College needs to facilitate adequate training and professional development of supervisors and trainers, particularly with respect to equipping them with the necessary tools to understand and deliver the ACRRM-specific components of general practice training. Further work is also required to ensure that Directors of Training and Medical Educators within training providers are well versed in the ACRRM curriculum and expectations of the training program.

As detailed under standard 5 of this report, the team considers that assessor training and support is carried out effectively, and the College is commended for its investment. However, it is recommended that the College develop and implement defined criteria for selection of its assessors.

The College needs to consider the further development of mentoring, and an emphasis on registrar involvement in the selection of mentors, is encouraged. The AMC will look forward to reports of progress in this area.

## 2010 Accreditation Conditions and Recommendations

*2010 Commendations*

R    The recent work by ACRRM, with General Practice Education and Training support, to develop additional support for supervisors and to provide resources explaining ACRRM training requirements to regional training providers.

*2010 Conditions to satisfy accreditation standards*

22    Ensure that the supervisors accredited to deliver ACRRM training, have the necessary resources and support, and access to appropriate professional development and training. (Standard 8.1.1)

23    Communicate actively with regional training providers and supervisors to ensure they are informed about training requirements, standards of supervision, and expectations of the supervisor as they currently apply and when changes are made. (Standard 8.1.1)

24    Working collaboratively with other stakeholders, implement processes for regular evaluation of supervisor effectiveness, with feedback from registrars. (Standard 8.1.3)

*2010 Recommendations for improvement*

Nil

The 2014 team considers that condition 24 from 2010 has been met. Progress towards meeting the 2010 conditions 22 and 23 is ongoing, and these conditions are reflected in the 2014 conditions 13 and 14 listed below.

## 2014 Accreditation Conditions and Recommendations

*2014 Commendations*

U    The significant contribution of ACRRM supervisors to the supervision, mentoring and assessment of registrars in training.

V    The College's processes for training and preparation of its assessors, including the use of practice examinations for training and the provision of online modules with high-quality training videos.

W    The effective evaluation of assessor competence with appropriate use of registrar feedback to inform the College regarding assessor performance.

*2014 Conditions to satisfy accreditation standards*

13    Document, implement and subsequently evaluate a plan for ensuring that individuals involved in the supervision and delivery of ACRRM training across all pathways are trained and supported about the curriculum, training and assessment requirements, and expected standards of supervision for the ACRRM training program. (Standard 8.1.1)

| 14 | Develop and implement strategies for improved relationships and engagement with regional training providers, directors of education, medical educators and supervisors, as well as mechanisms for using the accreditation process to assure compliance with ACRRM training policies and procedures. (Standard 8.1.1) |
|---|---|
| 15 | Establish criteria for the selection of assessors, which define eligibility for appointment as an assessor, specifying differences for different assessments if applicable. (Standard 8.1.4) |

*2014 Recommendations for improvement*

Nil

## 8.2 Clinical and other educational resources

The accreditation standards are as follows:

- The education provider has a process and criteria to select and recognise hospitals, sites and posts for training purposes. The accreditation standards of the education provider are publicly available.

- The education provider specifies the clinical and/or other practical experience, infrastructure and educational support required of an accredited hospital/training position in terms of the outcomes for the training program. It implements clear processes to assess the quality and appropriateness of the experience and support offered to determine if these requirements are met.

- The education provider's accreditation requirements cover: orientation, clinical and/or other experience, appropriate supervision, structured educational programs, educational and infrastructure supports such as access to the internet, library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated time for teaching and training and opportunities for informal teaching and training in the work environment.

- The education provider works with the health services to ensure that the capacity of the health care system is effectively used for service-based training, and that trainees can experience the breadth of the discipline. It uses an appropriate variety of clinical settings, patients and clinical problems for training purposes, while respecting service functions.

### 8.2.1 Accreditation of training posts and providers for ACRRM training in 2010

*The College provides training for medical graduates wishing to practice in rural and remote settings for at least part of their career. This training includes a strong focus on procedural skill acquisition to support independent remote practice. Training by ACRRM for rural and remote medicine practice is characterised by an expanded scope of clinical practice, participation in emergency and hospital care and responsibility for population health.*

*The standards set out by the College for accreditation of hospital, general practice, community and other training posts are defined and publicly available in the College's*

*Standards for Teaching Posts and Teachers in Rural and Remote Medicine published in 2006 and under revision at the time of the Team's visit.*

*Accreditation of training posts has two components. The first relates to the practice environment and the learning opportunities and infrastructure available to the registrar. The second component is the accreditation of supervisors available and capable of providing adequate training, support and supervision of registrars.*

*The College advised that there were 258 training posts available for training of registrars. This number of posts was sufficient for the registrar requirements.*

*The College has responsibility for accreditation of training posts and supervisors. This involved applications being received by the College, which would then undertake a desktop assessment and arrange a site visit by College fellows. If Royal Australian College of General Practitioners (RACGP) accreditation was also sought by the practice, the visit could include representatives from both Colleges.*

*The team heard varying reports about this process. Some practices indicated it worked well, others felt that the documentation provided by ACRRM could be clearer. In addition, pressure on the College relating to costs and the availability of fellows to complete visits across hundreds of sites had meant a large number of practices had not completed the full accreditation process. At the time of the team's visit, accreditation at a number of sites had lapsed.*

*In October 2009, responsibility for accreditation of training posts and supervisors began to be transferred from the College to the training providers. The College's March 2011 update to the AMC indicated that, following the team's visit, both ACRRM and RACGP had implemented a training provider-delegated post and supervisor accreditation model. The model aims to streamline the accreditation process and improve the accountability of training providers and supervisors. The training provider would collect information relevant to post and supervisor standards for both Colleges, and provide a recommendation to each college on their ability to meet the standards and their suitability for accreditation. The College would then approve or decline accreditation.*

*ACRRM regards this model as formalising the post and supervisor accreditation process that it had been using to date.*

*The College requires training providers to submit documentation of policies, processes, templates and forms to demonstrate how they ensure that posts and supervisors meet the relevant ACRRM standards. The arrangement is formalised by the signing of a management agreement, which defines the roles and responsibilities of each party. The training provider has annual reporting and exception-reporting requirements. The College intends to undertake random audits and request further information of training providers if there are concerns. ACRRM is working with each training provider to ensure documentation and processes meet the ACRRM standards.*

*The College expected to sign agreements with the 14 training providers providing ACRRM training by the end May 2011.*

### 8.2.2   2010 team findings

*The team found a high level of satisfaction amongst registrars with their clinical experience. Registrars described a good mix of experience, good GP supervision on the whole, and variable, although appropriate, access to a variety of educational resources.*

*The College standards clearly document the criteria on which accreditation of posts must be assessed. At the time of the team's assessment, the College described the forms for the desktop assessment as describing all essential features which must be provided at sites. However, the team noted that it was possible to answer with a 'Not Applicable' response. The team recommends their review.*

*In sections 3 and 4 of this report, the team has raised concerns about the elements of ACRRM policy that make it possible for some registrars to complete ACRRM fellowship without having undertaken a post in a community-based general practice. This is not consistent with ACRRM's stated view that completion of the training signifies that the registrar has met the standard expected of a safe, confident and independent general practitioner able to work across a full and diverse range of healthcare settings in Australia, including rural and remote settings.*

*The team noted concerns from some stakeholders that ACRRM training policy, combined with financial incentives for registrars, such as are provided to registrars training with the rural generalist pathway of Queensland Health, had led to registrars increasingly choosing hospital-based training posts, at the expense of the posts available in the general practices in some rural towns and centres.*

*The team considers it important that a period of community-based general practice is a training requirement.*

*The team commends the work by the RTPs and the two Colleges to review and improve post and supervisor accreditation processes. The AMC will expect ACRRM to report in its progress reports on the implementation of this process, the measures the College has in place to ensure that its standards are being met, and how it is addressing any concerns raised about training quality*

*It is important especially for registrars that all posts have current accreditation. ACRRM must take leadership to finalise accreditation processes and clear the backlog of posts awaiting accreditation and reaccreditation.*

*ACRRM had accredited 14 of the rural RTPs as meeting its requirements for delivery of training at the time of the team's assessment. The team visited a number of these training providers. It was concerned that relations between the College and the RTPs were very variable and sometimes dysfunctional. Commonly, areas of difficulty related to the accreditation of posts and what is delivered in the curriculum.*

*To meet AMC accreditation requirements, ACRRM needs to be assured that the delivery of the training by RTPs meets its standards. It follows that there must be a process to confirm, strengthen and clearly articulate the College's role in the accreditation and ongoing monitoring of RTPs and the training environment.*

### 8.2.3  Accreditation of training posts and providers for ACRRM training in 2014

The standards for posts are contained within the various *Standards for Supervisors and Teaching Posts* documents. Training providers are responsible for arranging posts for the registrars training with them. Registrars on the Independent Pathway are responsible for finding their own accredited post or having the post they are already working in accredited.

Core Clinical Training (CCT) posts must be accredited by the state or territory Postgraduate Medical Council or by the College against the standards for CCT. Primary Rural and Remote Training (PRRT) and Advanced Specialised Training (AST) must take place in a post which is accredited against the *Standards for Supervisors and Teaching Posts*.

In 2011, the College delegated to AGPT training providers the responsibility to collect information against the *Standards for Supervisors and Teaching Posts*, and to make an accreditation recommendation to the College. This delegation applies to the Primary Rural and Remote training. For Core Clinical Training and Advanced Specialised Training stages, the College will be provided directly with information and evidence to support the recommendation.

In 2013, ACRRM and RACGP introduced the Bi-College RTP Accreditation Program which provides one streamlined process for the accreditation of training providers on the AGPT program and RVTS Pathway against College standards. RTPs are reviewed every three years. The RTP is required to provide a written submission against the Bi-College RTP Accreditation Principles and Outcomes framework and submit the report to the Bi-College program.

The accreditation visit is conducted by an accreditation review team comprising two experienced general practice reviewers and supported by the Bi-College Program Manager. The review team also includes a senior education team staff member from each college. The review team assesses the RTP against College standards, through the Principles and Outcomes framework. Both Colleges are provided with a copy of the team's report with the recommendations and conditions that should be applied. As at December 2014, 9 out of 18 RTP accreditation visits had been completed.

Training providers that meet the ACRRM standards are granted ACRRM accreditation for three years. RTPs that do not meet the standards are given accreditation with conditions or recommendations. The period of accreditation may be reduced from three years if there are significant concerns. The RTP will be provided with a report outlining actions required and timeframe for compliance. This is monitored by the College to determine when the outcome is met.

### 8.2.4  2014 team findings

The AMC recommended in 2010 that the College report on its contribution to ensure that all posts have current accreditation and to clear the backlog of posts awaiting accreditation and reaccreditation (condition 25); and work with GPET and other stakeholders to ensure ACRRM-accredited regional training providers deliver training that meets ACRRM standards (condition 26). The College satisfied condition 26 in 2013

with the implementation of the Bi-College RTP Accreditation Program ensuring that RTPs are directly accredited against ACRRM standards. Condition 25 was considered by the 2014 team as part of the assessment.

The College is commended for the way it effectively uses the capacity of the healthcare system for service-based training, using a broad variety of clinical settings that cover the breadth of the discipline of general practice. The College has moved to ensure that all registrars undertake a minimum of six months of training in accredited community-based general practice settings. Once the current round of changes are completed, following the closure of GPET, there may be an opportunity to refine the post accreditation processes across the various pathways to reduce the administrative burden in a particular setting.

The College continues to rely on training providers to deliver the majority of training leading to ACRRM fellowship. This program delivery function includes accreditation of individual training posts and supervisors. Therefore, robust ACRRM processes for accreditation of RTPs and the RVTS are crucial to ensuring that the ACRRM training program is delivered as intended, and that accreditation of training posts and supervisors is carried out in accordance with ACRRM accreditation policies.

The establishment of the Bi-College RTP Accreditation Program is seen as a real strength, both in terms of the improved collaboration with the Royal Australian College of General Practitioners (RACGP) and improved oversight of the accreditation of training providers. The Bi-College RTP Accreditation Program enables ACRRM to work closely with RACGP and also provides a mechanism for ensuring compliance with specific ACRRM requirements for the training program. The majority of RTPs have commenced the accreditation process, and early feedback from both ACRRM and RACGP is encouraging.

The team found that registrar involvement in the Bi-College and training post accreditation processes are limited. Notwithstanding the financial and logistic issues, the team recommends that the College consider ways to develop greater registrar input in this area.

The team noted that an apparent disconnect between the College and some training sites has been attributed to the intermediary role of RTPs and the RVTS, making it challenging for the College to ensure accredited training posts consistently comply with requirements for ACRRM training. This should be combated using robust processes for accreditation of training providers, as well as further development of strategies for improved communication with training providers, directors of training, medical educators and supervisors.

In 2010, it was recommended that the College contribute to ensuring that all training posts have current accreditation and to clear the backlog of posts awaiting accreditation and reaccreditation (condition 25). The College indicated that under the Bi-College RTP Accreditation Program, its role is to contact the regional training provider requesting action whenever accreditation is overdue. The training providers are required to follow-up and either withdraw the post or arrange to expedite the re-accreditation. Delays can often be due to regional training providers opting to process accreditations

in groups. In these instances the College does not receive the necessary paperwork until the entire group is complete, by which time some are overdue. The team recommends that College continue to ensure that through the Bi-College RTP Accreditation Program all operating training posts and supervisors have up-to-date accreditation status.

As detailed under standard 1 of this report, changes to the general practice training environment in Australia are afoot, potentially affecting the funding and function of RTPs. The outcome of these changes and the impact on accreditation of training posts and providers are not yet known.

The proposed changes to RTPs in Australia may impact on the College's ability to continue rigorous accreditation of training providers and to ensure accreditation of individual sites and supervisors is carried out in accordance with ACRRM accreditation policies. The AMC will expect further reports on the impact of changes as they are implemented.

While accreditation activities are currently occurring in a fluid environment with an uncertain future, the team considers that the College has addressed the issues raised in conditions 25 and 26 from 2010. Given that it is likely that the College will need to make some changes to its accreditation processes, and given the risks inherent in failure to maintain accreditation of training providers, training posts and supervisors, condition 16 requires ongoing vigilance from the College to maintain the integrity of the training pathways through effective accreditation processes.

## 2010 Accreditation Conditions and Recommendations

*2010 Commendations*

R    The recent work by ACRRM, with General Practice Education and Training support, to develop additional support for supervisors and to provide resources explaining ACRRM training requirements to regional training providers.

S    The work by General Practice Education and Training, the regional training providers, ACRRM and RACGP to review and improve post and supervisor accreditation processes.

*2010 Conditions to satisfy accreditation standards*

25    Report on its contribution to ensure that all posts have current accreditation and to clear the backlog of posts awaiting accreditation and reaccreditation. (Standard 8.2)

26    Working with General Practice Education and Training and other stakeholders, establish College mechanisms and contribute to GPET processes that will provide assurance of ACRRM-accredited regional training providers deliver training that meets ACRRM standards. (Standard 8.2)

*2010 Recommendations for improvement*

Nil

The 2014 team considers that conditions 25 and 26 from 2010 have been met.

## 2014 Accreditation Conditions and Recommendations

*2014 Commendations*

X      The collaboration with the Royal Australian College of General Practitioners in the establishment of the Bi-College Regional Training Provider (RTP) Accreditation Program which facilitates greater oversight of accreditation of regional training providers.

Y      The College's use of a wide variety of training settings within the healthcare system for service-based training positions, facilitating a broad training experience for registrars in general practice.

*2014 Conditions to satisfy accreditation standards*

16      Progress and report on developments in accreditation processes affecting regional training providers, training posts and supervisors, focusing on the impact of Australian Government led changes to the funding and structure of general practice training provision. (Standard 8.2)

*2014 Recommendations for improvement*

VV      Through the accreditation of regional training providers, ensure that all operating training posts and supervisors have up-to-date accreditation status. (Standard 8.2)

WW      Include registrar representatives on the accreditation teams for both the Bi-College Regional Training Provider Accreditation Program and training post accreditation. (Standard 8.2)

# 9 Continuing professional development

## 9.1 Continuing professional development programs

The accreditation standards are as follows:

- The education provider's professional development programs are based on self-directed learning. The programs assist participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine as well as changing societal expectations.

- The education provider determines the formal structure of the CPD program in consultation with stakeholders, taking account of the requirements of relevant authorities such as the Medical Board of Australia and the Medical Council of New Zealand.

- The process and criteria for assessing and recognising CPD providers and/or the individual CPD activities are based on educational quality, the use of appropriate educational methods and resources, and take into consideration feedback from participants.

- The education provider documents the recognised CPD activities of participants in a systematic and transparent way, and monitors participation.

- The education provider has mechanisms to allow doctors who are not its fellows to access relevant continuing professional development and other educational opportunities.

- The education provider has processes to counsel fellows who do not participate in ongoing professional development programs.

### 9.1.1 The ACRRM Professional Development Program (PDP) in 2010

*The two general practice colleges have been assisted in mandating participation by the requirements of the vocational register for general practitioners. From 1989 until 2010, recognised general practitioners were required to participate in an authorised quality assurance program in order to retain vocational registration status.*

*The ACRRM Professional Development Program (PDP) was established in 1998. Since 2003, participation in the ACRRM PDP has been recognised towards the Australian Government quality assurance requirement for vocational registration.*

*While the vocational registration requirements are changing, and with the introduction of the National Registration and Accreditation Scheme on 1 July 2010, the Medical Board of Australia registration standards require medical practitioners engaged in any form of medical practice to participate regularly in continuing professional development relevant to their scope of practice. CPD must include a range of activities to meet individual learning needs including practice-based reflective elements, such as clinical audit, peer-review or performance appraisal, as well as participation in activities to enhance knowledge such as courses, conferences and online learning. Members or fellows of medical colleges accredited by the AMC, by meeting the standards for CPD set by their college will meet these registration requirements.*

ACRRM's *Professional Development Committee*, which is chaired by a member of the Censors Committee, overviews and reviews the development of professional development standards and policy. The Committee has established working groups for specific tasks such as professional development accreditation, credentialing and clinical privileging. The PDP is administered and managed through the College's Professional Development Unit which documents the CPD activities of participants, and monitors and reports on participation to the relevant ACRRM committees or officers.

The *Professional Development Program Handbook 2008-2010* details the requirements for professional development for the current triennium. Participants must accumulate a minimum of 100 points each triennium through participation in the three categories of accredited activities. The allocation of points is shown in the table below.

## Points Allocation Framework

| CATEGORY | ACTIVITIES | CAP |
|---|---|---|
| **Maintenance of Advanced Life Support Skills** *(Mandatory)* | *Advanced Life Support course* | *10 points per activity* |
| **Extended Skills** *(Mandatory)* *Activities in this section may also be claimed as core/other* | *Clinical Audit* | *30 points per audit* |
| | *Clinical Attachment* | *30 points per attachment* |
| | *Peer Review* | *30 points per review* |
| | *Skills Analysis/Appraisal of Practice* | *30 points per activity completed* |
| | *Skills/Simulator Practical Training* | *30 points per activity* |
| | *University Modules, PhD or Masters Research Based (Clinical)* | *70 points PhD* *40 points Masters (completed)* |
| | *Development of Educational Programs (clinical)* | *30 points per program* |
| | *ACRRM Teaching Practice Accreditation* | *30 points per accreditation per triennium* |
| **Core/Other Continuing Professional Development** | *Conferences, workshops, scientific meetings, clinical/non-clinical short courses and seminars* | *All 30 points per triennium (unless otherwise stated)* |
| | *Theory Practice* | |
| | *Practice Accreditation* | |
| | *Planned Learning Projects* | |
| | *Remote/Distance based education modules* | |
| | *Self Directed Learning (journal reading, tapes, videos)* | |
| | *Academic Detailing* | |
| | *Teaching Medical Students* | |
| | *Supervision of Registrars* | |
| | *External Clinical Teaching (ECT) visit* | |
| | *Co-ordinating and Moderating Clinical Forum Discussions* | |
| | *University Courses: Masters, Diploma, Certificate etc* | |
| | *Formal Research Project Non Clinical* | |
| | *Publications* | *20 points per referred work* |

| CATEGORY | ACTIVITIES | CAP |
|---|---|---|
| | *Scientific Presentation* | *10 points per poster* <br> *15 points oral* |
| | *Presentation to Non Medical Groups* | *10 points* |

*Activities in the Core/Other Continuing Professional Development category are allocated one point per hour, and activities in the other two categories are awarded two points per hour.*

*The program is self-directed. ACRRM recommends that participants develop a personal learning plan for the triennium, based on self analysis of education and training need which should reflect practice requirements and community need. ACRRM advises participants they should broadly address the professional development categories and ACRRM curriculum areas. ACRRM provides a Practice Analysis Kit or participants can use other approved appraisal of practice tools to develop monitored educational activities and practice outcomes. Each participant has access to an online learning planner, through Rural and Remote Medical Education Online (RRMEO). The planner provides a record of the educational experiences and information about PDP requirements and allows the participant to set learning goals.*

*The learning planner is also used to identify learning needs defined by the individual's current and future professional directions.*

*Fellows must meet the PDP requirements each triennium. ACRRM offers remediation to fellows who have not met the requirements 90 days before the conclusion of the triennium and remain noncompliant at the end of the triennium. If a fellow does not participate or is still noncompliant following remediation, then ACRRM may withdraw fellowship.*

*Documentation of educational activities will be conducted through a combination of self-recording and automatic notification. Verification documentation is the responsibility of the individual practitioner and must be made available to ACRRM upon request.*

*ACRRM has endorsed educational activities provided by a wide range of organisations including regional training providers, university departments of rural health/rural clinical school networks, universities and other medical colleges, as well as activities provided directly by the ACRRM. It allows substantial cross-accreditation of education with similar programs run by other medical colleges.*

*The College's Accreditation Subcommittee considers applications for accreditation of educational events that:*

- *are based on members' educational needs*

- *relate to one or more of the ACRRM educational domains*

- *have members involved in the planning and implementation stages of the educational event/activity*

- *have clear, specific learning objectives*

- *have planned educational strategies based on adult learning principles*

- *include a combination of educational interventions, which predispose, enable and reinforce behaviour change*

- *show that some impact evaluation (changes in knowledge, skill, attitude, practice or patient outcome) is planned.*

*Approved activities are displayed on RRMEO Educational Inventory. This database can be searched across multiple requirements and parameters. It includes data on educational events, clinical attachments, training posts, online education, and other resources. Activities are mapped to the curriculum and enable participants not only to achieve CPD requirements but also to obtain an overall view of their learning plans and requirements.*

### 9.1.2 2010 team findings

*ACRRM's continuing professional development program is the most well established of the College's educational programs. The team commends a well designed and well established CPD program that awards CPD points on a triennium cycle.*

*The responsibility for the program is under the appropriate oversight of College committees with both managerial and office-bearer input and Board scrutiny.*

*The team acknowledges the outstanding work by ACRRM to enable practitioners in the more rural and remote areas to access high quality and relevant learning materials and activities. This has been achieved through comprehensive networking, partnering and development of material which relates to the curriculum, and that has been developed for all stages of training and practice.*

*ACRRM's online resource, RRMEO, facilitates identification and secure booking of workshops and meetings, self-directed learning using specifically designed modules, electronic resources such as clinical protocols and online submission of PDP points. RRMEO is a valuable tool for monitoring both progress and educational achievement for the participant. This is highly commended and the team would recommend the formal presentation of this in the medical education literature.*

*The College reviews the Professional Development Program before the end of each triennium. As part of its accreditation submission, the College provided the results of its most recent (2008) survey of professional development program participants. The results indicate that overall the program, content and delivery were satisfactory for most respondents. Participants also rated their top five educational topic requirements, with Emergency Medicine and Mental Health the major areas identified. Obstetrics and Gynaecology, Paediatrics, Anaesthetics, Dermatology and Cardiac/Cardiology were also priority areas. The College submission outlines its response to this feedback, in particular its actions to deliver an advanced life support Emergency Medicine program, to assume responsibility for the Rural Emergency Skills Training program developed by the Rural Workforce Agency Victoria, and to deliver Mental Health Level 1 and Level 2 accredited training in collaboration with psychiatrists, psychologists, physicians, mental health nurses and rural consumers and carers.*

*The survey did propose improvements in the delivery of the program by RRMEO, which was reported to be difficult to navigate, slow and non-intuitive. There were also*

*complaints about delays in ACRRM processing credits points. The College is responding to these criticisms by providing additional training and simplifying its protocols for RRMEO use. The AMC will be interested in the College's future reports on these issues.*

*The College has introduced mandatory requirements which relate to life support skills. While this is applauded, the College should consider how to profile other common and very important conditions. In this context the team noted the excellent program in Mental Health and its online availability. Equally, the College has continued to profile the importance of procedural skills to the Fellowship.*
*The team recommends that the College undertake more formal evaluation of outcomes. Through the Research Committee, this could include measures of competence.*

*The Medical Board of Australia continuing professional development registration standards indicate that continuing professional development must include practice-based reflective elements, such as clinical audit, peer-review or performance appraisal. Audit is a suggested component of the CPD program, and the team recommends that ACRRM introduce a regular compulsory audit of procedures undertaken. This would serve as a useful practice profile analysis as well as ensure tracking of patient outcomes. Audits are now being established in many regions that look at issues relating to mortality. While mortality is an infrequent event, the College should consider how all hospital related deaths are reviewed.*

### 9.1.3  The ACRRM Professional Development Program (PDP) in 2014

The College has been active in reviewing and refining the Professional Development Program (PDP) since 2010. The ACRRM PDP, overseen by a Professional Development Committee, is the College's most mature educational program, having been in place for eleven years, reflecting its importance to the College.

In the last triennium 2011–13, the College provided PDP services for 1,718 medical practitioners, 1,634 being fellows, through 2,906 accredited courses. The overall PDP compliance for this triennium was as follows.

| Professional Development Program | Compliant or reporting not needed | Uncompliant |
|---|---|---|
| Fellows | 1305 | 24 |
| Non-fellows | 226 | 1 |
| Exemption / Extension | 39 | - |
| Retired / Other | 5 | - |
| No reporting requirement | 25 | - |
| Will let FACRRM lapse | 9 | - |
| Totals | 1609 (98.5%) | 25 (1.5%) |

The Chair of the Professional Development Committee is appointed by the College Board and is automatically a member of the College Education Council, to which the Committee reports. The PDP is managerially supported through the College's Fellowship Services Unit.

The PDP has been reviewed and now lists eight objectives and incorporates three categories of approved educational activities, including mandatory life support skills (10 points), practice reflective professional development (30 points) and core continuing professional development (60 points), requiring a minimum of 100 points each triennium.

In the 2011–13 triennium, the PDP's second category was changed from Extended Skills to Planned Reflective Professional Development and its approved activities were reviewed to reflect this change. The Planned Reflective Professional Development has again been reviewed for the 2014–16 triennium and renamed as Practice Reflective Professional Development.

Participants enter approved PDP activities undertaken in the online Rural and Remote Medical Education Online (RRMEO) platform, which also requires certificates of attendance or equivalent documentation. This online program is transitioning to a new Customer Relationship Management (CRM) system in early 2015.

Continuing professional development (CPD) education activities are assessed and approved through the College's Fellowship Services Unit and overseen by the Professional Development Committee. Approved CPD education providers are included in the annual *Professional Development Program Annual Evaluation Report*. This data assists the College with program planning, development and resourcing.

While there are currently no specific PDP point requirements related to a fellow's advanced practice, the Professional Development Committee is investigating this issue as part of the review of the Advanced Specialised Training curricula. However, there are Maintenance of Professional Standards (MOPS) requirements through the Joint Consultative Committees (JCCs) for Anaesthetics, Medical Acupuncture and Obstetrics and Gynaecology. There are also MOPS reporting requirements for Radiology and Mental Health. Each of these areas requires Practice Reflective Professional Development points as part of the overall triennium requirements.

The role of multi-source feedback in the PDP, which is currently not mandatory, is under review by the College's Professional Development Committee.

The PDP remediation policy currently used, covered the 2011–2013 triennium and is now under active review by the Professional Development Committee. Fellows who fail to provide sufficient certification of continuing professional development to comply with the College's PDP requirements in a triennium are advised in writing by the Professional Development Committee chair and are required to provide evidence of compliance, or undertake additional appropriate activities by no later than 31 March of the following year. The escalation process for non-compliance is from the Professional Development Committee to the Censor in Chief and then to the ACRRM Board.

A member who attains fellowship of ACRRM will be allocated full compliance in ACRRM PDP for the triennium in which the fellowship is awarded.

### 9.1.4   2014 team findings

The Professional Development Committee has appropriate, reviewed terms of reference. The 2014–16 triennium enhancements address previous concerns regarding the need for Practice Reflective Professional Development within the College's Professional Development Program (PDP).

The team commends the College on its continued efforts to provide a best practice PDP for its fellows, focussing on setting standards and encouraging self-directed learning. The importance of continuing to focus on the PDP is emphasised by the finding of the 2013 *PDP Annual Evaluation Report* that only eighty percent (80%) of new ACRRM fellows consider that they are adequately prepared for rural and remote general practice.

The College continues to provide and enhance valuable remote learning modules and opportunities through its Rural and Remote Medical Education Online (RRMEO) platform and is planning to implement the enhanced Customer Relationship Management (CRM) system, which will allow a 360 degree view of all fellow and registrar interactions with the College, including current RRMEO functionality and PDP documentation and tracking.

In 2010, the AMC recommended that the College review the ACRRM Professional Development Program requirements to ensure compliance with the Medical Board of Australia's continuing professional development registration standard, and specifically those requirements relating to practice-based reflective activities. The College has addressed this recommendation through its extensive review of the PDP and the production of the PDP requirements for the triennium 2014–16, embodied in the publication *Your Professional Development Program Triennium Requirements 2014–16*. The Practice Reflective Professional Development includes a range of approved activity categories such as clinical audit, peer review and practice accreditation.

In 2010, the AMC recommended the College introduce a requirement for a compulsory audit of procedures undertaken by fellows on a regular basis. In response to this recommendation, the College has reviewed the issue of regular, compulsory audits of procedures undertaken by fellows and clarified the respective roles and responsibilities of the College and fellows, determining that the College's role is the collection and review of PDP activity reporting, while the fellow is responsible for maintaining records of procedures necessary to meet jurisdictional requirements related to credentialing and currency of practice. Where a fellow has gained a diploma as part of Advanced Specialised Training or after completion of fellowship training, the fellow must separately meet the additional continuing professional development requirements to maintain those qualifications and these may include procedural logbook requirements. Such activities can satisfy both maintenance of professional standards (MOPS) and PDP practice-reflective requirements.

Given the procedural skills requirements in both the Primary Curriculum and the Advanced Specialised Training curricula, the Professional Development Committee is currently considering the need to require fellows engaged in procedural work to maintain procedural logbooks as part of their PDP for the College. This could allow audits to be undertaken if there are any concerns about the fellow's skills in these areas,

and also facilitate reflection by the fellows about other PDP requirements. An example of this could be the need for refresher PDP activities in areas where exercise of the fellow's procedural skills may be infrequent but necessary for the community in which they practise.

Currently, attainment of ACRRM fellowship status in any PDP triennium provides 100 points to the new fellow, essentially completing their triennium PDP obligations. The Royal Australian College of General Practitioners has a similar policy. While the rationale for this policy is understandable in the rural and remote context, there remains an expectation of ongoing commitment of new fellows to PDP. It is recommended that the College considers including the expectation that new fellows will demonstrate an ongoing commitment to continuing professional development, perhaps on a pro-rata points basis for the remainder of the triennium following attainment of their fellowship.

The current Professional Development Committee deliberations regarding the role of multi-source feedback for fellows, which is currently not compulsory, and its place in the College's PDP requirements, is appropriate and should be pursued.

## 9.2    Retraining

The accreditation standards are as follows:

- The education provider has processes to respond to requests for retraining of its fellows.

### 9.2.1    Retraining in 2010

*ACRRM has developed a Retraining Program to support Fellows who wish to return to active general practice following a prolonged absence or who have, or wish to, modify their practice direction. This policy relates to fellows who have either identified themselves, or have been identified by a Regional Health Board or Medical Board of Australia, as requiring retraining. Fellows requiring retraining in order to return to safe general practice with the requisite skills for their practice demographics will be required to enrol in the ACRRM Retraining Program. They will be required to complete a Self-Assessment Activity form for submission to the PDP Committee for approval prior to commencement of the program. If deemed necessary by the Committee and upon recommendation from the chair, a mentor may be assigned to support the fellow's progress.*

*The ACRRM Retraining Program is documented and tracked on the College's Rural and Remote Medical Education Online (RRMEO) website.*

*The College has developed good methods for retraining and skills development for practitioners who want to address gaps in their skills. Facilitated through the RRMEO platform and the chair of PDP Committee, learning plans can be developed and monitored online with appropriate moderation, if required.*

### 9.2.2    Retraining in 2014

The ACRRM Retraining Program has been developed to support ACRRM fellows who wish to return to active general practice following a prolonged period of absence or who

have modified, or wish to modify, their current practice direction. The policy covers fellows who have either identified themselves or have been identified by a Regional Health Board, Medical Board or Medical Council as requiring retraining.

Fellows requiring retraining submit a learning plan with timelines for Professional Development Committee approval. The retraining program is documented and tracked on the College's Rural and Remote Medical Education Online (RRMEO) platform. At an agreed review date, the Committee reviews the retraining outcomes and, subject to the outcome, the fellow will then continue retraining under the College Professional Development Program, have their retraining period extended, or potentially have their fellowship suspended or withdrawn. A mentor is assigned to support fellows undergoing retraining if deemed necessary by the Committee chair.

The team considers that the College's Retraining Program is appropriate and fit for purpose.

In addition, the team acknowledges the opportunity provided by the current Commonwealth grants program for retraining whereby there are 20 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)-determined obstetric up skilling grants and 15 ACRRM-determined anaesthetic up skilling grants of $40,000 each per annum for fellows who are entering a new phase of their career requiring the application of new or advanced skills.

## 9.3    Remediation

The accreditation standards are as follows:

- The education provider has processes to respond to requests for remediation of its fellows who have been identified as under-performing in a particular area.

### 9.3.1   Remediation of underperforming fellows in 2010

*The remediation process is appropriately an extension of the re-training process but requires a more tailored and monitored approach. However this often involves a number of Board members due to the inherent challenges of addressing the requirements for such fellows, and the increased complexity of dealing with individuals if they are in isolated environments.*

*The Board and officers of ACRRM are aware of concerns about underperforming doctors who do not respond to up-skilling opportunities and remediation issues. The discussions with the team suggested these are handled sympathetically, but with attention to concerns about professionalism. Guidance and possible remedies are identified and outcomes monitored.*

### 9.3.2   Remediation of underperforming fellows in 2014

The College's *Professional Development Program Remediation Policy 2011–2013* which outlines the process and procedures for engaging and assisting fellows who are required to undertake remediation as well as how to deal with fellows who fail to meet their PDP requirements for the triennium. The current remediation policy is under review by the Professional Development Committee to align with the 2014–2016 PDP triennium requirements.

Fellows involved in remediation are handled sympathetically and supported to achieve a successful outcome to the remediation process. However, the policy is clearly effectively used as 20 fellows have had their fellowship withdrawn by the College during the past triennium. Seven of these were voluntary withdrawals. One fellowship was subsequently reinstated.

The team recommends that the College review the remediation policy in line with the Medical Board of Australia's requirements and ensure that the policy is finalised as soon as practicable to ensure a current policy is in place.

## 2010 Accreditation Conditions and Recommendations

*2010 Commendations*

T       The well-established and well-designed ACRRM professional development program.

U       ACRRM's work to enable practitioners in the more rural and remote areas to access high quality and relevant learning materials and activities.

V       The capacity of ACRRM's Rural and Remote Medical Education Online system to support delivery of the professional development program.

*2010 Conditions to satisfy accreditation standards*

Nil

*2010 Recommendations for improvement*

SS      Review its professional development program requirements to ensure compliance with the Medical Board of Australia's continuing professional development registration standard, and specifically requirements relating to practice-based reflective activities. (Standard 9.1.2)

TT      Introduce a requirement for a compulsory audit of procedures undertaken by fellows on a regular basis. (Standard 9.1.2 and 9.1.3)

There were no conditions from 2010 in relation to Standard 9.

## 2014 Accreditation Conditions and Recommendations

*2014 Commendations*

Z       The College's Professional Development Program continues to represent best practice with a focus on continual renewal, ease of access and optimal use of information and communication technology.

*2014 Conditions to satisfy accreditation standards*

17      Review the current *Remediation Policy 2011–2013* and implement a revised policy in line with the College's 2014–2016 Professional Development Program triennium requirements and the Medical Board of Australia's requirements. (Standard 9.3)

*2014 Recommendations for improvement*

XX      Review the requirement that fellows engaged in procedural work maintain procedural logbooks as part of their ACRRM Professional Development Program. (Standard 9.1)

YY      Implement a process for new fellows to demonstrate an ongoing commitment to continuing professional development, perhaps on a pro-rata points basis for the remainder of the triennium following the attainment of their fellowship. (Standard 9.1)

ZZ      Introduce multi-source feedback for fellows as part of the College's Professional Development Program requirements. (Standard 9.1)

## Appendix One    Membership of the 2010 AMC Assessment Team

**Professor Gavin Frost (Chair)** MBBS, MPH, FAFPHM, RACMA, HKCCM (Hon)
Dean, School of Medicine, Fremantle, The University of Notre Dame Australia

**Mrs Barbara Daniels** Dip Ed
Member of the Health Consumers' Council of Western Australia

**Dr David Hillis** MBBS (Hons), MHA, FRACGP, FRACMA, FCHSE, FAIM, FAICD
Chief Executive Officer, Royal Australasian College of Surgeons

**Dr Bronwyn Peirce** MBBS, FACEM
Staff Specialist, Emergency Medicine, Western Australia Country Health Services – South West

**Dr Paul Scown** MBBS, BHA, FRACMA, AFCHSE
Consultant to Health and Research Sectors

**Professor Dame Lesley Southgate** MB ChB, MClinSci, DSc (Hon), ScD and Distinguished International Professor Medical Academy of St Petersberg, Russia, DSc (Hon), Honorary Fellow Royal Society of Medicine
Professor of Medical, Education, St George's Hospital Medical School, London

**Dr Robert Stone** MBBS, Dip Child Health, MRCP
Psychiatry Registrar at Perth Clinic

**Ms Theanne Walters**
Deputy Chief Executive Officer, Australian Medical Council

## Appendix Two Membership of the 2014 AMC Assessment Team

**Professor Ian Civil MBE (Chair)** KStJ, ED, MBChB, FRACS, FACS
Professor of Surgery, University of Auckland; Director of Trauma Services, Auckland City Hospital

**Associate Professor Alexandra Cockram** MBBS, M.Med (Psych), FRANZCP, GAICD, Chief Executive Officer, Western Health

**Dr Joshua Francis** BAppSc (MedSc), MBBS, FRACP
Staff Specialist Paediatrician, Royal Darwin Hospital

**Ms Mary Lawson** BSc (Hons)
Director of Education, Australasian College for Emergency Medicine

**Dr William Milford** MBBS (Hon), FRANZCOG
Staff Specialist, Department of Obstetrics & Gynaecology, Royal Brisbane & Women's Hospital and Obstetrician at Arrivals South Brisbane

**Dr Paul Scown** MBBS, BHA, FRACMA, AFCHSE
Consultant to Health, Education and Research Sectors

**Ms Fiona Tito Wheatland** BA (Hons), LLB
Member, Healthcare Consumers of the ACT

**Ms Jane Porter**
Manager, Specialist Training and Program Assessment, Australian Medical Council

## Appendix Three List of Submissions on the Programs of ACRRM in 2010 and 2014

**2010**

Australian Medical Association Council of Doctors in Training

Australian and New Zealand College of Anaesthetists

Bond University

Department of Health and Human Services Tasmania

Department of Health Victoria

Greater Western General Practice Training Limited

James Cook University, Discipline of General Practice and Rural Medicine

Medical Board of Queensland

Monash University, Faculty of Medicine, Nursing and Health Sciences

Newcastle University, Centre for Rural and Remote Mental Health, Orange

Northern Territory General Practice Education

NSW Health

Queensland Health

Royal Australasian College of Surgeons

SA Health

The Australasian College of Dermatologists

The Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Ophthalmologists

The Royal Australian College of General Practitioners

University of Western Sydney, School of Medicine

Western Australia General Practice Education and Training (WAGPET)


**2014**

Australasian College of Dermatologists

Australian and New Zealand College of Anaesthetists

Australian Medical Association

General Practice Supervisors Australia

General Practice Training Tasmania

James Cook University

Kidney Health Australia

North Coast GP Training

Palliative Care Australia

Royal Australasian College of Surgeons

Royal Australian and New Zealand College of Ophthalmologists

Royal Australian and New Zealand College of Psychiatrists

Royal New Zealand College of General Practitioners

Rural Doctors Association of Australia

SA Health

Services for Australian Rural and Remote Allied Health

University of Adelaide

Western Australian General Practice Education and Training Limited

# Appendix Four   Summary of the Team's Program of Meetings 2010

| Location | Meeting |
|---|---|
| **ADELAIDE, SA** | |
| *Thursday 4 March – Professor Gavin Frost, Dr Paul Scown, Mr John Jamieson (AMC staff)* | |
| Teleconference | Supervisors |
| Adelaide to Outback RTP | Chief Executive Officer, Adelaide to Outback<br>Adelaide to Outback staff |
| | Chief Executive Officer, Sturt Fleurieu<br>Sturt Fleurieu staff |
| Department of Health, South Australia | Chief Medical Officer |
| Rural Doctors Workforce Agency | Medical Director |
| School of Medicine, Flinders University | Registrars |
| | Flinders University staff |
| **ALBURY/WODONGA, NSW/VIC** | |
| *Tuesday 2 March – Professor Gavin Frost, Dr David Hillis* | |
| Remote Vocational Training Scheme | Chief Executive Officer |
| | RVTS staff |
| Bogong | Supervisors<br>Registrars |
| | Chief Executive Officer<br>Medical Educator |
| **ALICE SPRINGS, NT** | |
| *Friday 12 March – Dr Bronwyn Peirce, Dame Lesley Southgate* | |
| General Practice Network NT | Joint meeting with General Practice Network Northern Territory and Northern Territory General Practice Education (RTP)<br>NTGPE Senior Medical Educator |
| Northern Territory Clinical School, Flinders University | Northern Territory Clinical School Flinders University |
| The Alice Springs Hospital | Director of Medical Services |
| | Registrars |
| Central Australian Aboriginal Congress | Supervisors |
| | General Practitioners |

| Location | Meeting |
|---|---|
| **BEAUDESERT, QLD** | |
| *Monday 15 March – Dr Paul Scown, Mrs Barbara Daniels* | |
| The Beaudesert Medical Centre | Independent Registrar |
| | Supervisors |
| **BRISBANE, QLD** | |
| *Monday 15 March – Dr David Hillis, Dr Bronwyn Peirce* | |
| The Sebel Brisbane | Teleconference with QLD Independent Pathway Registrars |
| | Queensland Rural Medical Education<br>Medical Director/ Chief Executive Officer |
| | Teleconference with Rural Health (DOGP) – Toowoomba Division<br>Chief Executive Officer |
| *Monday 15 March – Professor Gavin Frost, Dame Lesley Southgate, Ms Theanne Walters (AMC staff)* | |
| Central and Southern Queensland RTP | Chief Executive Officer<br>ACRRM Medical Advisor<br>Director of Medical education. |
| Queensland Health | Deputy Executive Director of Rural & Remote Medical Services<br>Executive Director, Rural and Remote Medical Services<br>Director, Queensland Medical Education and Training |
| *Monday 15 March – Dr Robert Stone, Mr John Jamieson (AMC staff)* | |
| Postgraduate Medical Education Council of QLD | Chief Executive Officer |
| **BUNBURY AND BUSSLETON, WA** | |
| *Wednesday 10 March – Mrs Barbara Daniels, Dr Bronwyn Peirce* | |
| Rural Clinical School – Bunbury | Head of the Rural Clinical School of WA<br>Rural Clinical School staff |
| | Greater Bunbury Region Division of General Practice<br>Chief Executive Officer |
| | South West Aboriginal Medical Service<br>Chief Executive Officer<br>Health Services Manager |
| The Forrest Family Practice | Supervisor |
| Duchess Medical Practice | Independent Pathway Registrar and Supervisor |

| Location | Meeting |
|---|---|
| **CAIRNS, QLD** | |
| *Tuesday 9 March – Dr Paul Scown, Dame Lesley Southgate, Ms Theanne Walters (AMC staff)* | |
| The Cairns Base Hospital | Hospital Director of Medical Services |
| | Registrars |
| | Supervisors |
| | Supervisor Teleconference |
| Far North Queensland Division of General Practice and General Practice Cairns | Chief Executive Officer Program Manager |
| Wuchopperen Aboriginal Medical Service | Chief Executive Officer Wuchopperen Aboriginal Medical Service staff |
| **CANBERRA, ACT** | |
| *Tuesday 23 February – Professor Gavin Frost* | |
| Australian Medical Council Office | Rural Doctors Association of Australia (RDAA) President Immediate Past President Chief Executive Officer |
| Commonwealth Department of Health and Ageing | Senior staff of the Department |
| General Practice Education and Training (GPET) Limited | Chair, GPET Chief Executive Officer National General Manager Program Improvement & Workforce National General Manager Quality & Education Senior Medical Adviser |
| **HOBART, TAS** | |
| *Friday 5 March – Professor Gavin Frost, Mr John Jamieson (AMC staff)* | |
| Department of Health and Human Services | Deputy Secretary Care Reform Director Medical Integration Primary and Rural Health |
| General Practice Training Tasmania | Senior Medical Educator Assistant Chief Executive Officer Education Manager Accreditation Officer |
| The Calvary Hospital | Supervisors |
| Hobart Private ED | Registrars and Supervisors |

| Location | Meeting |
|---|---|
| **KARRATHA, WA** | |
| *Wednesday 10 March – Professor Gavin Frost, Dr Robert Stone* | |
| Mawarnkarra Aboriginal Health Service | Chief Executive Officer<br>Clinic Manager<br>ACRRM registrar |
| Karratha Medical Centre | Supervisor of Training |
| Nickol Bay Hospital | Independent Pathway candidate<br>WA Director and supervisor |
| | North West Division of General Practice<br>Medical Director |
| | Pilbara General Practice Network |
| | Rural Clinical School<br>Medical Coordinator – Rural Clinical School |
| **MELBOURNE, VIC** | |
| *Wednesday 3 March – Professor Gavin Frost, Dr David Hillis* | |
| Royal Australian College of General Practitioners | Chief Executive Officer<br>Director of Education |
| General Practice Registrars Association | Chief Executive Officer |
| | Supervisors |
| | Registrars |
| General Practice Victoria | Chief Executive Officer |
| Department of Human Services | Director, Sector Workforce Planning |
| **PERTH, WA** | |
| *Thursday 11 March – Professor Gavin Frost, Dr Robert Stone, Mrs Barbara Daniels* | |
| Western Australia Postgraduate Medical Council and WA Health | Western Australia Postgraduate Medical Council Chair<br>Representative, Directors of Postgraduate Medical Education<br>Coordinator PMCWA |
| | WA Health<br>Executive Director Medical Workforce, WA Country Health Services |
| Western Australian General Practice Education and Training (WAGPET) | Chief Executive Officer<br>Director of Education |
| | Registrars and Supervisors |

| Location | Meeting |
|---|---|
| Rural Health West | Manager of Retention Services |
| **TOWNSVILLE, QLD** | |
| *Wednesday 10 March – Dr Paul Scown, Dame Lesley Southgate, Ms Theanne Walters (AMC staff)* | |
| Tropical Medical Training (TMT) | Chief Executive Officer, TMT<br>Director of Training<br>Registrar Administration Officer, TMT |
| | Chief Executive Officer, Townsville General Practice Network (TGPN) and North and West Queensland Primary Health Care<br>Programs Manager, TGPN<br>GP Liaison Consultant, TGPN |
| James Cook University | College Censor<br>Associate Professor of General Practice and Rural Medicine |
| | Dame Lesley Southgate presentation |
| | QLD Independent Pathway Registrar Teleconference |
| The Townsville Hospital | Supervisors |

**Meetings with the Australian College of Rural and Remote Medicine Committees and Staff**

**Monday 15 March – Wednesday 17 March 2010**
Professor Gavin Frost (Chair), Mrs Barbara Daniels, Dr David Hillis, Dr Bronwyn Peirce, Dr Paul Scown, Professor Dame Lesley Southgate, Dr Robert Stone, Ms Theanne Walters (AMC staff)

| Meeting | Attendees |
|---|---|
| *15 March 2010* | |
| Governance, decision-making structures, challenges, strategic directions, communication<br>College relationships<br>Feedback from team | ACRRM Board |
| Site visits and teleconferences | AMC Team |
| *16 March 2010* | |
| Vocational training<br>Management of ACRRM education and training<br>Structure of the three programs<br>The Primary Curriculum, including a presentation on curriculum review<br>Advanced Specialised Training curricula<br>Additional issues:<br>• Registrar research<br>• Recognition of Prior Learning<br>• Topics given special emphasis.<br>ACRRM appeals | Chair, Vocational Training Committee<br>Member, Vocational Training Committee<br>Vocational Training Manager<br>Program Coordinator, Vocational Training<br>Chief Executive Officer<br>President<br>Vice President |
| Advanced Specialised Training and how standards for specialties are developed – example obstetrics and gynaecology | Chief Executive Officer<br>Chair, Conjoint Committee for the Diploma of Obstetrics and Gynaecology (CCDOG)<br>Member, Conjoint Committee for the Diploma of Obstetrics and Gynaecology (CCDOG) |
| Advanced Specialised Training and how standards for specialties are developed – example anaesthesia | Chair, Vocational Training Committee<br>Vocational Training Manager<br>Chair, Joint Consultative Committee on Anaesthesia (JCCA)<br>Member, Joint Consultative Committee on Anaesthesia (JCCA) |

| Meeting | Attendees |
|---|---|
| Assessment and examination | Chair, Assessment<br>Vocational Training Manager<br>Academic Director<br>President<br>Vice President<br>Chief Executive Officer |
| Assessment of overseas-trained specialists | Chair, IMG Committee<br>Member, IMG Committee<br>Strategic Projects Manager<br>Member<br>President<br>College Censor |
| Role of College Staff | Chief Executive Officer<br>Program Managers |
| Role of College Censor | Chief Executive Officer<br>President<br>College Censor<br>Immediate Past President and Past Censor |
| *17 March 2010* | |
| Monitoring and evaluation | Vocational Training Manager<br>Chief Executive Officer<br>President<br>Vice President<br>Censor |
| Teleconference with NSW RTPs | Chief Executive Officer, Beyond Medical Education<br>Co-Chair, Beyond Medical Education |
| Selection to ACRRM pathways | Chief Executive Officer, Remote Vocational Training Scheme<br>Member, ACRRM Selection Panel |

| Meeting | Attendees |
|---|---|
| Continuing professional development programs | Fellowship Services Manager<br>Strategic Projects Manager)<br>Chair, Post-Fellowship Committee<br>On-Line Services Manager<br>Censor<br>Chief Executive Officer<br>President<br>Chair, Procedural Grants Collaboration<br>Chair, Professional Development Program |
| Issues relating to trainees | Registrar Director and Chair, Registrar Committee<br>Members, Registrar Committee |
| Environment for training | Vocational Training Manager<br>Censor<br>Chief Executive Officer<br>President<br>Chair, Vocational Training Committee<br>Medical Educator |
| Teaching and learning approaches | Vocational Training Manager<br>On-Line Services Manager<br>Censor<br>Chief Executive Officer<br>President<br>Vice President<br>Chair, Vocational Training Committee<br>Medical Educator |
| Supervisors and examiners | Chief Examiner<br>Vocational Training Manager<br>Developer<br>Pre-vocational Training Manager<br>Chair, Vocational Training Committee<br>Censor<br>President<br>Chair, Vocational Training Committee |

# Appendix Five    Summary of the Team's Program of Meetings 2014

| Location | Meeting |
|---|---|
| **ADELAIDE, SA** | |
| *Saturday 11 October – Ms Mary Lawson* | |
| Adelaide to Outback Head Office | ACRRM Primary curriculum Structured Assessment using Multiple Patient Scenarios (StAMPS) Examination |
| **BRISBANE, QLD** | |
| *Saturday 22 November – Associate Professor Alex Cockram* | |
| ACRRM Office, Brisbane | Emergency Medicine Structured Assessment using Multiple Patient Scenarios (StAMPS) Examination |
| *Sunday 30 November – Dr Joshua Francis, Dr William Milford, Ms Fiona Tito Wheatland, Ms Jane Porter (AMC staff)* | |
| Teleconferences at Marriott Hotel | Overseas trained general practitioners |
| | Independent Pathway candidates |
| | Independent Pathway supervisors |
| **CANBERRA, ACT** | |
| *Friday 28 November – Mr Ian Civil, Ms Fiona Tito Wheatland, Ms Jane Porter (AMC staff)* | |
| General Practice Education and Training | General Manager, Programs<br>Manager, Quality |
| National Rural Health Alliance | Executive Director, National Rural Health Alliance<br>Rural Health Continuing Education Program Manager, National Rural Health Alliance<br>Policy Officer, National Rural Health Alliance |
| Australian Government Department of Health | First Assistant Secretary, Health Workforce Division<br>Department Officer, Health Workforce Division<br>Director, Rural Training Pathways, Health Workforce Division |
| Regional Training Providers via teleconference | Chief Executive Officer, General Practice Training Tasmania (GPTT)<br>Chief Executive Officer, GP Synergy<br>Director of Training, Director of Education, and Director of Research and Development, Western Australian General Practice Education and Training (WAGPET)<br>Chief Operating Officer, WentWest<br>Director of Training, Northern Territory General Practice Education (NTGPE)<br>Chief Executive Officer, Sturt Fleurieu |

| Location | Meeting |
|---|---|
| Conjoint Committee for the Diploma of Obstetrics and Gynaecology (CCDOG) via teleconference | Chair, CCDOG |
| General Practice Registrars Australia (GPRA) via teleconference | Chair, GPRA |
| **SYDNEY, NSW** | |
| *Thursday 30 October and Saturday 1 November – Dr Joshua Francis, Dr Paul Scown, Ms Fiona Tito Wheatland, Ms Jane Porter (AMC staff)* | |
| Rural Medicine Australia (RMA) 2014 Conference | Registrar Committee |
| | Independent Pathway registrars |
| | Vocational Preparation Pathway registrars |
| | Remote Vocational Training Scheme registrars |
| | Independent Pathway Medical Educators |
| | Vocational Preparation Pathway Supervisors, Directors of Training, Medical Educators |
| | Staff of the Regional Training Providers |
| | Remote Vocational Training Scheme Supervisors, Directors of Training, Medical Educators |

**Meetings with the Australian College of Rural and Remote Medicine Committees and Staff**

**Sunday 30 November – Wednesday 3 December 2014**

Mr Ian Civil (Chair), Associate Professor Alex Cockram, Dr Joshua Francis, Ms Mary Lawson, Dr William Milford, Dr Paul Scown, Ms Fiona Tito Wheatland, Ms Jane Porter (AMC staff), Ms Ellana Rietdyk (AMC staff)

| Meeting | Attendees |
|---|---|
| *1 December 2014* | |
| The College<br><br>College governance; decision-making structures; challenges; strategic directions; priority setting, communication; College's relationship with GPET and RACGP. | President<br>Immediate Past President<br>Council member<br>Treasurer<br>Registrar Director<br>Immediate Past Registrar Director<br>Board Members<br>Censor in Chief<br>Tasmanian Director<br>Chief Executive Officer |
| The College's vocational education and training programs<br><br>Management of education and training including Joint training programs; Curriculum review and implementation; Review and reform of education and training; Structure, duration and sequencing of training; The content of education and training; Research in training; Recognition of prior learning<br><br>Graduate outcomes | Chair, Education Council<br>President<br>Immediate Past President<br>Censor in Chief<br>Registrar Director<br>Registrar Committee Member<br>Chair, Post-Fellowship Education Committee<br>Vocational Training Committee Member<br>Chair, Research Committee<br>Board Member<br>Manager, Training and Assessment<br>Director of Education |

| Meeting | Attendees |
|---|---|
| Assessment and examination<br><br>Overall assessment and examination policies; In-training assessment and formative assessment; Examinations - standards setting, training of examiners; Function of the written and clinical examinations; Procedures re: unsatisfactory performance: performance feedback, remediation; Assessment of competencies other than "medical expert" | President<br>Immediate Past President<br>Chair, Assessment Committee<br>Principal Examiner<br>Censor in Chief<br>Registrar Committee Member<br>Assessment Committee Member<br>Director of Education<br>Manager, Training and Assessment<br>Chief Executive Officer |
| Continuing professional development programs; College process for retraining under-performing fellows | Professional Development Committee Members<br>Board Member<br>Immediate Past President<br>Post-Fellowship Education Committee Member<br>Manager, Fellowship Services |
| Royal Australian College of General Practitioners (RACGP) via teleconference | President, RACGP<br>Censor-In Chief, RACGP<br>RACGP National Rural Faculty Censor<br>Chair, RACGP Victoria Faculty, and Chair, National Faculty of Specific Interests |

| State and Territory Health Department representatives | Manager, Medical Workforce, Department of Health Victoria |
| --- | --- |
| | Senior Policy Advisor, Department of Health Victoria |
| | Chief Medical Officer, Department of Health Northern Territory |
| | Executive Director, Medical Services, WA Country Health Service, Department of Heath Western Australia |
| | Principal Medical Advisor, Medical Workforce, Department of Health Western Australia |
| | Director, Rural and Remote Medical Support including Queensland Rural Generalist Program, Queensland Health |
| | Manager, Medical Workforce, Office of the Principal Medical Officer (OPMO), Queensland Health |
| | Director, Rural Pathways, Department of Health and Human Services Tasmania |
| | Medical Advisor, Workforce Planning and Development, NSW Ministry of Health |
| | Manager, South Australian Medical Education and Training Unit, SA Health |
| Supervisors, trainers and examiners<br><br>Appointment, training, review of performance; College role in supporting supervisors and examiners, and clarity of roles | Principal Examiner |
| | Director of Education |
| | Manager, Training and Assessment |
| | Vocational Training Coordinator |
| | Accreditation Coordinator, Vocational Training and Assessment |
| | Assessment Coordinator, Vocational Training and Assessment |
| Environment for training<br><br>Interaction with, and accreditation of Regional Training Providers (RTPs); Bi-College RTP Accreditation Program; Accreditation of posts for training; Interactions with health departments about training requirements and training to meet community need | Chair, Education Council |
| | President |
| | Censor in Chief |
| | Board Members |
| | Registrar Committee Member |
| | Education Committee Member |
| | Chief Executive Officer |

| | |
|---|---|
| Role of the College education staff in supporting education, training and continuing professional development | Director, Operations<br><br>Manager, Training and Assessment<br><br>Vocational Training Coordinator<br><br>Accreditation Coordinators, Vocational Training and Assessment<br><br>Fellowship Services Manager<br><br>Director of Education<br><br>Principal Examiner |
| Monitoring and evaluation, quality assurance processes | Chair, Education Council<br><br>President<br><br>Board Member<br><br>Chair, Research Committee<br><br>Chief Executive Officer<br><br>Evaluation Coordinator<br><br>Manager, Training and Assessment |
| Assessment of overseas-trained specialists | Chair, International Medical Graduate (IMG) Assessment Committee<br><br>Censor in Chief<br><br>International Medical Graduate (IMG) Assessment Committee Members<br><br>Strategic Projects Manager and International Medical Graduate (IMG) Program Manager |
| Issues relating to registrars<br><br>Selection of registrars; Registrars' involvement in College affairs; Mechanisms to provide support, counselling, and ongoing monitoring of registrars' wellbeing; Registrars' involvement in decision-making about their training; Dispute resolution | Vocational Training Committee Member<br><br>Registrar Committee Member<br><br>Director of Education<br><br>Board Members<br><br>President<br><br>Chief Executive Officer<br><br>Manager, Training and Assessment<br><br>Vocational Training Coordinator |
| Learning and teaching methods<br><br>Rural and Remote Medicine Education Online (RRMEO) and Customer Relationship Management (CRM) demonstration | Vocational Training Committee Member<br><br>President<br><br>Board Member<br><br>Director of Education<br><br>Registrar Committee Members<br><br>Chief Executive Officer<br><br>Manager, Training and Assessment<br><br>Online Services Manager<br><br>Director, Corporate Services |

| | |
|---|---|
| Royal Australasian College of Surgeons (RACS) via teleconference | Dean of Education, RACS<br>Director, Fellowship and Standards, RACS |
| Australasian College for Emergency Medicine (ACEM) via teleconference | Chief Executive Officer, ACEM |
| *3 December 2014* | |
| AMC team prepares preliminary statement of findings | AMC Team |
| Team presents preliminary statement of findings | President<br>Board Member<br>Chief Executive Officer<br>Director, Operations<br>Manager, Training and Assessment<br>Manager, Strategic Programs<br>Manager, Fellowship Services<br>Director, Corporate Services<br>Manager, Online Services |

College Governance Structure