



The Royal New Zealand  
College of General Practitioners

**Postgraduate**  
**Generalist Placement**  
**Education Programme**  
HANDBOOK

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# Welcome

Kia ora and welcome to the RNZCGP Postgraduate Generalist Placement (PGGP) education programme. This handbook outlines the programme's structure and expected learning outcomes.

## Opportunities for vocational education

The Royal New Zealand College of General Practitioners (RNZCGP) was established in 1957 as a branch of the Royal College of General Practitioners (UK). The New Zealand College was formed in 1974 and granted a Royal Charter in 1979. The vision of the College is to improve the health of all New Zealanders through high quality general practice care. The College has 4000 members representing the majority of active general practitioners and rural hospital generalists in New Zealand. It sets professional standards for general practice and rural hospital medicine, as well as providing vocational training and continuing medical education programmes.

Vocational education in general practice is now a widely accepted part of specialist medical education internationally. General practice education in New Zealand has been in existence since the 1970s. As well as the PGGP education programme, the RNZCGP offers the General Practice Education Programme (GPEP) for those doctors who wish to become Fellows of the College and apply for vocational registration in the scope of general practice with the Medical Council of New Zealand.

Vocational education in rural hospital medicine began in 2008. The four year training programme is led by the Division of Rural Hospital Medicine and hosted by the RNZCGP.

The PGGP education programme was offered for the first time in 2002. The programme is funded by the Ministry of Health under the auspices of Health Workforce New Zealand (HWNZ).

# Overview of the training programme

## Entry criteria

The trainee must:

- be a graduate in medicine and surgery of a medical school recognised by the Medical Council of New Zealand
- hold general registration with the Medical Council of New Zealand
- have held general registration for no more than 24 months before commencing the placement
- be undertaking their second or third postgraduate year of training
- have New Zealand or Australian citizenship or NZ permanent residency
- be positively motivated to engage in the training practice.

Medical graduates who do not meet the above criteria may be considered on a case-by-case basis. Where applications exceed places, preference will be given to applicants that have completed hospital runs relevant to general practice.

## Placements

Trainees will be placed in a three-month attachment in an RNZCGP approved rural general practice scoring 35 or more on the Ministry of Health rural ranking scale.

Some provincial general practices will also be available.

## Structure of Programme

You will see patients and receive one-to-one teaching and oversight from an approved teacher.

You will participate in the following:

- seeing patients
- a minimum of two hours teaching time per week
- 'corridor teaching'
- direct observation by the teacher during consultations
- opportunities to observe the teacher consulting with patients
- review of videotaped consultations (where available)
- review of notes
- case discussions
- visits to other primary health practitioners
- fortnightly teleconferencing with peers and a medical educator.

## Learning activities in general practice attachments

The practice attachment will allow you to learn about continuing care of patients through patient consultations. Patient numbers will be kept at a rate appropriate to your level of experience and to enable you sufficient time for reflection and alternative activities.

Patient loads will normally be a minimum of five and maximum of eight patients in each consulting session (half day). You will be given 30 minutes per patient initially, with the time reducing as you gain more experience.

## Practice-based teaching

Teaching in the general practice will be centred on your needs, as identified by your teacher. Specific time is set aside for discussion, observation, review and feedback based on your experiences with patients.

Teaching sessions can be held in a number of different ways:

- **Review sessions** in which you and your teacher review your diary and patient records. The aim is to get both an overview and a brief appraisal of each consultation.
- **Random record review** in which patient records are chosen randomly from those seen on a particular day and discussed in some depth. This approach focuses on what can be learned from individual patient consultations.
- **Problem case analysis** looks at the patients you have found to be a challenge or those cases recognised as having particular points of interest. Difficult consultations can be role-played.
- **Audit** of a general practice topic.
- **Direct observation** with you sitting in with your teacher often happens in the early weeks of an attachment but is also valuable at regular intervals throughout the attachment. Sometimes a teacher and other practice staff members may call you in on a particularly interesting case or with patients with conditions you have not often seen.
- **Direct observation** with the teacher/practice nurse.
- **Videotape review of consultations** offers a less intrusive method of observation, with the added benefit of you being able to reflect on your performance in conjunction with your teacher.
- **Topic discussion** can be facilitated with reference to patients who present with the condition and through the usual journals and reference books on the subject.
- **Trainee log** (procedural skills).

Your teacher will also be available for informal discussions or corridor teaching and able to respond to on-the-spot queries and concerns.

## Teaching/supervision approaches

The primary method of teaching and supervision is from your designated teacher. Clinical supervision is an integral part of the programme's quality assurance processes, with the goal of protecting the safety of patients at all times.

The Health Practitioners Competence Assurance Act (2003) requires all doctors who are not vocationally registered to have a collegial relationship with a vocationally registered doctor. This requirement is provided by your teacher through close super-

vision of your work. Your teacher is available to supervise you five days a week and during the required general practice after-hours sessions.

Medical educators will teleconference with your peer group fortnightly to discuss issues common to rural primary care. Preparation and attendance is required at these teleconferences.

## Developing a learning plan

You will need to identify and discuss your learning goals and plans with your teacher. This plan should be recorded during the first few weeks of your attachment. The plan will need to include:

- a timetable for consulting
- practice activities including out-of-hours services
- details of supervision arrangements when your teacher is at or away from the practice.

## Medical educator visit to the attachment

Your medical educator will visit you during the attachment. If you have any issues or concerns before the scheduled visit, it is important for you or your teacher to request an earlier visit. The purpose of the visit is to ensure the attachment is meeting your learning needs and the requirements of the programme.

In particular, the medical educator will want to ensure that:

- the physical and cultural aspects of the practice environment are conducive to good learning
- the relationship between you and your teacher is conducive to good learning
- any problems within the attachment are dealt with
- barriers to learning are acknowledged and minimised
- your needs are balanced with those of your teacher.

The rural programme co-ordinator will contact you and your teacher to arrange an appropriate time and to facilitate completion of the in-practice visit questionnaire. Most visits will include:

- discussion with you about your learning plan, career development and planning and your evaluation of the attachment

- observation of three consultations
- discussion with your teacher about your progress and your feedback about the attachment
- observation in a teaching session
- a discussion with the practice staff.

You and your teacher will receive a brief written report from the in-practice visit detailing recommendations for further teaching and learning.

## **Assessment and feedback**

You will receive feedback from your teacher on your progress in developing consultation, diagnostic and patient management skills. This feedback will be based on questioning and direct observation and will relate back to the learning goals discussed between you. Teachers will provide ongoing feedback throughout the attachment on the basis of video-recorded consultations and review of patient records etc. They will also provide feedback following discussions with practice staff.

## **Evaluation of the practice attachment**

You will be asked to provide feedback on your attachment. The '*Evaluation of PGGP Attachment*' form seeks information on key aspects of the attachment. You will complete it at the end of your attachment. A copy of the completed form will be sent to the College for analysis and feedback. Your teacher will receive a copy of this evaluation. The information will be used for review purposes, particularly for the quality assurance programme for teaching practices and to help plan teacher development. The Clinical Leader and Education Development Officer will also receive a copy of this form and will discuss it with your teacher

## **Staff of the training programme**

### **Royal New Zealand College of General Practitioners**

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### **Medical Educators and Teachers**

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A number of general practice medical educators and teachers—who are RNZCGP Fellows—contribute to the programme.

Medical Educators assist and support the PGGP Clinical Leader, teachers and trainees.

Teachers are contracted by the College to teach trainees and registrars and to provide oversight of their training. Teachers contributing to the programme are approved by the RNZCGP, and have usually attended a two day teacher orientation workshop.

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# Aims of the training programme

## Aims and objectives

The training programme provides an opportunity for year two/three house officers to experience three months in a general practice or rural hospital placement.

This experience provides trainees with an opportunity to apply prior learning in a community based primary health team context and to integrate new learning as they focus on the clinical needs of general practice.

The programme is clinically-based and focuses on clinical and practical experiences as well as on the doctor-patient relationship and consultation skills.

The key concepts underpinning the programme are:

- patient-centred medicine
- the generalism of general practice
- evidence-based medicine.

The education programme's objectives are for trainees to:

- experience and participate in general practice or rural hospital work in a supportive environment.
- acquire medical knowledge and expertise in a rural or provincial context.
- enhance their interpersonal and communication skills, particularly in relation to patient consultations.
- develop an understanding of the general practitioner/hospital interface and the interface between health professionals in the rural sector.
- gain an understanding of the relevant cultural context including Māori and rural
- develop collegial and peer associations and linkages
- develop an understanding of the pathway to a career in general practice.

# Managing relationships within the general practice attachment: communication and informed consent

## Relationships with patients

Most patients you see in general practice will not regard you as their family doctor but as a substitute. They need to understand your role and the responsibility for explaining this is shared between you and your teacher.

Because you will spend a lot of time seeing people who usually see other doctors, you may come across treatments or practices you disagree with, or patients who are dissatisfied with their usual doctor. These problems can raise difficulties that are worth considering in advance and discussing with your teacher.

At the same time, you may have patients who come to regard you as their doctor. This can cause ethical difficulties that need to be resolved.

You may need to learn about and conform to the 'culture' of your host practice. To do otherwise could abuse the trust you are granted and lead to a strain between your teacher and the practice partners and their patients. Pay attention to your dress, punctuality and your general manner.

## Patient consent

You are in a supervised situation in the practice. Patients need to understand this and be given the option to say no to seeing you.

Also, remember that general practice teachers are doctors first and teachers second. Their main responsibility is to their patients and to ensure ethical management of the practice. Teachers will want to protect their patients and this can sometimes lead to problems with consent.

Guidelines for ethically correct practice are provided below. In many cases, the practice will have its own way of conforming to the legislative requirements around informed consent.

## **Guidelines for ethically correct practice**

- Patients should be made aware that they are involved in medical education.
- Patients should be specifically informed that you may become involved in their medical care and told about the practice's involvement in the programme and what it means. They should be told your name.
- Explanations should state that you are a fully-qualified doctor gaining experience and learning more about general practice.
- Patients should be told of the benefits expected as a result of their involvement in the programme.
- Patients should be given a choice to see you or their own doctor. This should happen at the time the appointment is made.
- You should identify yourself and your position in the practice in every encounter with a patient.
- You should obtain a patient's consent for any intervention that is intimate, personally sensitive, invasive or hazardous.
- Specific informed consent that accurately describes your role in the procedure must be obtained from the patient by your teacher before you perform any complex, invasive diagnostic, therapeutic or prophylactic procedure.
- Written consent should be obtained from the patient for any action that might violate his or her right to confidentiality e.g. production of enduring materials such as photographs, audio/videotapes or publications.
- It is important that both you and your teacher recognise the need for continuity and so, from time-to-time, your teacher should see each patient personally.

## Video consultations

You may video some of your patient consultations to review with your teacher. Please note the following important points:

- Video consultations must occur only with the informed consent of the patient.
- All registrars must use the consent form and process which is included in this Handbook—see Appendix I.
- The patient must be informed of the full scope of how the video will be used i.e. who will see it and under what circumstances. You must ensure that video recordings are used only for the purpose for which the patient has consented.
- You are responsible for ensuring that the video is kept secure at all times. Video recordings must not be left in cars or in other situations where theft may occur. They must be kept secure at the practice when not in use as they are no different to patients' written records or other confidential information.
- Video recordings must be wiped or destroyed as soon as they are no longer required for education purposes. No recordings should be kept at the end of the attachment.

See Appendix I for further specific information about informed consent.

## Medical Council (MCNZ) requirements regarding having a third person present during a consultation

In 2004, the MCNZ produced a guideline for informed consent related to having a third person present during a consultation. The issues raised in the guideline that are particularly relevant to you and your teachers include:

*“Policies related to having a third person present during a consultation should be displayed in the practice waiting room and examination areas. Arrangements for the presence of a third person should be in place prior to the start of the consultation.*

*All parties involved in the consultation must understand the role of the third person. The patient must give informed consent for the person to be present and the role they will take.*

*The MCNZ advises that the doctor speak with the patient about the presence of a third person in private, away from the nominated third person. This is to ensure that the patient does not feel obligated to accept someone due to the discomfort of saying 'no' in front of the third person.*

*The Council recommends to doctors that if they require a third person to attend a consultation the third person should preferably be another health professional.*

*If a third person attends all or part of a consultation or procedure you need to ensure that the third person is aware of its confidential nature and that the patient's personal information and physical privacy must be respected.*

*Not every patient will want to have a third person in attendance, especially if there is an intimate aspect to the consultation that includes a physical examination for which the patient may have to undress. Some patients have indicated that a third person makes them feel an audience is present. A patient has the right to decline a third person being present.*

*If there is no agreement on the attendance of a third person or who that third person should be, either the doctor or the patient has the right to withdraw from the consultation until a mutually acceptable third person is available. Alternatively the patient may be referred to another doctor. This should not have any adverse effect on the care that is provided."*

## **Relationships with staff in the teaching practice**

All doctors in a group must accept a trainee attachment before a teacher and practice can be approved. The degree to which these doctors are directly involved with trainees will vary from practice to practice and time-to-time. Disagreements or misunderstandings can sometimes arise with practice staff. Such problems are uncommon, but should be discussed with your teacher or the clinical leader of the programme.

## **Financial responsibility during practice attachments**

At times you may need to collect money directly from patients. It is your responsibility to charge for services according to the policies of the practice. You are responsible for recording payments, bookkeeping and management of any money taken. When

you receive direct payments, do not keep them. You are paid a training bursary and accepting other money jeopardises your position as well as the good standing of the programme in general.

## **Using IT in teaching practices**

Trainees are expected to comply with teaching practice IT policies. For example, do not access personal email or non-medical sites while working unless your practice specifically authorises you to do so. The use of datasticks, external CD/DVD will also be limited in some teaching practices. Please check with your practice manager.

## **Practice activities and services**

Trainees are required to participate in the full range of services offered in teaching practices.

As well as scheduled patient consultations within the practice, there are specific and varied activities provided by different teaching practices. These include rostered after hours services, house calls, rest home visits, hospice visits, specific clinics such as pharmacy, physiotherapy, rural hospital, Plunket, local vet etc.

Rostered after-hours, house or rest home visits provide an opportunity to care for patients in a setting other than the practice premises with all its attendant resources. After-hours call is a reality of rural practice and trainees are expected to participate in the call roster for a minimum of one out-of-hours session per month. Your teacher is required to be available out-of-hours work to provide supervision and support. You and your teacher are required to have a debrief after each duty period about the patients seen.

Other special activities or services that teachers and practices provide will give you an opportunity to experience this range of treatment settings and more fully understand the modern scope of general practice. It will also help you to develop your own specific interests.

During each attachment, you will be expected to participate, according to your learning needs defined in conjunction with your teacher, in extra activities such as after-hours, house calls, rest home care or other specific activities in each particular

practice. These activities may or may not be during normal consulting hours and will usually be detailed in the practice profile on the website.

Duties outside the normal consulting hours of the practice will attract time off in lieu, hour-for-hour. These duties will be recorded and you will be encouraged to reflect on how they have enriched your experience and learning.

You will also bring your own specific interests and experiences to the teaching practice. Contributing these skills to the teaching practice is encouraged and supported and must be documented.

You or your teacher can only change this agreement during the attachment by mutual agreement. If you can't agree, the medical educator will mediate.

If you have any concerns about the amount of out-of-hours work you are required to do, or about safety and support issues, please discuss these with your teacher and if they are not resolved, with your medical educator.

## **Locum work**

You may work as a locum in rural general practice for limited periods, provided your learning and community involvement are not compromised. Locum work might include the occasional week day or weekend day during your attachment and would be in addition to, and separate from, the programme requirements.

If you want to work as a locum during your attachment, you will need your teacher's support and agreement, a collegial relationship with a FRNZCGP for the duration of the locum work (ideally your teacher) and ACLS Level 7 certification. Supporting documentation needs to be completed and accepted by the Clinical Leader before starting the locum work.

## **Collegial relationship**

As noted previously, the Health Practitioner Competence Assurance Act (2003) requires doctors who are not vocationally registered to form a collegial relationship. This requirement is met for trainees through the supervision/support provided by

teachers. Doctors in vocational training need to advise the Medical Council that they are on the training programme at the time of applying for their practising certificate.

***Please note that if you engage in work outside the auspices of the programme you will need to arrange a separate collegial relationship for this work.***

***Please ensure that you are aware of the requirements of the Medical Council in those circumstances.***

## **Professional liability**

You are responsible for the professional decisions you take, and may be liable in case of errors. It is a condition of your appointment that you carry up-to-date medical indemnity protection and you are asked to provide evidence of current cover. This needs to be forwarded to the rural programme co-ordinator before you are appointed to a training post.

# Communication issues

## Support for trainees

You may experience financial problems, relationship worries, study concerns or some other personal issues that affect your learning. Your teacher and/or medical educator will be able to arrange support to assist you. It is important that you take responsibility for raising any issues as soon as possible, so they can be quickly resolved.

## Concerns related to the programme

If you have any concerns about the programme including the teaching you receive, please raise them in the first instance with your teacher. If your concerns are not addressed, discuss them with your medical educator or the Clinical Leader who will follow them up and arrange an attachment visit to help assist resolve the issues.

Trainees who have concerns or complaints of a serious nature which can't be resolved at a local level, should make contact with the Clinical Leader who will take appropriate action.

## Māori Director of Training

Dr Keri Ratima is the Māori Director for the Postgraduate Generalist Placement education programme. She is available to assist and support Māori and Pacific trainees. Please do not hesitate to contact her.

# In conclusion

The programme team wishes you an enjoyable and stimulating postgraduate generalist placement. Your attachment will provide you with unique opportunities for learning—we hope that you will enjoy these experiences and are able to make the most of them. We are here to assist you in any way we can and look forward to being part of your experience in general practice or rural hospital medicine.

## APPENDIX I

# Informed consent

### Informing patients about the practice's teaching role

#### **General notifications to all patients**

Practices should inform their patients that the practice is a teaching practice. This should be a continuous process. The most common way of notifying patients is by a waiting room notice provided by the programme which tells patients of their right to refuse to see a trainee. There is a space for the trainee's name to be entered. Another way of informing people is in a practice newsletter or by including an item in a practice booklet. Your practice may need to provide translations in Māori or other languages.

#### **Individual notification to patients**

All new patients should be informed of the teaching programme when they join the practice. If this is done by a receptionist or nurse, it is appropriate for the teacher to discuss with them exactly what patients should be told and how the information should be passed on. This first explanation is important.

At other times, opportunities will arise to talk to patients about the programme. However, the best time to inform patients will be when he or she sees you for the first time. It is essential that you know how to do this and what written information is available.

Names are important—patients may not know the name of an unfamiliar doctor. A nameplate on the desk or a name badge is a good idea.

## Referring patients to the trainee

### How will the practice be organised?

It is important for practices to decide how patients are to be referred to trainees. Sometimes you may see the ‘overflow’ i.e. patients who cannot be seen by your teacher or another principal in the practice because they are fully booked. This tends to give you mostly acute problems and probably younger patients. It also puts additional pressure on patients to see you if they want prompt attention. While you may be extending service, the ‘overflow’ method can have significant problems.

Some practices have a system of asking patients if they would see you instead of their usual doctor—and they do that each day to give you a sufficient number of patients. Such a system can work well but it is important that patients are told of their options. In some practices, a small ‘trainee practice’ has been built up of patients who are always happy to be seen by the current trainee. This system means patients don’t have continuity and can be a problem when there is no trainee in the practice.

In nearly all teaching practices, a receptionist is responsible for making appointments. So it will be his or her job to offer an appointment with you and the way that is done is crucial.

Here are some examples of what and what not to do:

### Asking patients to see the trainee

*Dr Teacher isn't here today so you'll be seeing Dr Trainee*

(This is not ideal as the patient gets neither choice nor explanation)

*I can give you an appointment at 11 o'clock*

(Needs more information before it can be considered informed consent)

*How about seeing Dr Trainee who's working with Dr Teacher?*

(Again needs more information—and ‘working with’ is misleading)

*Dr Teacher is fully booked today. I can give you an appointment with Dr Trainee, the doctor who is here for three months learning about general practice.*

(Good. The patient should be offered an alternative appointment with Dr Teacher when one is available.)

*Would you mind seeing Dr Trainee who's just finished hospital training and is here for three months learning more about general practice? I can give you an appointment at 11 o'clock or you can see Dr Teacher if you prefer.*

(Good. The receptionist must be ready to answer other questions about Dr Trainee.)

A common method is for the consulting doctor—either teacher or trainee—to ask for the patient's consent to being observed at the start of the consultation.

*This is Dr Teacher—you know her don't you—would you mind if she sits in and watches us today? OR This is Dr Trainee, the GP trainee. She's sitting-in watching me this morning. Is that alright with you?*

(Neither of these is enough. Asking the patient in this way brings a lot of pressure to bear. It's hard for patients to say 'No' to their doctor—more so when there is another doctor in the room.)

## **Consent for observing consultations**

Observation of your consulting is an essential part of every general practice attachment. It can be done by your teacher sitting-in or by recording the consultation on either audio or video tape. Sometimes you will observe your teacher and, on these occasions, informed consent is needed. The practicalities of how, when and who are important. Different ways of doing this result in different rates of consent—suggesting that some methods work better than others.

## **Asking for consent—what not to do**

Some practices have put up a notice in their waiting room stating:

*"This practice is involved in teaching young doctors and medical students. From time-to-time we record consultations with patients for educational purposes. If you would prefer that your consultation is not recorded please let the receptionist know."*

Such notices—no matter how carefully and sympathetically worded—are inadequate and in no way can be considered as having sought informed consent. This applies to any sort of observation, whether or not there is a recording made.

## **Asking for consent—how to do it better**

The practice nurse or receptionist should explain and seek consent when the patient first arrives. This can be done using a written form like the one over the page, but if no recording is to be made, written consent from the patient is not necessary. The consulting doctor should explain further why you are sitting in. This should happen outside the consulting room.

Some practices have a regular session where teacher and trainee observe each other. In that situation, patients should be told about it when they make their appointment and a full explanation given. They may still refuse on the day, but the acceptance rate will be higher if they have had prior warning.

Written consent should be obtained for any action that might violate the patient's right to confidentiality e.g. production of enduring materials like tapes. The information given to patients must be clear. It must state the purpose of the recording, who is to view it and what will happen to the tape when it is no longer wanted. Patients should be told that they are under no obligation to agree to being recorded, and they should be given the option of having the tape stopped and erased at any stage during or after the interview.

A good way to get this written consent is for the patient to be given a form when they arrive for their appointment and be asked to return it before seeing the doctor. The receptionist can then indicate to the doctor if a patient has agreed to being recorded. The doctor should always check that patients who have agreed are still happy to be recorded.

Patients can also be told at the time they make their appointment that a consultation at that time will be recorded and given the option to choose another time. They still need to give written consent at the time.

Patients can also be asked to complete the form and return it only if they agree to being recorded—if they do not return a form, they do not wish to be recorded. This opting in process may result in a lower acceptance rate.

Sometimes you may want to ask a patient to give consent in two separate ways.

Recordings of patient interviews should be clearly labelled and stored in a secure locked place. Erase or destroy any interviews when you are finished with them.

## Video recording consent form

*Dear Patient*

*If you agree, I would like to record our consultation today for educational purposes.*

*The camera used is small—you may not even notice it. There will be no camera operator. Even though you appear on the recording it will be used mainly to look at me rather than you. The examination couch is off-camera.*

*The tape may be viewed and discussed by other doctors involved in the General Practice Educational Programme. I can tell you the names of those doctors on request. No-one else will see it. It will be treated confidentially and erased when no longer required. If you wish to see the recording, please let me know and I will arrange that.*

*If you do not wish to be recorded, do nothing—there is no need to explain why and it will make no difference to the way you are treated.*

*If you agree to being recorded—thank you. Please sign below and give this form back to the receptionist now.*

*If at any time during or after the consultation you change your mind, please tell me and I will stop the recorder and wipe the tape.*

*Yours sincerely*

*I agree to having today's consultation recorded on video and used as described above.*

Signed: \_\_\_\_\_

Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_

## Teaching practical skills

There are a number of practical skills and procedures taught in general practice. Such teaching involves explanation, discussion, demonstration and supervised practice. Patients will be involved as models for demonstration and for supervised practice. Appropriate informed consent is essential.

Give a clear explanation to the patient of what is proposed. Check with your teacher that the following information has been covered and guidelines met:

- what the procedure involves
- whether there is likely to be any risk or pain (if this is likely to be increased by your participation)
- who will be doing the procedure (if it is proposed that you do it, introduce yourself and describe your level of experience)
- what benefit there will be from the procedure
- seek the patient's consent
- check that the patient understands what is proposed and tell him or her there is no obligation to agree to your involvement
- ensure the patient has not been pressured in any way and be sensitive to any hesitation. It may be best for the teacher to do this without you present
- you may be seeking consent for the supervision of a procedure you are learning. It is essential for full informed consent to be obtained
- unless your involvement is likely to lead to an increased risk or the procedure is to be recorded, verbal consent will be sufficient.

## APPENDIX II

# Terms and conditions

### Definitions

**Attachment:** the placement of a trainee in a teaching practice for the purposes of training.

**College:** The Royal New Zealand College of General Practitioners.

**Group Manager Professional Development:** the person employed by The Royal New Zealand College of General Practitioners to manage the postgraduate vocational education programmes.

**Clinical Leader:** the person contracted by The Royal New Zealand College of General Practitioners as clinical leader of the Postgraduate Generalist Placement (PGGP) education programme.

**Medical Educator:** a general practitioner contracted by the College to assist in the running of the programme and to support trainees and teachers.

**Programme:** the PGGP education programme as administered by the College.

**Rural programme co-ordinator:** the person employed by The Royal New Zealand College of General Practitioners to administer the programme.

**Trainee:** a medical practitioner appointed by the College as a trainee in the programme.

**Teacher:** a general practitioner contracted by the College to teach and supervise trainees in the teaching practice.

**Teaching practice:** a general practice to which a trainee is attached under the supervision of a teacher.

## Appointment procedures

### Notification of appointment

The Royal New Zealand College of General Practitioners will send each trainee a letter of appointment setting out the start and finish dates of the PGGP education programme and the level of training bursary to be paid.

The letter will need to be signed by the trainee indicating their:

- acceptance of a place on the programme
- agreement to abide by the terms and conditions of the programme and
- intention to complete the programme in full.

### Termination of appointment

By accepting the position, a trainee has indicated their intention to complete the full training period.

In exceptional circumstances appointments may be terminated by the College:

- without notice if the trainee is no longer a registered medical practitioner in New Zealand.
- with no less than one month's notice in writing if the College considers the performance or non-performance of duties or responsibilities required under the programme's terms and conditions to be unsatisfactory. Such written notice will clearly state the reasons why the appointment has been terminated and if the duties or responsibilities need to cease for the period of notice.
- with no less than one month's notice in writing if funding for the PGGP education programme is withdrawn or reduced.
- if the College has received no less than one month's notice in writing from the trainee that exceptional circumstances are preventing him or her from continuing on the programme.

The College can also suspend a trainee from duties and responsibilities required under the programme's terms and conditions in order to undertake investigations related to misconduct, health status or other serious concerns.

## Training bursary

Trainees will receive a tax-free training bursary for the duration of the three-month training period to a total of \$12,500 (2011 amount may be subject to change). Being in receipt of the bursary alone does not count as paid employment.

**Note:** The IRD has ruled under section CB9(d) of the Income Tax Act 1994 that monthly payments made to trainees are exempt from tax. This ruling is available on request from the IRD or the College.

## Income Security

Trainees are advised to consider taking out income protection insurance for cover in the event of illness or accident. As the trainee bursary is tax exempt, the Accident Compensation Corporation (ACC) is unlikely to provide income assistance.

## KiwiSaver

As trainees are not employees of the College, KiwiSaver deductions are not applicable. If you are already in a KiwiSaver scheme, seek advice from your financial adviser.

## Conditions of attachment

### Teacher/Trainee

- The trainee will be attached to a teaching practice under the supervision of a teacher. He or she will be involved in educational activities both within and outside the practice and, in doing so, will attend to patients and provide clinical services while undertaking those educational activities.
- In smaller groups, the trainees will participate in fortnightly teleconferences, facilitated by an experienced medical educator. The teleconferences will focus on different clinical topics each time and discussions will often be based around the trainee's actual cases.
- Some teaching practices may grant the trainee a half day per week to engage in educational activities outside the practice. This is at the discretion of the

individual teacher. This may be used for community visits, visits to other health professionals or outpatients' clinics or to engage in other activities that support learning.

- Trainees can expect to have, on average, two hours each week of protected teaching time with his or her teacher.

## **Hours of participation**

- Trainees are expected to complete one full-time three-month attachment in general practice.
- Trainees are expected to participate in the programme 40 hours per week (excluding meal times).
- Wherever possible, trainees are expected to stay in the area where the practice they are appointed to is located for the duration of the programme.
- Where the practice provides after-hours services, trainees are required to complete a minimum of three 'out-of-hours' supervised sessions during the training attachment i.e. one session per month. The teacher is required to be available during these hours.
- Time off in lieu for out-of-hours experience is to be negotiated between the teacher and trainee and confirmed in writing at the start of the attachment. Each teacher is to provide a 'Practice Attachment Profile' that includes a statement on after hours/on-call experience offered and time in lieu arrangements.

Any changes to this agreement during the attachment can only be made by mutual agreement. The clinical leader of the programme is to mediate if agreement cannot be reached.

## **Patients**

The trainee's patient load will be a minimum of five and a maximum of eight patients seen in each consulting session (half day).

## **Current practising certificate and medical defence indemnity**

Trainees are required to provide evidence of a current practising certificate and medical defence indemnity for the duration of the programme. This must be sent to the rural programme co-ordinator before attachment starts. The College does not cover the cost of practising certificates or medical defence indemnity.

## **Evaluations of attachment**

- Trainees are required to complete evaluations of each attachment. These evaluations are important for quality improvement. Teachers receive a copy of the evaluations, as does the clinical leader of the programme and Health Workforce New Zealand.
- Payment of the training bursary is conditional on these evaluations being received by the specified due date.

## **Attendance and participation**

Trainees are expected to participate fully in all aspects of the programme. At the end of the programme, trainees will receive a certificate of completion from the College indicating their period of enrolment in the PGGP education programme.

## **Standards of conduct**

During the programme, trainees are expected to familiarise themselves and abide by all legislative requirements including the:

- Privacy Act 1993
- Health and Safety Act
- Health Practitioners Competence Assurance Act
- Code of Health and Disability Commissioner Act.

Copies of these are available through the programme clinical leader.

Trainees are expected to behave respectfully and ethically with patients and staff at all times.

## Leave

**Note:** All references to ‘leave’ refer to leave from the programme while retaining entitlement to receive the training bursary.

### Statutory holidays

- Trainees will be granted leave on full payment of the training bursary on any of the following statutory holidays that occur during their appointment:
  - New Year’s Day
  - 2nd January
  - Waitangi Day
  - Good Friday
  - Easter Monday
  - ANZAC Day
  - Queen’s Birthday
  - Labour Day
  - Christmas Day
  - Boxing Day
  - Anniversary Day (as observed in the locality)
- When any of the above holidays (other than Waitangi Day and ANZAC Day) fall on a Saturday or Sunday, the next week day will be allowed as a day of leave.
- When a statutory holiday or substituted succeeding day falls during a period of paid leave, that holiday will not be debited as leave.

### Leave without payment of bursary

Leave without payment of bursary will be considered only in special circumstances and if all annual leave entitlement has been taken. A trainee will not be entitled to payment for a statutory holiday or a substituted succeeding day falling during a period of leave without pay.

## **Leave of absence**

Trainees may apply for up to five days leave of absence and still receive the training bursary. This leave must be taken during the three-month attachment and is not transferable.

In special circumstances (e.g. sickness, parenting, bereavement etc) trainees may apply for leave of absence. Applications will be considered on an individual basis.

## **Trainee entitlements for transport and accommodation costs**

- Where a trainee is required to use his or her own car for the purpose of practice duties, but not for travel to and from the attachment, a mileage allowance will be paid by the training practice.
- Trainees can claim up to a maximum of \$2000 (GST inclusive) for actual and reasonable travel, relocation and accommodation costs directly associated with the three-month placement. Reimbursement will be made on production of receipts. Claims for reimbursement should be made monthly on the appropriate form and sent to the rural programme co-ordinator.

## **Fitness to practise and competence**

All trainees in the PGGP education programme should be aware of the following:

- The Health Practitioners Competence Assurance Act makes it mandatory for a medical practitioner who has reason to believe that another medical practitioner is not fit to practise medicine because of a mental or physical condition to notify the Medical Council of their concerns.
- The College is also of the view that if concerns arise about a trainee's competence to practise medicine to the extent that public safety is compromised, it is the duty of the College to convey those concerns to the Medical Council.
- The Medical Council would normally only be notified following a process of working with the trainee to address the concerns that have been raised. At all times,

the intention would be to help the trainee address the concerns and remove the need to contact the Medical Council.

- It is a condition of all trainees undertaking general practice education that if a trainee's performance raises concerns about his or her fitness to practise and/or competence, the College and/or its contractors/employees have the right to convey such concerns to the Medical Council.

## **Collection of information**

The trainee can access and correct any personal information the College holds on him or her that has been gathered in the course of administering the training programme.

## **Workplace harassment policy**

The Royal New Zealand College of General Practitioners is committed to providing a safe, pleasant and harassment-free environment in which all employees and trainees are treated with respect and dignity. Trainees who have concerns about harassment should in the first place contact their teacher and/or the clinical leader of the programme.

Issues which remain unresolved or that the trainee feels are inappropriate to be discussed with the programme clinical leader should be discussed with the Group Manager Professional Development.

## **Personal grievance procedure**

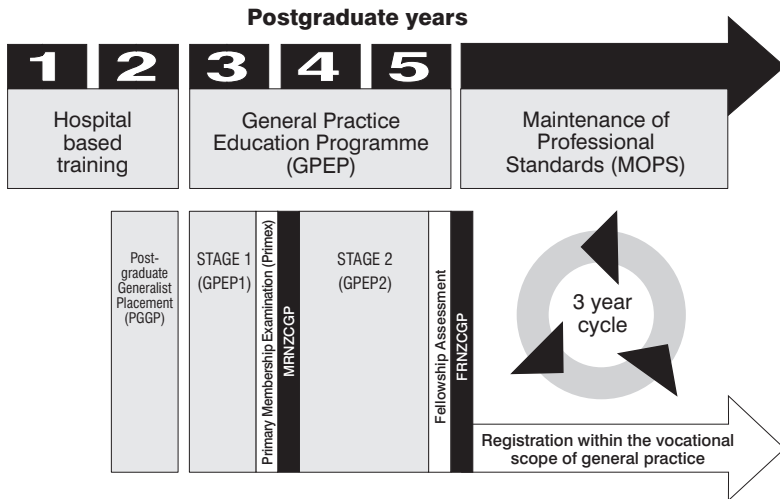
Personal grievance/disciplinary measures will be dealt with under the DHB Collective Agreement or other agreed process.

## APPENDIX III

# General practice vocational education

The Royal New Zealand College of General Practitioners provides education and training programmes to enable doctors to gain the skills, knowledge and ability to practice safely as a general practitioner in New Zealand.

### Education Pathway to Fellowship and Vocational Registration



### General Practice Education Programme Stage 1 (GPEP1)

The RNZCGP offers those wishing to enter general practice, the General Practice Education Programme. Stage one of this programme is 42 weeks in length, based on supervised practice-based learning, one-to-one teaching with an approved vocational teacher and attendance at seminars and workshops for the equivalent of one day per week.

Registrars may participate in the programme on a full-time or part-time basis and can access a Health Workforce New Zealand training bursary. Training scholarships may also be available for rural or special interest registrars.

## Format of the training programme

### Practice attachments

Registrars state their preference for one or more of the regions in which they wish to train. Those who are flexible as to where they will be placed are more likely to have their application accepted. Registrars are usually attached to training practices for two, 21-week attachments and see patients under the supervision of an approved GP teacher. They receive one-to-one teaching from their teacher and assistance in making the most of the learning opportunities that the practice provides.

Medical educators and regional coordinators are responsible for the programme at a regional/local level.

### Day release seminar programme

The seminars and workshops offer a range of learning experiences related to general practice, including simulations and role plays, vignettes, review of videos of consultations, lectures, small group discussions etc. The seminars provide registrars with an opportunity to share their knowledge with others and be part of a supportive peer group.

### Primex examination

Registrars usually sit the Primary Membership Examination (Primex) at the end of their training period in November/December. Success in Primex leads to Membership of the College (MRNZCGP). Once they have sat Primex, candidates can enter General Practice Education Programme Stage 2 (GPEP2) where they continue to work towards Fellowship of the College (FRNZCGP) usually over a minimum of two years. Fellows of the College are entitled to apply to the Medical Council for vocational registration.

### How to apply

The College website will have details of application closing date. You need to complete an application form and state the names of two referees. If you meet the entry criteria, you will be offered an interview as part of the selection process. The following absolute requirements and selection criteria apply:

## Absolute requirements

- registration with the Medical Council of New Zealand
- completion of two full-time equivalent years of appropriate medical experience after graduating (normally RMO runs), see *Selection criteria*. One of these years must be in New Zealand
- New Zealand or Australian citizenship or NZ permanent residence
- two satisfactory referee reports of recent medical experience
- part-time registrars must be in general practice a minimum of five tenths during GPEP1. Those wanting to train part-time are encouraged to discuss their individual circumstances with the rural programme co-ordinator.

## Selection criteria

Factors which will be taken into account in the selection process:

- firm intention to enter general practice;
- RMO experience including at least six of the following:
  - Emergency medicine
  - Ear, nose and throat surgery
  - General practice rotations
  - Geriatrics
  - Obstetrics and Gynaecology
  - Orthopaedics
  - Psychiatry
  - Rheumatology
  - Rural general practice
  - Dermatology
  - General medicine (please specify)
  - General surgery (please specify)
  - Musculoskeletal
  - Ophthalmology
  - Paediatrics
  - Rehabilitation
  - Palliative care
- demonstrated commitment to general practice addressing:
  - Māori health needs
  - Rural health
  - Other government priority health areas
- demonstrated commitment to teaching medical students and colleagues.

For further information contact:

### **GPEP1 rural programme co-ordinator**

RNZCGP, PO Box 10440, Wellington 6143, New Zealand

Phone: (04) 496 5979, Fax: (04) 496 5997, Email: [gpep1@rnzcgp.org.nz](mailto:gpep1@rnzcgp.org.nz)

# APPENDIX IV

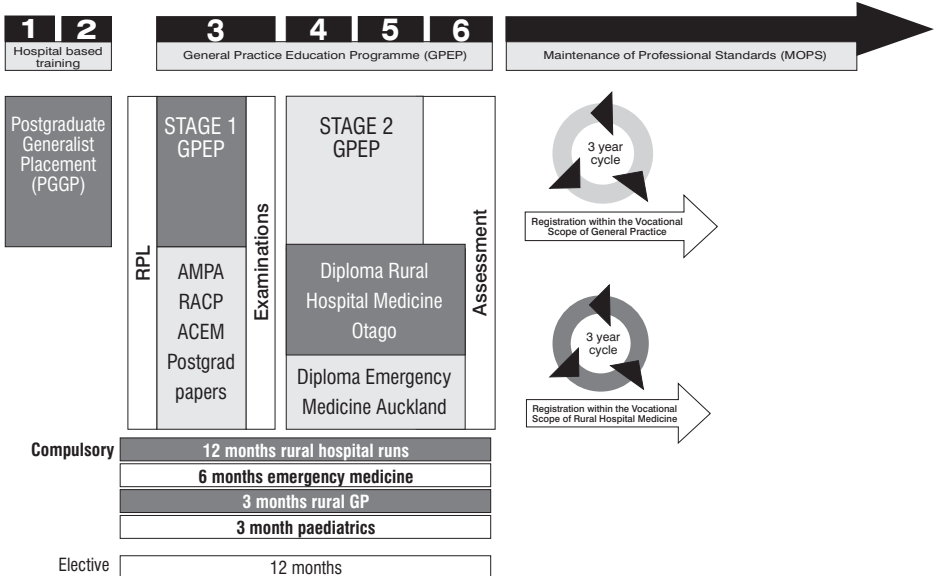
## The Division of Rural Hospital Medicine

# Rural Hospital Medicine Training Pathway

The Rural Hospital Medicine training pathway provides vocational education for rural hospital doctors and prepares them for a role in the community where they are able to improve the health of New Zealanders through high quality rural hospital care.

Following the pathway provides rural doctors with a core body of generalist knowledge and specific skills and attitudes needed to competently practice in a rural environment or a rural hospital.

### Postgraduate vocational training in NZ rural environments



The core body of knowledge is defined in the curriculum, which is outcome-based and consists of the following domains:

- the rural hospital context, including cultural competency and Māori health
- communication

- clinical expertise (basic clinical skills, adult internal medicine, emergency medicine, aged care, child and adolescent, surgical, musculoskeletal, radiology, anaesthetics, obstetrics and women's health, palliative medicine, rehabilitation, ophthalmology, dermatology, psychiatry and mental health, oral health, population health and optional advanced curricula)
- professionalism and ethical practice
- scholarship, including research and evidence-based practice.

Once a registrar is accepted into the training programme, he or she will be assigned an education facilitator (a vocationally-registered rural hospital doctor) for the four years of training to ensure they develop an appropriate portfolio to achieve Fellowship. Together they will produce a professional report and training plan: the report will identify areas of prior learning and learning needs; the plan will include intended clinical attachments, academic qualifications needed to meet the identified learning needs, and requirements for Fellowship. The training plan will expand to form the basis of the registrar's portfolio for the duration of the programme.

The training programme recognises prior learning and registrars can have parts of their academic and clinical components approved, depending on prior experience and training.

The training programme includes academic and clinical components and a final assessment. The Division of Rural Hospital Medicine accredits the clinical attachments and provides the final assessment for Fellowship.

The academic component requires registrars to complete postgraduate papers or qualifications provided by universities and/or other colleges over a minimum of three years. Registrars are also required to successfully complete the EMST, ACLS (level 7), and APLS courses, so they are current at Fellowship.

The clinical attachments occur over four years, full-time equivalent (FTE) in compulsory (12 months FTE); recommended (six months); and elective clinical training attachments (12 months). Compulsory runs include six months in Emergency Medicine, six months in Internal Medicine, one year in Rural Hospital Medicine, three months in Paediatrics and three months in General Practice.

The elective time built into the programme allows registrars to train concurrently in another scope such as Accident and Medical Practice, or to develop an advanced set of skills e.g. anaesthetics.

Rotational Supervisors within the hospital and general practice supervise the registrars, except for the run the registrar does with his or her Educational Facilitator.

## Entry Requirements

The minimum requirements are:

- New Zealand citizenship or permanent residence
- registration with the Medical Council of New Zealand
- two satisfactory referee reports of recent medical experience

The preferred requirements for admission into the training programme are:

- Completion of two full-time equivalent years of appropriate medical experience after graduating. Appropriate medical experience includes at least six of the following:
  - Emergency medicine
  - Ear, nose and throat surgery
  - General Practice rotations
  - Geriatrics
  - Obstetrics and gynaecology
  - Orthopaedics
  - Psychiatry
  - Rheumatology
  - Relevant rural hospital and rural general practice runs during postgraduate years 1 and 2
  - Dermatology
  - General medicine
  - General surgery
  - Musculoskeletal
  - Ophthalmology
  - Paediatrics
  - Rehabilitation
  - Palliative care
  - Rural General Practice
- Preference will be given to applicants who have had prior exposure to rural health and the rural environment.

For further information contact:

**Rural Programme Co-ordinator**

**Rural Hospital Medicine Training Programme**

RNZCGP, PO Box 10440, Wellington 6143, New Zealand

Phone: (04) 496 5999, Fax: (04) 496 5997, Email: [drhm@rnzcgp.org.nz](mailto:drhm@rnzcgp.org.nz)