Division of Rural Hospital Medicine
NEW ZEALAND
Te Whare Taiwhenua

Rural Hospital Medicine Training Programme Handbook 2026

The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Cover image: iStock.com/Sheryl Watson

Contents

Welcome 2
The Division's structure and governance. 3
The curriculum 5
Admission to the programme 7
Training time 7
Recognition of prior learning. 8
Working part-time or being 'on hold' 9
Training requirements 9
Educational support 17
Learning activities 19
Assessments 22
Academic Fellowship. 25
Dual Fellowship training. 25
Addressing issues. 26
Registrars requiring support 26
Hauora Taiwhenua (Rural Health Network) and Conference 27
Fees 27

Photo: iStock.com/swissmediavision

Welcome

Welcome to the training pathway leading to Fellowship of the Division of Rural Hospital Medicine (the Division). The Fellowship qualification (FDRHMNZ) is recognised by the Medical Council of New Zealand (MCNZ) as the standard practitioners must attain to be recognised for the speciality of rural hospital medicine.

Rural hospital medicine is a broad, horizontal field of practice that intersects with many medical specialties, other health practitioners, and community services – in ways that make it a separate and unique specialty. The scope includes a wide range of procedural skills at the secondary care level, including skills in managing complex cases with limited resources. It covers the entire spectrum of medical presentations.

Rural hospital medicine is a relatively new and growing speciality, and it offers the Fellow a stimulating and rewarding career in the most beautiful parts of New Zealand. As a generalist with expanded capabilities, the Fellow plays a vital role in rural hospitals and rural communities.

For a comprehensive definition of rural hospital medicine see section 1 of the Division's **Fellowship Pathway Regulations**.

The broad range of knowledge, skills, values and attitudes attained through the Rural Hospital Medicine Training Programme (RHMTP) will build on skills already held and open the door to further opportunities in our rural communities and beyond.

This handbook provides most of the information you need to prepare and plan for training. The handbook refers to the relevant section of the Regulations where relevant. Important documents for training are:

- DRHM Curriculum
- DRHM Fellowship Pathway Regulations
- DRHM Policies.

These are available on the **Division's pages** on the website of The Royal New Zealand College of General Practitioners.

The Division's structure and governance

Rural hospital medicine is a recognised independent scope of medicine. The Division sits as a semi-autonomous body within The Royal New Zealand College of General Practitioners (the College),* which has Vocational Education and Advisory Body status with the MCNZ. The Division sets standards for the rural hospital medicine vocational scope.

Objectives

The Division's objectives are to:

- promote excellence in rural hospital medicine care
- train rural hospital doctors to a high standard, with an appropriate range of generalist skills and special interests
- promote rural hospital medicine as a vocation
- advocate for rural health and education
- promote rural health research
- promote and develop professional relationships
- provide ongoing professional support
- acknowledge Māori rural communities as an important part of rural health and strive for equity in access and health outcomes for rural Māori.

Council and Board of Studies

The Division operates on two levels: the Council and the Board of Studies (BoS).

The Council represents rural hospital doctors across New Zealand and is a vocational and representative governance body for the vocational scope of rural hospital medicine. The Council meets three times a year to discuss important issues.

The objectives of the BoS are to:

- set national standards for rural hospital doctors' vocational education and ensure suitable assessment activities are provided.
- monitor the provision of high-quality vocational education and assessment activities for members wishing to attain Fellowship.
- encourage Fellows to maintain their vocational registration through professional development activities based upon personal development, including critical self-evaluation and improvement activities based on valid information and appropriate objectives.
- assess the equivalency of relevant medical training programmes for the purpose of entering the RHMTP and entering at Fellowship level.
- Establish links with relevant national and international groups to monitor trends in vocational education and assessment and incorporate suitable innovations into the programmes.

* The Division of Rural Hospital Medicine is established under the RNZCGP 2017 Rule 20 and 20.4 as a Chapter of The Royal New Zealand College of General Practitioners.

Registrar representation

Your group may be asked to elect a registrar representative for the Division's Council and BoS. The registrars' representative advocates for the interests of their fellow registrars. Their details are available on Te Ara.

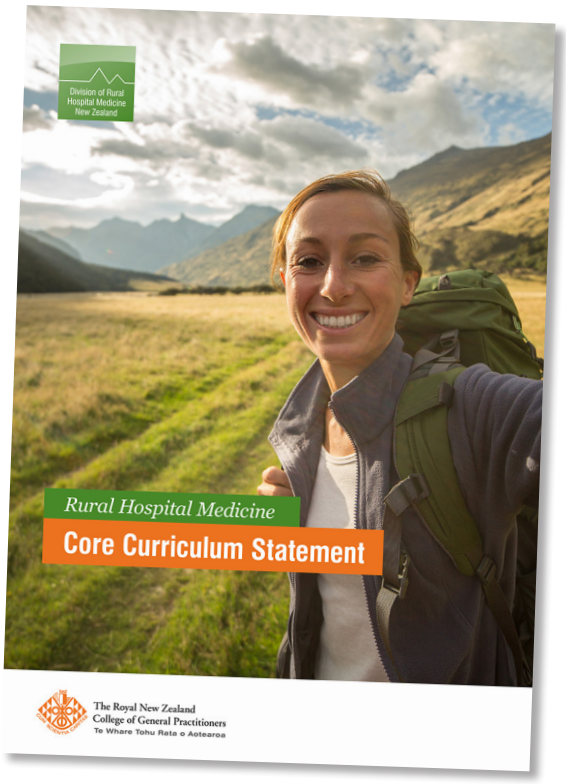
Who to contact

Contact the DRHM senior education coordinator if you have any queries:

DRHM senior education coordinator
E: drhmnz@rnzcgp.org.nz
T: 04 496 5999

The curriculum

The Division's curriculum defines the knowledge, skills, values and attitudes rural hospital medicine doctors need to work successfully and safely from postgraduate years to Fellowship and beyond. It is an essential resource for registrars, educators and assessors.

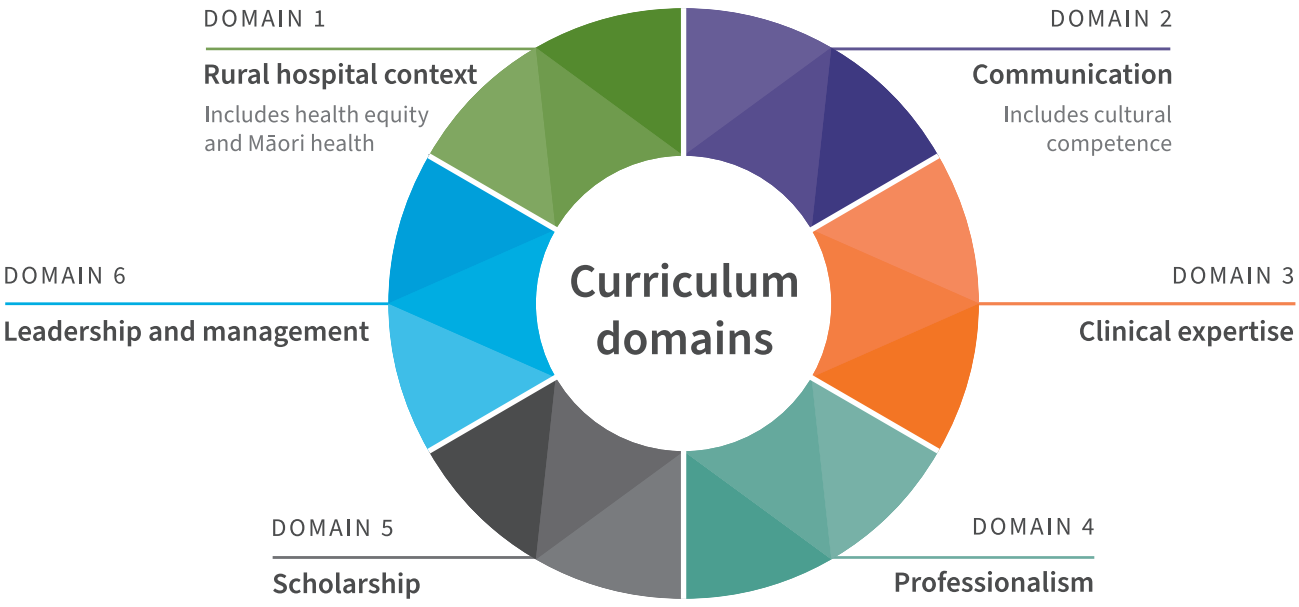


Overview

The curriculum consists of a **Core Curriculum Statement**, which outlines the six domains of rural hospital medicine and the core capabilities in each of these domains, and the **Curriculum Area Statements**, which details the capabilities required and learning frame for each of the 16 curriculum content areas. The **Procedural Skills Log** provides further details about the skills required.

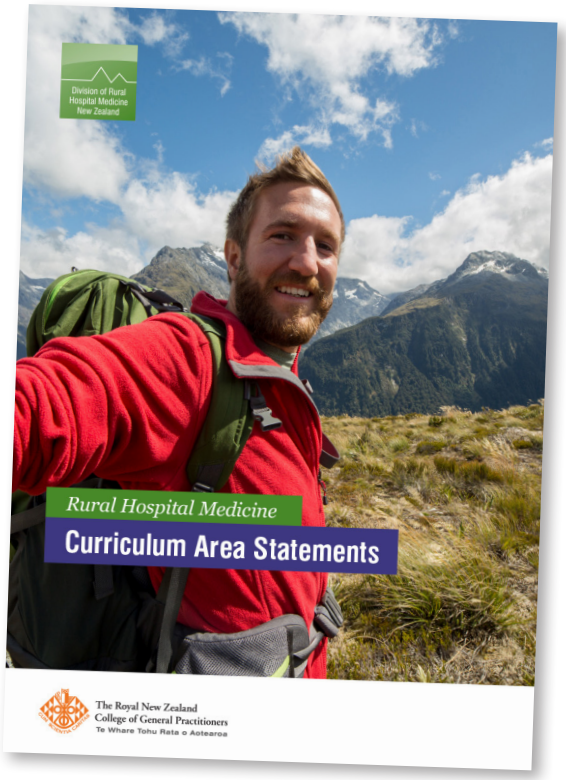
The six domains in the curriculum

1. Rural hospital context
2. Communication
3. Clinical expertise
4. Professionalism
5. Scholarship
6. Leadership and management



The 16 specific curriculum content areas

1. Adult internal medicine
2. Aged care
3. Anaesthesia
4. Child and adolescent health
5. Emergency medicine
6. Information technology
7. Mental health and addictions
8. Musculoskeletal health
9. Obstetrics and women's health
10. Ophthalmology
11. Oral health
12. Palliative medicine
13. Radiology
14. Rehabilitation medicine
15. Research and critical enquiry
16. Surgery



CORE CURRICULUM STATEMENT

Curriculum domains • Core capabilities • Key performance areas

16 AREA STATEMENTS

Specific capabilities • Recommended learning outcomes

Adult internal medicine	Aged care	Anaesthesia	Child and adolescent health
Emergency medicine	Information technology	Mental health and addictions	Musculoskeletal health
Obstetrics and women's health	Ophthalmology	Oral health	Palliative medicine
Radiology	Rehabilitation medicine	Research and critical enquiry	Surgery

PROCEDURAL SKILLS LOG

Admission to the programme

Registrars normally enter the programme at postgraduate year three (PGY3) or later, after two full-time years of appropriate postgraduate medical experience.

Preference is given to registrars who have had exposure to rural health and the rural environment.

Minimum requirements for admission are detailed in the DRHM **Admission Policy**, available on the website.

Training time

The total clinical time required on the programme is **48 months' full-time equivalent** (FTE). This is a minimum requirement, and many registrars take longer. FTE is calculated as 8/10ths or more clinical workload.

Up to 15 days taken in leave per six months while you are in the programme can be counted toward FTE time.

The maximum period that a registrar can remain on the programme, unless with permission, is eight years. Any time on hold is not counted in this equation.

See section 3.3 of the **Fellowship Pathway Regulations**.

Photo: iStock.com/Janice Chen

Recognition of prior learning

Previous clinical experience and academic papers

The Division recognises that registrars come from diverse backgrounds and bring a breadth of knowledge and experience. You may be able to apply for recognition of some of your clinical experience, if this is equivalent to training programme requirements. Previously undertaken academic papers, if equivalent to those required on the programme, may also be recognised.

To count as experience for the purpose of recognition of prior learning (RPL), 'previous clinical experience' will normally mean having worked at registrar or senior house officer (SHO) level at least from third postgraduate year (PGY3) onwards.

If you have been exempted from some programme requirements, this may shorten the minimum time you need to spend in the training programme. A maximum of 24 months of prior clinical experience and a maximum of four Mini-CEXs (two per 12 months of RPL) may be credited with approval from the BoS or approved delegate.

All exemptions are detailed in the **Fellowship Pathway Regulations**, section 5.

How to apply for recognition of prior learning

Applications to the BoS for recognition of prior learning are normally made at the time of application into the programme. Final decisions will be confirmed once you have officially commenced the training programme and paid the RPL application fee. You may also submit an RPL application after starting the programme, noting that all recognised experience must be within the past five years.

The application form for prior learning recognition is available on **Te Ara**. Please ensure you provide all the required supporting paperwork with your application. Contact the **DRHM senior education coordinator** if you have any queries.

Working part-time or being 'on hold'

Some registrars prefer to work part-time for family or lifestyle reasons, and the Division accommodates part-time training wherever possible. The limiting factor may be finding suitable part-time clinical attachments.

Some registrars will temporarily leave the programme and return at a later date. They might spend time in another programme, such as the General Practice Education Programme (GPEP), in order to work towards Fellowship of both scopes, or they may have family or lifestyle reasons for doing so.

To be active on the programme, you must be working at least 4/10ths FTE. If you are working less than the minimum of 4/10ths FTE clinical time required, you must be registered in the programme as 'on hold'. If you continue to work while on hold, the College will enrol you into the College's Annual Maintenance Programme (AMP) to maintain the conditions of your APC. If you continue to be on hold for longer than six months, you will need to register with Inpractice.

The maximum amount of time that you can spend on hold in the programme is three years.

See section 3.3 and 3.7 of the **Fellowship Pathway Regulations**.

Training requirements

Academic component

The academic component of the programme consists primarily of papers from the Postgraduate Diploma in Rural Clinical Practice (University of Otago) or equivalent courses as outlined in the **Fellowship Pathway Regulations**, section 3.4.

The papers can be completed in as little as two years, but this would be a very heavy workload, and the papers are usually spread over three or four years.

Most papers are distance-taught using a combination of readings, internet teaching, audio conferences and residential courses. You can find all the information on these papers on the **university website**.

To achieve the best learning outcome, it is recommended that you take the relevant course at the same time as your clinical run. For example, the paediatric course GENA726 Obstetrics and Paediatrics in Rural Hospitals would ideally be undertaken during your paediatrics run.

Please contact the universities well ahead of time to let them know the courses you would like to do and when.

You will be charged university fees for the papers, which can normally be claimed back from your employer along with reasonable expenses. Please check your employment contract.

Pass grades and criteria

For any grade below B-, the registrar will be identified for additional support in the particular area. The remedial requirements in each case will be determined by the BoS or approved delegate. These may be additional academic activities (such as research in a particular topic) or additional clinical or learning activities (reflective activities, skills log activities or Mini-CEXs). The specific activity will be decided by the BoS or approved delegate, with input from the academic coordinator of your university programme.

The Division now receives academic results directly from the University of Otago under a formal Memorandum of Understanding (MOU), enabling timely oversight and support for registrars. You are still responsible for ensuring that results from any other universities or training providers are submitted to the DRHM senior education coordinator as soon as they become available.

A full academic transcript must be submitted with your Fellowship application and must be an official transcript, i.e. issued digitally via My eQuals or a copy certified as a true copy of the original.

Completion of all of the academic component requirements will enable you to graduate with a Postgraduate Diploma in Rural Clinical Practice from the University of Otago. See the **diploma's regulations** on the University of Otago's website.

University contact details

University of Otago
Linda Reynolds, Client Services – Rural Postgraduate Administrator
E: **linda.reynolds@otago.ac.nz**
T: 03 440 4345
M: 021 279 0038

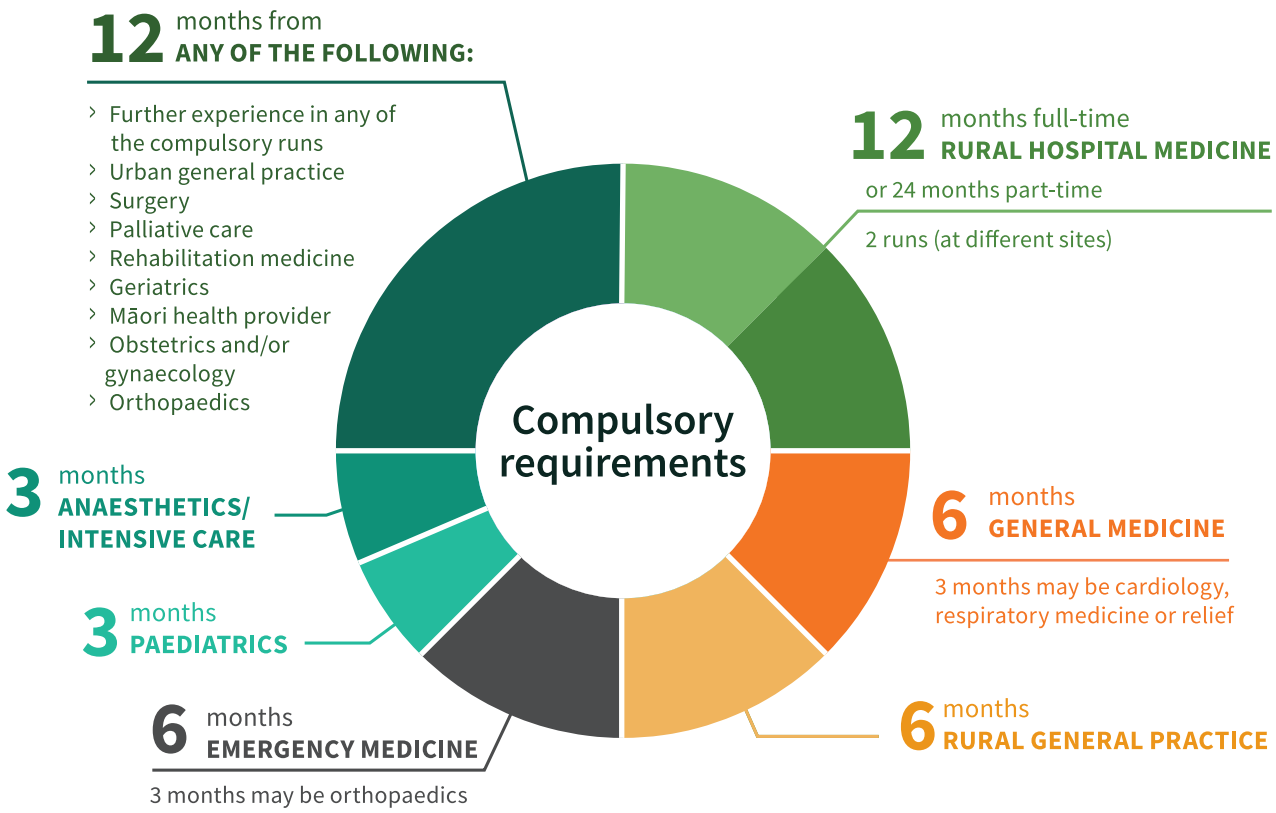
Clinical attachments

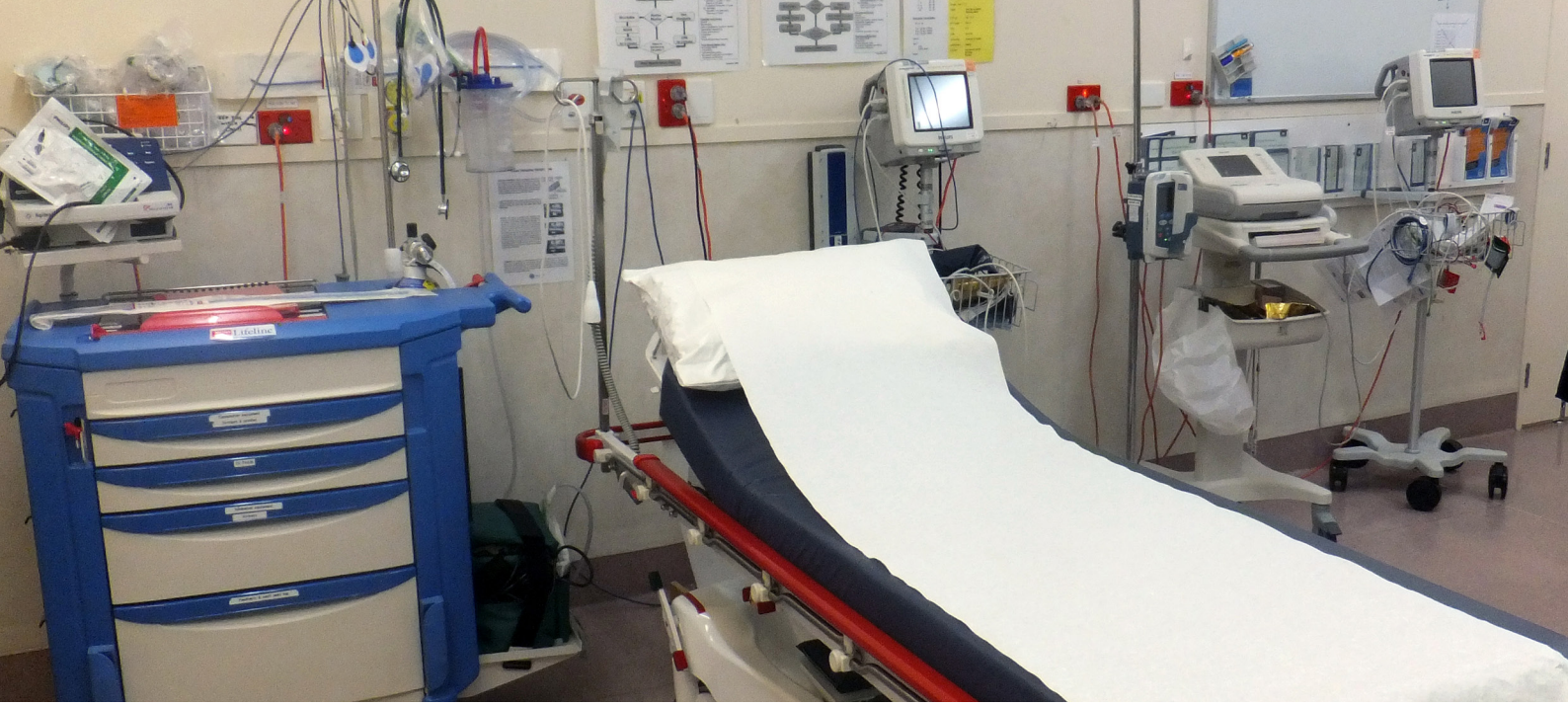
The RHMTP includes the following compulsory clinical runs, all of which must be completed at registrar level. SHO-level positions may be accepted only with prior approval from the Clinical Lead team.

- Two rural hospital medicine runs (six months FTE each, at two different sites; at least one must be a Level 3 rural hospital).
- One general medicine run (six months FTE; may include three months in cardiology, respiratory, or relief).
- One rural general practice run (six months FTE).
- One emergency medicine run (six months FTE, at registrar level).
- One paediatrics run (three months FTE).
- One anaesthesia or intensive care run (three months FTE).

In addition, registrars must complete a further 12 months of clinical experience drawn from the elective options listed in the Regulations.

New requirement: At least one rural hospital medicine run OR the rural general practice run must be completed within your first two years of active training to ensure early immersion in rural clinical practice.





Arranging clinical attachments

Your clinical attachments should be planned to provide balanced exposure across rural hospital, rural general practice, and base hospital environments. Early completion of a rural hospital or rural GP run helps inform your ongoing learning needs and supports more targeted run selection later in training.

Where possible, align clinical runs with academic papers to enhance learning (e.g. completing the paediatrics paper during the paediatrics run).

Review your programme annually with your Educational Facilitator and Clinical Lead to ensure your run plan addresses competency gaps, community needs in your intended practice region, and requirements for Fellowship.

The second rural hospital run is normally undertaken toward the end of training, as it is the preferred placement period for the Fellowship assessment visit.

All runs must be completed at accredited training sites. Accreditation may be held through another college (e.g. ACEM for emergency departments), or through DRHM accreditation for rural hospitals and some provincial departments.

Before starting any attachment, you must:

1. Confirm accreditation with the DRHM senior education coordinator or via Te Ara.
2. Notify the DRHM senior education coordinator of:
   - the run type
   - dates and location
   - the name and contact details of your rotational supervisor.
3. Provide your rotational supervisor with DRHM training programme information, establish learning goals at the start of the attachment, and complete Mini-CEX assessments at the required intervals.
4. Ensure all End-of-Attachment reports, Mini-CEXs, DOPS and feedback forms are submitted within two weeks of completion.

Hospital/practice accreditation

The Division has a responsibility to ensure clinical attachments meet learning needs, including that you see an appropriate range of conditions, have appropriate levels of responsibility and supervision, and have dedicated time and resources for learning. As such, clinical attachments must be taken at accredited sites.

The Division will recognise the site accreditation granted by another college. For example, if an emergency department is accredited to train emergency medicine registrars by ACEM, the Division will automatically accept that it has the necessary supports in place to teach rural hospital medicine registrars.

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

It is important to advise the DRHM senior education coordinator of your intended rotations in advance. If accreditation status of a clinical attachment does not meet the training criteria, the Division can advise you to find an alternative attachment or work with the hospital/department to investigate whether accreditation is possible. A list of accredited hospital departments and rural hospitals is available on Te Ara under **Find a Run**. The general practices need to have at least Foundation Standard. Please contact the **DRHM senior education coordinator** to confirm the practice is appropriate.

A rotational supervisor for your run must be a specialist who is registered in the vocational scope in which they are working.

See DRHM **Fellowship Pathway Regulations**, section 3.3.

Rural hospital placements

The MCNZ accepts this definition of a rural hospital:

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

More than 10 percent of New Zealanders depend on a local rural hospital. Approximately half of the rural hospital medicine workforce work full-time in the hospital and about half share their time between the hospital and rural general practice.

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

The Division recognises **three broad levels of rural hospital** (see the map on page 15):

Visiting medical cover once a day, with on-call medical cover at other times. Some of the after-hours on call may be supplied by appropriately trained nursing staff with medical backup at a distance. No on-site laboratory services. Radiology services are limited and often involve non radiographers working under special licences or a visiting radiographer. Acute inpatient beds.

On-site medical cover during normal working hours. On-call medical cover at other times. A combination of off-site laboratory services and point-of-care testing; 24-hour access to on-call radiographer. Acute inpatient beds.

On-site 24-hour medical cover; 24-hour access to radiology and laboratory services. There may be limited specialist cover. Acute inpatient beds.

Overseas clinical attachments

Overseas experience can be a valuable part of training. If you are planning an overseas clinical attachment, and you believe that this will meet your training needs, you should apply to the Division for recognition of the attachment before taking up the post.

Australian posts recognised as suitable by ACRRM and other Australasian colleges for the training of their registrars will be recognised by the Division.

All compulsory rural general practice and rural hospital medicine attachments need to be taken in New Zealand.

New Zealand rural hospitals, including those accredited for training

Levels of rural hospital

- Level 1
- Level 2
- Level 3

NOTE:

Only hospitals marked ☆ are accredited for rural hospital training.

Photo: iStock.com/kasto80

Resuscitation skills courses

Registrars must complete the following resuscitation skills courses and keep their certification current:

1. Emergency Management of Severe Trauma (EMST) or Emergency Trauma Management (ETM). **Validity of the certificate is five years**.
2. Advanced Life Support (ALS). Registrars are required to complete a College-endorsed resuscitation course at CORE advanced level appropriate to their training programme. The Primary Response in Medical Emergencies (PRIME) course can be taken as an alternative. **Validity of the certificate is three years**.
3. Advanced Paediatric Life Support (APLS) or Paediatric Advanced Life Support (PALS). **Validity of the certificate is five years**.
4. Newborn Life Support (NLS) Advanced. **Validity of the certificate is five years**.

Please ensure that you take these courses at an appropriate time; for example, do the APLS before your paediatric attachment.

The courses need to be current at the time you finish training and seek Fellowship. Post-Fellowship, you will be required to maintain your ACLS and emergency management skills at a level appropriate to your practice situation, or as required by your employer.

The College website has up-to-date information on appropriate and College-endorsed courses.

The Division recommends you consider taking some of the following courses to add to your training, depending on your learning goals or the needs of your rural community:

- AIMS
- BASIC
- PIMS
- PROMPT
- Ultrasound courses
- Māori Health courses
- ECHO
- Expedition/remote medicine
- RISC

Educational support

Your primary education support contacts during the programme are the programme's clinical leaders, your educational facilitator (EF), and your rotational supervisors.

Clinical leaders

The clinical leaders are there to ensure the RHM training programme is delivered as approved. They provide advice to the DRHM BoS to ensure the content and structure of the programme is up to date and relevant to rural hospital medicine.

The clinical leaders make recommendations to the BoS on the accreditation of rural hospital medicine clinical training posts. The clinical leaders liaise with the Division, College staff and other specialties in planning placements. They also provide guidance and leadership to the registrars through their learning journey.

Registrars are required to meet with a clinical lead once a year to review their learning plan, reflection log, rotational supervisor reports, MiniCEX, and skills log. The clinical lead must be satisfied that the registrar is making adequate progress through the training programme and has no significant concerns regarding the registrar's practice.

Currently the clinical leaders are Dr Chloe Horner and Dr Ralston D'Souza.

Dr Chloe Horner

Dr Ralston D'Souza

If you need to contact a clinical leader, please email or call the DRHM senior education coordinator at the College.

DRHM senior education coordinator
E: drhmnz@rnzcgp.org.nz
T: 04 496 5999

Educational facilitator

When you start the programme you will be assigned an educational facilitator (EF). They will be a vocationally registered rural hospital doctor.

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

It is recommended you meet with your EF four times a year to review progress. If you need to put your RHM training programme on hold for various reasons, please inform your EF so they know about your plans and progress and can complete their reports for you accordingly. It is likely you will meet at Hauora Taiwhenua Rural Health Network conference.

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

The MCNZ requires all junior doctors to have a collegial relationship, and the doctor providing this signs your application for an annual practising certificate. This role can be undertaken either by your EF or one of the senior medical staff in the hospital you are working at that year.

Rotational supervisor

Make sure you have a rotational supervisor for each attachment. They will need to be vocationally registered in the run specialty. While your rotational supervisor will have expertise in their particular speciality, they may have less understanding of the scope and context of rural hospital medicine, and as a result, of your learning needs.

For each attachment, formulate a clear set of learning goals, including the knowledge, experience and skills you wish to gain. Your EF will help you do this. You should discuss these learning goals with the rotational supervisor at the start of the attachment and review them at the end.

Whenever you are faced with a clinical problem, try to think about how you would manage it in the rural hospital setting (with limited resources and potential bad weather that may prevent the helicopter retrieval service getting to you).

You should have dedicated time with your rotational supervisor every week. Your rotational supervisor (or an appropriately qualified doctor delegated by your rotational supervisor) will undertake your Mini-CEXs and DOPS for the run. You should successfully complete one Mini-CEX or DOPS every three months during the relevant runs (i.e. one Mini-CEX or DOPS during a three-month FTE run, two during a six-month FTE run, four during a 12-month FTE run). At the end of the run, Your rotational supervisor will also complete an evaluation form (End of Attachment Assessment report) that is part of your formative assessment.

It is the registrar's responsibility to submit the assessment reports, Mini-CEXs and DOPS to the **DRHM senior educational coordinator** within two weeks of completion.

Learning activities

Throughout your training, you will discuss and review cases with the rotational supervisor for the attachment. The rotational supervisor will provide feedback to you on your performance in that attachment. You will also meet with a clinical leader once a year to discuss your progress and your learning goals. You also need to complete a learning plan and reflection log, and a clinical skills log throughout your training.

Learning plan and reflection log

Rural hospital medicine training is intentionally flexible, and you have opportunities to seek out training opportunities to best meet your learning needs. At the same time, you take personal responsibility for identifying your learning needs and planning your training.

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

The scope of rural hospital medicine is very broad. At the end of your training you will not be an expert in managing every condition that presents – you will continue to learn and develop your knowledge and skills. Over time, the learning plan and reflection log becomes a reflective portfolio that establishes a habit of continuous learning and is a regularly updated, written record. The writing of it is a 'conversation with self', enhanced by discussions with others, principally your EF, rotational supervisors and colleagues.

The learning plan

Start by developing a DRHM Learning Plan. Do this with your EF at the beginning of your training. The Division's **curriculum** is available on the College website and the learning plan template can be downloaded from Te Ara.

1. First, you will need to revisit the areas you already have adequate experience and/or qualifications and experience in and think whether further training in these areas is still required. Then you can decide which parts of the programme (academic, clinical attachments, courses) you would like accredited, and complete an application for Recognition of Prior Learning form for consideration by the BoS and clinical leaders. Please note that only clinical experience at PGY3 and above obtained before enrolling in the DRHM programme can be considered. (Please refer to Fellowship Pathway Regulations Section 5).
2. Then identify your skills and knowledge gaps and from this your learning needs.
3. Finally, work out a programme of intended clinical attachments, academic qualifications and courses that will meet your learning needs and the requirements for Fellowship.

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

The reflection log

The aim of the reflection log is to develop the skills to critically analyse your own practice, both in terms of your strengths and weaknesses, to aid in planning your training to address learning goals and to document your growth as a clinician. These are important skills that you will need to carry with you throughout your professional life post-Fellowship.

The reflection log is your ongoing record of learning, insight and professional growth during rural hospital medicine training. It complements (but is distinct from) your learning plan.

Where the learning plan outlines what you intend to learn, the reflection log documents how your learning is occurring, what it means for your practice, and how your needs evolve over time.

How to use the learning plan and reflection log

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

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

With each later entry:

- Think about the **experience** – what challenging cases have stayed with you, what skills you learnt, what you observed your supervisors doing and any feedback you have been given. What strategies did you find helpful in managing the case?
- What have you **learnt** – how will your practice change in the future as a result of these experiences?
- How have your **learning needs** changed; where do you need to go next?
- What future **learning opportunities** do you need to seek? Make appropriate changes to your training plan.
- What did you learn about **cultural safety** and about different cultures?
- Have you developed **strategies to keep yourself safe and effective** both in terms of your own wellbeing and your clinical practice, e.g. how you balance work–life commitments?
- What strategies do you use to **review and process** a difficult case or an adverse outcome?

You and your EF and clinical leader use the reflective portfolio as an important formative assessment tool. It gives you the chance to reflect on feedback from teachers and peers. You will monitor and shape your own learning by reviewing and reflecting on your progress and, through this, resetting objectives and goals.

The reflection log should be a minimum of 2000 words and a maximum of 12,000 words.

At the time of your assessment visit, the assessor will discuss your learning plan and reflection log with you. They will be looking for evidence that you can identify your learning needs and take appropriate steps to meet them. The reflection log is not a summative assessment, but the Fellowship assessor will use this tool to see your skills in reflecting on your practice.

Hauora Māori case reflection

The Hauora Māori case reflection supports registrars and prior specialist doctors to reflect on clinical care involving Māori patients, with a focus on cultural safety, equity, and Te Tiriti o Waitangi in rural hospital practice. You are required to complete one case reflection per year of active training time.

Skills log

The skills log details the key procedural skills and the level of competency required for independent rural and remote practice. Your skills logbook will record when you have satisfactorily completed a skill.

Skills are divided into **compulsory skills** and **highly recommended skills**. Registrars should be able to perform all compulsory skills independently by the end of their training (category 3)* and as many of the highly recommended skills as they are able to. Wherever possible these skills should be performed on actual patients; however, it is appreciated that some high-acuity low-occurrence (HALO) skills (e.g. cricothyroidotomy, jet insufflation, pericardiocentesis) may be performed in simulation scenarios only, and this is sufficient as long as the skill is able to be performed independently in that scenario.

You should review your skills logbook when you meet with your EF and clinical leader and make plans to remedy any gaps before your Fellowship assessment visit.

The skills log will be looked at by your Fellowship assessor, and you may be asked questions about your level of confidence to undertake certain procedures.

Rural generalists increasingly practise a broad scope of point-of-care ultrasound that, when used as a part of the full clinical assessment, has a positive impact on patient care, improving diagnostic certainty and reducing the need for hospital admission and inter-hospital transfer.† The Division does not offer formal training or credential registrars in the use of ultrasound in their practice. However, it is recommended that you gain experience in clinician-performed ultrasound and, where possible, undertake courses during your training that credential you in this important skill. Using diagnostic and/or interventional ultrasound in the absence of formal training creates clinical risk, and all registrars using ultrasound must do so in compliance with their employer's policies around the use of ultrasound.

* In 2025 the Board of Studies approved for the skill of drainage of thrombosed perianal haematoma/haemorrhoid to no longer be considered a compulsory skill.

† Nixon G, Blattner K, Koroheke-Rogers M, Muirhead J, Finnie WL, Lawrenson R, Kerse N. Point-of-care ultrasound in rural New Zealand: Safety, quality and impact on patient management. Aust J Rural Health. 2018 Oct;26(5):342–349. doi: 10.1111/ajr.12472. PMID: 30303278.

Assessments

Academic papers

The Division relies on the universities and other colleges to assess candidates for this part of the training programme. A Pass grade must be achieved for each compulsory academic paper. For any grade below B- the registrar will be identified for additional support in the particular area. The remedial requirements in each case will be determined by the Board of Studies or approved delegate.

The University of Otago and the Division have a Memorandum of Understanding (MOU) that enables secure information sharing between the partners. Through this agreement, the Division is notified of your academic paper results directly.

Note that you will still be asked to provide a full academic transcript from the universities for your Fellowship visit application.

Mini-CEX and DOPS

The Mini-CEX is a practice-based assessment undertaken by your rotational supervisors or appropriately qualified doctors delegated by your rotational supervisor. They will observe you taking a history and conducting an examination and then ask about diagnosis and management. They will assess competency in communication skills, history taking, physical examination, clinical judgement, organisation and efficiency, and overall clinical competence. They will provide you with immediate feedback and complete a rating form.

The DOPS (Direct Observation of Procedural Skills) is an assessment tool used to evaluate registrars' proficiency in clinical procedures through real-time observation and structured feedback. It aims to enhance registrars' learning and skill acquisition by providing immediate, formative feedback. There are three mandatory procedures to perform using DOPS, these are:

1. **Advanced airway** – Laryngeal Mask Airway (LMA) or Endotracheal Tube (ETT); adult or paediatric
2. **Procedural sedation** – paediatric
3. **Tube thoracotomy** – adult or paediatric.

You need to complete a combination of 12 DOPS and Mini-CEXs over the course of the training programme, with a **minimum of four** DOPS. They must be successfully completed every three months (**one DOPS or Mini-CEX per three months**). You need to keep the results of your Mini-CEXs and DOPS in your portfolio and review them with your EF and clinical leader and send copies to the **DRHM senior education coordinator**.

For registrars on the dual pathway, two Mini-CEXs done during GPEP year 1 can count toward the compulsory 12 assessments. These two Mini-CEXs can be undertaken by a College teacher, a visiting medical educator or your clinical supervisor.

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

It is highly recommended that registrars who have received RPL for clinical time complete two Mini-CEXs of medium or high complexity in each area of RPL while in the RHMTP. Where the registrar is working outside of a rural hospital for an extended period of time immediately prior to the Fellowship Assessment, (for example in general practice) it is recommended that the RPL mini-CEXs are completed within six months of the assessment. This is a strong recommendation, and not following it may lead to difficulties at Fellowship assessment.

The Mini-CEXs and DOPS are crucial tools for the Fellowship assessor at your final Fellowship visit, so please ensure they are completed with as many details as possible by your rotational supervisors/assessors.

Rotational supervisor reports

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

You need to provide your rotational supervisor with the correct form, and request they complete it at the end of your rotation and submit it to the DRHM senior education coordinator within two weeks of completing the run.

StAMPS

Structured Assessment using Multi Patient Scenarios (StAMPS) is an Objective Structured Clinical Examination (OSCE)/viva-type examination developed by Professor Tim Wilkinson from the University of Otago's Christchurch School of Medicine for the Australian College of Rural and Remote Medicine (ACRRM).

It provides rural and remotely located candidates with a reliable, affordable, flexible, acceptable and contextually relevant assessment method. It is designed to assess, at a distance, your ability to discuss, within a realistic period of time, the implications arising from several defined clinical scenarios. StAMPS is an online virtual assessment where the candidate remains in a virtual room, with examiners joining to deliver each scenario. StAMPS assesses learning outcomes such as communication and interpersonal skills, diagnostic reasoning skills, flexibility in response to new information, management of complex problems in the rural and remote context, and developing an appropriate management plan that incorporates relevant contextual factors.

The exam consists of eight case scenarios, each with three questions. Two of these scenarios are in the New Zealand context. These questions aim to reflect our rural hospital presentations more accurately with regard to Hauora Māori, cultural safety and, more broadly, our system functions and processes (ACC, WINZ etc). For more information about the exam and how to prepare, please read the available guidance on **Te Ara**.

StAMPS will be undertaken no earlier than 12 months before the end of training. If you wish to complete StAMPS, you will need to book an examination session directly via the **ACRRM website**. Please notify the **DRHM senior education coordinator** and clinical leaders **before** you apply online to sit the StAMPS examination. The exam will be conducted online, and candidates can take the exam from their private residence or workplace. Please refer to the ACRRM website for detailed venue requirements.

Multisource feedback

Multisource feedback (MSF), also known as the 360° assessment, is a well-recognised, validated and reliable measure used widely across the globe in a variety of educational settings. The specific tool used by the Division is a web-based one facilitated through Best Practice Advocacy Centre New Zealand (bpac^{nz}). Your performance in professional contexts will be independently assessed by a range of individuals who have working relationships with you, including medical colleagues, other clinical colleagues, administrators and patients. The MSF process provides a focus for discussion and learning. MSF assesses interpersonal and professional behaviour and development and is undertaken within the last six months of the training programme. When you are completing your final rural hospital medicine run, please contact the Senior Education Coordinator and they will organise the assessment for you.

Other results

Documentation confirming participation (or results of assessments) from any other courses, conferences or training activities attended will also be considered.

Fellowship assessment visit

The final assessment for the programme is the Fellowship visit. This will normally take place in the final two months of your last clinical placement (and will not take place before this). The visit cannot be undertaken until all programme requirements (except for the final rotational supervisor report) have been completed.

The registrars must receive recommendation from their clinical leader and EF before they can progress to Fellowship assessment.

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

- Registrar portfolio, including all of the components listed in the **Fellowship Pathway Regulations** (section 4.3).
- An interim report from the rotational supervisor of the clinical placement on which you are employed at the time of the visit.

The DRHM senior education coordinator and the Fellowship advisor of the College can assist you in collating your portfolio if you have sent copies of all your formal records to them. Therefore, it is important that you submit all the reports and certificates to the College as soon as they become available during your training.

Academic Fellowship

The College and the Otago University endorses you to a year of training completing an academic fellowship year with Otago University and an accredited rural hospital or general practice. The year consists of 0.5 FTE rural hospital medicine or rural general practice clinical attachment and 0.5 FTE academic/research position to complete or work towards a higher degree (research Master's or PhD) and is suitable for senior registrars who have completed (or nearly completed) a postgraduate diploma programme (including PGDipRCP).

At the end of GPEP/RHMTP, registrars will have a Master of Health Sciences and experience being involved in teaching postgraduate students, and they will be eligible for senior academic positions within the University.

For more information please contact Dr Rory Miller (**rory.miller@otago.ac.nz**)

Dual Fellowship training

Dual Fellowship training in rural hospital medicine and general practice is highly recommended and provides a range of opportunities for rural practice.

Registrars who undertake a dual Fellowship in rural hospital medicine and general practice must be independently accepted to each training programme and can only be active in one programme at a time, i.e. you need to put your GPEP on hold while you are active in DRHM.

Dual trainees may claim up to 18 months against the Division's clinical experience requirements for general practice experience gained on GPEP, provided that at least six months of GPEP training is undertaken in rural general practice. The same amount of time in rural training is recognised towards the general practice programme.

The clinical requirements as well as the additional learning activity requirements of the dual Fellowship programme are outlined in the **Fellowship Regulations** section 7.

Addressing issues

In the event of a problem, these documents may help:

- Policy on disputes and grievances
- Policy on reconsiderations and appeals

If you have any further concerns, please contact your EF, the DRHM senior education coordinator or a programme clinical leader.

The Division's aim is to ensure that registrars can learn and perform to the best of their abilities in a safe work environment. The Division does not condone bullying in any form.

Registrars requiring support

Registrars will be identified as needing extra support if they:

- are not making adequate progress
- have reports that flag concerns
- have failed any summative components
- have received less than a B- for an academic paper.

A remedial course of action will be developed for the registrar with the assistance from the clinical leaders and the College. The BoS may be informed when registrars are not meeting the requirements of the programme.

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

Accreditation of such rotations may be deferred pending further assessment.

A registrar may at any time appeal against a decision they receive regarding any part of the programme. Please see the Division's Appeals Policy for further information. You may also appeal against decisions made by the universities or by other colleges, using the appeal mechanisms of those bodies.

Hauora Taiwhenua (Rural Health Network) and Conference

All rural hospital doctors, including registrars, are welcome to join Hauora Taiwhenua (Rural Health Network). Membership is also open to rural GPs and nurses, and you can **join online**.

Attendance at the National Rural Health Conference, organised by Hauora Taiwhenua, is recommended to all regstrars. It is the one national meeting that rural hospital doctors try to attend each year. It includes sessions that meet our continuing medical education needs, as well as the Division's AGM and dinner. It is generally a very social event and the chance to meet others in the rural hospital community.

The conference is usually held over the last weekend in March or in April – **see their website for more details**. Your employer should give you adequate leave to attend.

Registrar Meeting day

The Division organizes a registrar meeting day on the day prior to the conference. This day is part of your training programme and attendance is compulsory. Its a great opportunity to network with other registrars, EFs, hospital representatives around the country and College staff.

Fees

The College and the Division charges fees for running the training programme and for membership of the College and the Division. See the website for **current rates**.

From 2026, where a registrar is employed by Health NZ | Te Whatu Ora, all training fees and Division/College membership fees will be paid directly by Health NZ | Te Whatu Ora. Registrars employed under these contracts do not need to pay these fees personally or seek reimbursement.

Registrars who are not employed by Health NZ | Te Whatu Ora (e.g. trust hospitals, general practices) remain responsible for ensuring their training and membership fees are paid. In most cases, these registrars may still be able to claim fees back from their employer under the terms of their employment agreement.

Academic papers completed through the University of Otago or other educational providers will continue to incur separate fees. Where eligible, registrars may claim these back from their employer in accordance with their employment contract or relevant MECA entitlement.

The Royal New Zealand
College of General Practitioners
Level 4, 50 Customhouse Quay, Wellington
PO Box 10440, Wellington, 6140

Telephone: +64 4 496 5999
Facsimile: +64 4 496 5997

drhmnz@rnzcgp.org.nz
www.rnzcgp.org.nz