Recent Developments in Rural Hospital Medicine II:

Experiential pathway to Fellowship of the Division of Rural Hospital Medicine

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This paper outlines the process by which doctors who are currently working in rural hospital medicine can seek Fellowship and registration in the new vocational scope of Rural Hospital Medicine.

Whenever a new vocational scope of practice is recognised by the New Zealand Medical Council (MCNZ), experienced doctors working in that scope are offered the opportunity to apply to become Fellows. Traditionally this has been termed 'grandparenting', although in the current case 'experiential pathway to fellowship' may be a better description. This is because the process requires not just years of experience, but also evidence of an ongoing commitment to professional development and an assessment of competence.

The Board of Studies of the Royal New Zealand College of General Practitioners (RNZCGP) Division of Rural Hospital Medicine (RHM) sets standards and provides oversight of the experiential assessment process. This Board includes not only elected rural hospital generalists (general practitioners (GPs) and full-time rural hospital doctors) but, in recognition of the overlap with other scopes of practice, representatives from the RNZCGP, the Royal Australasian College of Physicians (RACP), the Royal Australasian College of Surgeons (RACS) and the Australasian College of Emergency Medicine (ACEM).

The experiential pathway process for rural hospital medicine will remain open for five years. This provides an opportunity for those with the necessary years of experience to meet criteria that may still be outstanding. The initial step requires the candidate to submit a portfolio to the Board of Studies. The portfolio will outline the doctor's experience and qualifications, which are the key determinants of eligibility. The portfolio will also include other evidence of professional development, principally around leadership, teaching and research.

The minimum experience required is eight years of relevant postgraduate practice of which at least three years must be full-time (or six years part-time) rural hospital experience. The Board of Studies will determine what is relevant, but the intention is to include medical work that will have significantly contributed to the doctor's skills as a rural hospital generalist. It will certainly include the generalist disciplines such as general practice, accident and medicine (A&M) experience, internal medicine, emergency medicine and many of the other hospital-based disciplines. It is unlikely to include cardiothoracic surgery or pathology for example.

Candidates should also have a postgraduate qualification. For most this will be a fellowship (FRNZCGP, FAMPA, FACEM, FRACP or equivalent) or a postgraduate diploma (postgraduate diploma in community emergency medicine or rural hospital medicine or equivalent).

It is not surprising that, despite years of practical experience, many full-time rural hospital doctors do not have a formal postgraduate qualification because in the past there has been a real lack of relevant and available educational courses. The Board of Studies has some discretion and a number of options in dealing with applications from rural doctors without formal educational qualifications. It can take into account other aspects of their portfolio that show evidence of a commitment to ongoing professional development and accept these in lieu of a formal qualification; in conjunction with the doctor it can develop a plan to see them obtain all or a part of a relevant postgraduate qualification within the five year grandparenting window; or it can require a more thorough assessment, most likely employing Fellowship examinations run by ACRRM (Australian College of Remote and Rural Medicine).

After the Board of Studies is satisfied about the candidate's experience and qualifications they move on to an assessment. This is very different to the traditional Part One examinations of some specialist colleges that primarily test a candidate's factual knowledge (much of it of questionable relevance to their day to day practice). The purpose of this assessment is to test for competent and safe practice. Older and more experienced doctors may be likely to perform best in these assessments. These are the sort of assessments that in future all practising doctors will probably face on a regular basis as medical councils and colleges move from regular reaccreditation to regular reassessment.

The first assessment is a multisource feedback (MSF). The tool that has been chosen is one developed by the Royal College of Physicians specifically to assess experienced senior doctors. The candidate is asked to provide the email addresses of 15 colleagues who have agreed to complete a confidential online questionnaire about the candidate's clinical and professional performance. Colleagues will include not only medical colleagues the candidate works with, but also doctors they refer to, or accept referrals from, and a range of other health professionals – nursing, allied health, administration and management. An assessor will then visit the doctor in their workplace. This visit will initially be undertaken by doctors experienced in RNZCGP assessment who also have a background in rural hospital medicine. The assessment is of two to three clinical encounters with patients while the doctor is undertaking their normal clinical duties. It is held in their own workplace, by someone with an understanding of that context. The Board of Studies has the discretion to require a more thorough and targeted assessment of any candidate who does not clearly meet the standard required.

In order to finally be granted Fellowship, all candidates must have up to date certificates of competence for Early Management of Severe Trauma (EMST), Advanced Paediatric Life Support (APLS), and Advanced Cardiac Life Support (ACLS approved by the NZ resuscitation council to level 7). GPs may substitute PRIME for EMST. These courses will also be required for the ongoing reaccreditation of rural hospital doctors. EMST and APLS courses are valid for five years and ACLS for three years. If a doctor has previously completed an APLS course the BOS has the discretion to accept a shorter paediatric emergency care course (usually one day) as an update, although repeating the full course is the preferred option. EMST runs a specific update course for those who have previously completed the full course.

Meeting these requirements, particularly the APLS, may be the major hurdle to gaining fellowship for many GPs. The courses are intensive, require several days away from practice, are relatively expensive and have long waiting lists. They are, however, invaluable CME for rural hospital doctors. They are well structured, educationally sound and collectively cover the early management of most major medical problems. They also provide the opportunity for the Division to apply a set of recognised standards to rural hospital emergency care – an important task, but one that is difficult to achieve because of the breadth and diversity of the scope and doctors working in it.

Because of the long waiting lists for some courses, doctors who have otherwise met all the criteria for Fellowship, including successful assessment, will have two years in which to obtain up-to-date certificates. Fellowship can be awarded as soon as certificates have been supplied. The Division has asked rural hospital doctors who need to complete an APLS course to contact the RHD administrator at the RNZCGP. If there is enough interest they will try to cluster most of the rural doctors on one or two APLS courses in 2009. This would give everyone the opportunity to undertake the course with a group of rural colleagues.

Cost is a significant issue and may prove a barrier, particularly for doctors working part-time. Every effort has been made to minimise costs, including making substantial changes to the assessment visits. The Division believes this has been achieved while maintaining the validity and credibility of the overall process. The current fee of $2100 for the assessment visit and the multisource feedback compares favourably with the costs associated with gaining fellowship in other branches of medicine. After fellowship has been gained, the MCNZ will charge a further $125 to place the doctor on the vocational register. The MCNZ will also charge $40 for each of the two certificates of good standing, one being required at the start of the process and one at its completion.

District Health Boards should be obliged to offer rural hospital doctors the same conditions as other senior doctors working in the public health system. The fees associated with gaining vocational registration are work related expenses and as such should be reimbursed under Association of Salaried Medical Specialists employment contracts.

Conclusion

The challenge has been to create a process that determines competence in the RHM scope in a reliable and defensible manner but with a minimum of barriers.

A standard of fellowship must be set that ensures the qualification is seen as credible by regulatory bodies and other colleges both in New Zealand and overseas. The aim must be to assess performance – what the doctor 'does' as opposed to their 'knowledge of facts'. The process must not be onerous and costs need to be kept to a minimum. All this needs to be done for a group of doctors who come from diverse backgrounds, work in a range of very different hospitals and are scattered across the remotest parts of the country. The Division believes that the experiential pathway to Fellowship in rural hospital medicine comes as close to meeting these conflicting demands as is possible. The aim of the Division of Rural Hospital Medicine continues to be the provision of excellent secondary services to rural people in New Zealand.

Competing interests

None declared.