Division of Rural Hospital Medicine
NEW ZEALAND
Te Whare Taiwhenua

Rural Hospital Medicine Training Programme Handbook 2022

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

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Contents

Welcome

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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 training programme 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 Royal New Zealand College of General Practitioners' website.

The Division's structure and governance

The Division sits as a semi-autonomous body within The Royal New Zealand College of General Practitioners (the College).* Rural hospital medicine is a recognised independent scope of medicine. The Division has Vocational Education and Advisory Body status with the MCNZ and 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 Rural Hospital Medicine training programme (RHM training programme) 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.

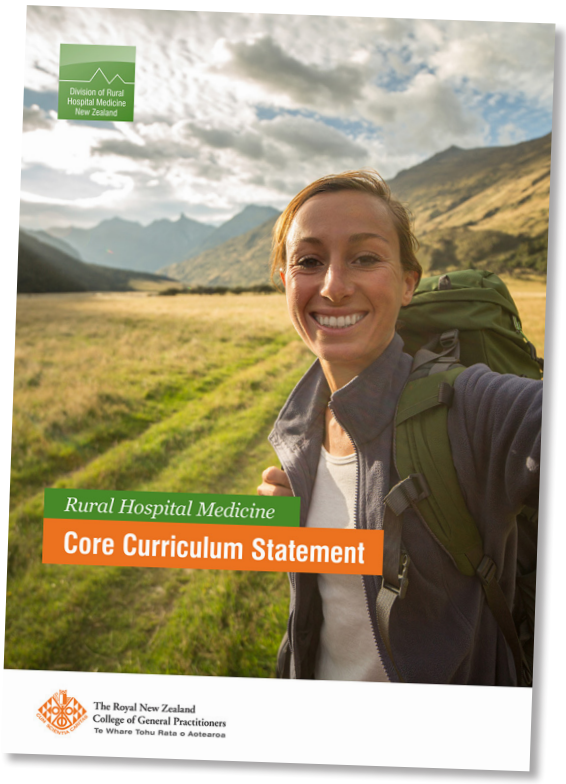
Who to contact

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.

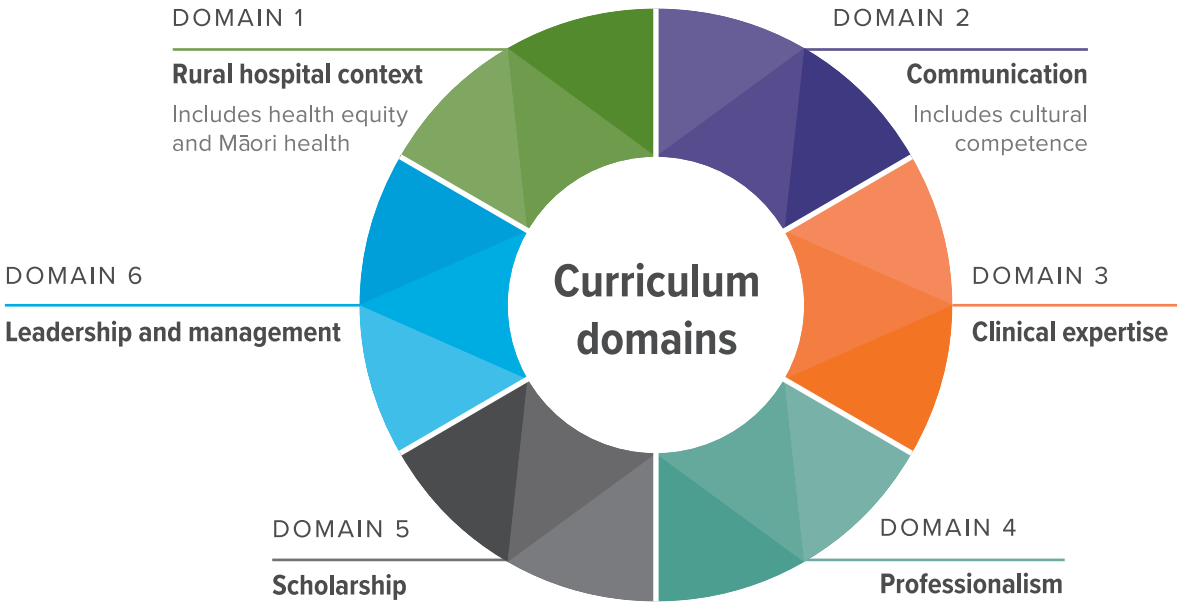


Overview

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.

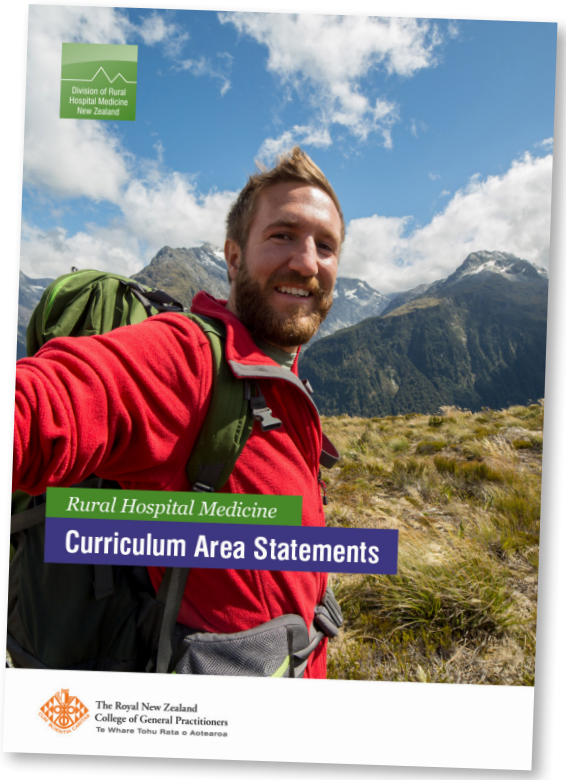
The six domains in the curriculum

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 Fellowship Pathway Regulations, section 3.2. The selection and admission process is detailed in the DRHM Admission Policy, available on the website.

Registrar rights and responsibilities are outlined in the registrar training agreement.

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.

Recognition of prior learning

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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. However, consideration may be given at any stage after joining the programme.

The application form for prior learning recognition is available on Te Ara. 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 hold a practising certificate, you must report your continuing professional development activities to the Division to comply with MCNZ recertification requirements.

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 and Provincial Hospital 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.

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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, with input from the academic coordinator of your university programme.

It is your responsibility to ensure that the academic result notifications issued by the universities are submitted to the DRHM senior education coordinator as soon as possible after completing each paper. The College can now receive the academic results required under DRHM training directly from the University of Otago if your consent is received. You can complete your consent form and return it to the DRHM senior education coordinator.

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 and Provincial Hospital Practice from the University of Otago. See the diploma's regulations on the University of Otago's website.

University contact details

University of Otago
Leigh-Ann Moir, Client Services – Rural Postgraduate Administrator
E: leigh-ann.moir@otago.ac.nz
T: 03 440 4345
M: 021 279 0038

Clinical attachments

Clinical attachments provide the broad experience you need to practise safely and independently as a rural hospital doctor. The clinical attachment requirements take a minimum total of four years full-time learning to complete and are made up of compulsory and elective runs.

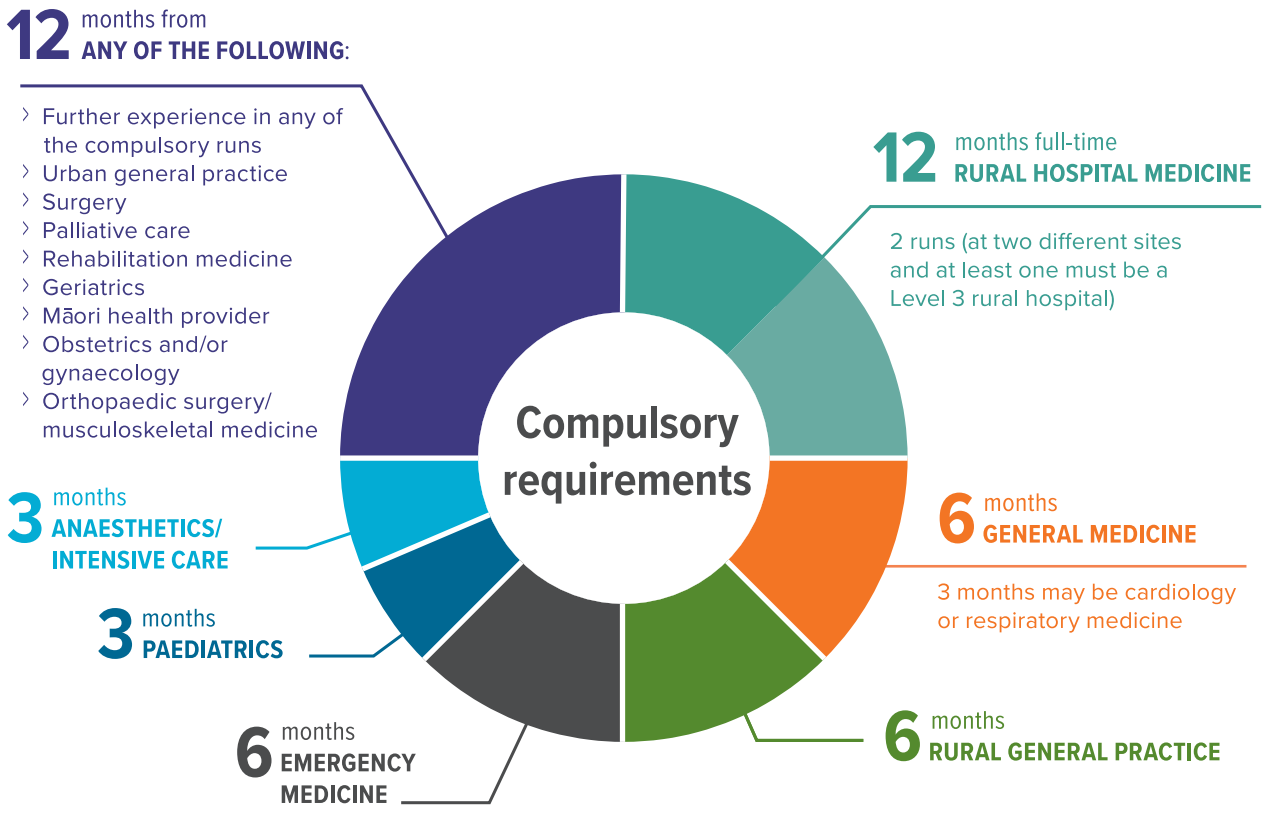
The requirements are detailed in the Fellowship Pathway Regulations (section 3.3).

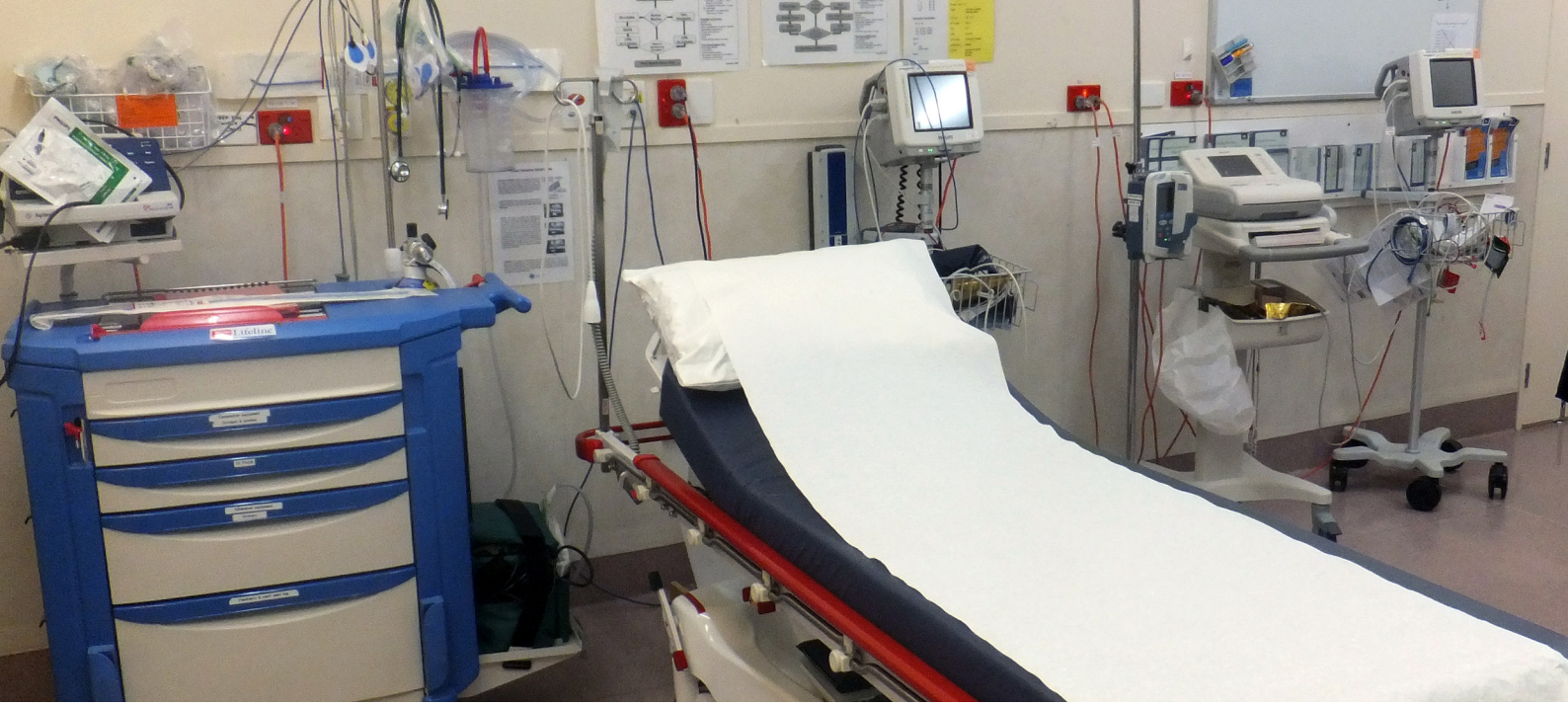
In summary, the compulsory requirements are:

- Two runs (six months FTE each) in rural hospital medicine (at two different sites and at least one must be a Level 3 rural hospital)
- One run (six months FTE) in general medicine (three months may be cardiology or respiratory medicine)
- One run (six months FTE) in rural general practice
- One run (six months) in emergency medicine
- 0.5 run (three months) in paediatrics
- 0.5 run (three months) in anaesthetics/intensive care.

You must complete a further 12 months from any of the following:

- Further experience in any of the compulsory runs above
- Urban general practice
- Surgery
- Palliative care
- Rehabilitation medicine
- Geriatrics
- Māori health provider
- Obstetrics and/or gynaecology
- Orthopaedic surgery/musculoskeletal medicine





The hospitals in which you complete your runs must be accredited training sites for the relevant specialities or recognised by the Division. Please see Find a Run on Te Ara for approved training sites. Attachments that are different to those above may be taken with the Division's prior approval.

Generalist runs in provincial base hospitals will provide better training opportunities than more specialised attachments in large tertiary hospitals.

The Division recommends that:

- one of your rural hospital runs is undertaken early in training. This is important so that you have a good understanding of rural hospital medicine to enable you to make the best use of your time in other attachments.
- the second rural hospital run is undertaken at the end of training and you may have your Fellowship visit towards the end of this run at the hospital.
- you take the relevant course at the same time as your clinical run to achieve a better learning outcome.
- you advise the DRHM senior education coordinator of your planned runs to make sure that runs can be recognised under the training programme or that prior approval can be granted by the BoS.

During attachment you must accept an appropriate level of clinical responsibilities. The compulsory emergency medicine run must be completed in a registrar position.

All the other runs, including elective runs, must be completed at SHO level or above.

Your employer should grant you study leave to attend university and other courses that are part of the training programme, as well as leave to attend the New Zealand Rural General Practice Network Conference.

Arranging clinical attachments

Clinical attachments are funded by contracts between Health Workforce New Zealand (HWNZ) and the district health boards (DHBs). Some base and rural hospitals offer training hubs coordinating placements for rural hospital medicine registrars. However, many other registrar and SHO runs are also suitable as training attachments. It is advisable to check with the DRHM senior education coordinator whether a given run is accredited for rural hospital medicine training purposes.

It is your responsibility to find jobs by applying for registrar and SHO posts that will meet the criteria of the RHM training programme. When you are applying for a job, please inform your employer that you are a rural hospital medicine registrar.

You must also let the DRHM senior education coordinator and your educational facilitator (EF) know your run intention. This is so the DHB and Division can ensure your run is appropriately accredited for training.

Before each clinical attachment you must email the DRHM senior education coordinator to advise them of the following:

1. What run is to be completed.
2. The duration and location of the run.
3. The name and contact details of your rotational supervisor for the run.

At the start of the attachment, make sure that you do the following:

1. Give a copy of **DRHM Training Programme Information** to your rotational supervisor.
2. Work out your learning goals for the attachment with your rotational supervisor and write these into your learning plan and reflection log.

During the attachment, you must:

1. arrange for your rotational supervisor to do a Mini Clinical Evaluation Exercise (Mini-CEX) at roughly three-monthly intervals and provide them with the **Mini-CEX assessment form and marking guide**.
2. ensure that a **Mini-CEX form** is completed by the assessor and their comments are included.

At the end of the attachment, please complete the following:

1. Provide your rotational supervisor with a copy of the **End of Attachment Registrar Assessment form** and make sure that they complete it with comments.
2. Discuss your attachment with your rotational supervisor and review the learning goals for the attachment, and record this in your learning plan and reflection log.
3. Complete the **Registrar Feedback form**.

Copies of all these forms can be downloaded from Te Ara. Once completed, retain a copy of all the forms in your portfolio and send a copy to the DRHM senior education coordinator.

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, rural hospitals and general practices is available on Te Ara under Find a Run.

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

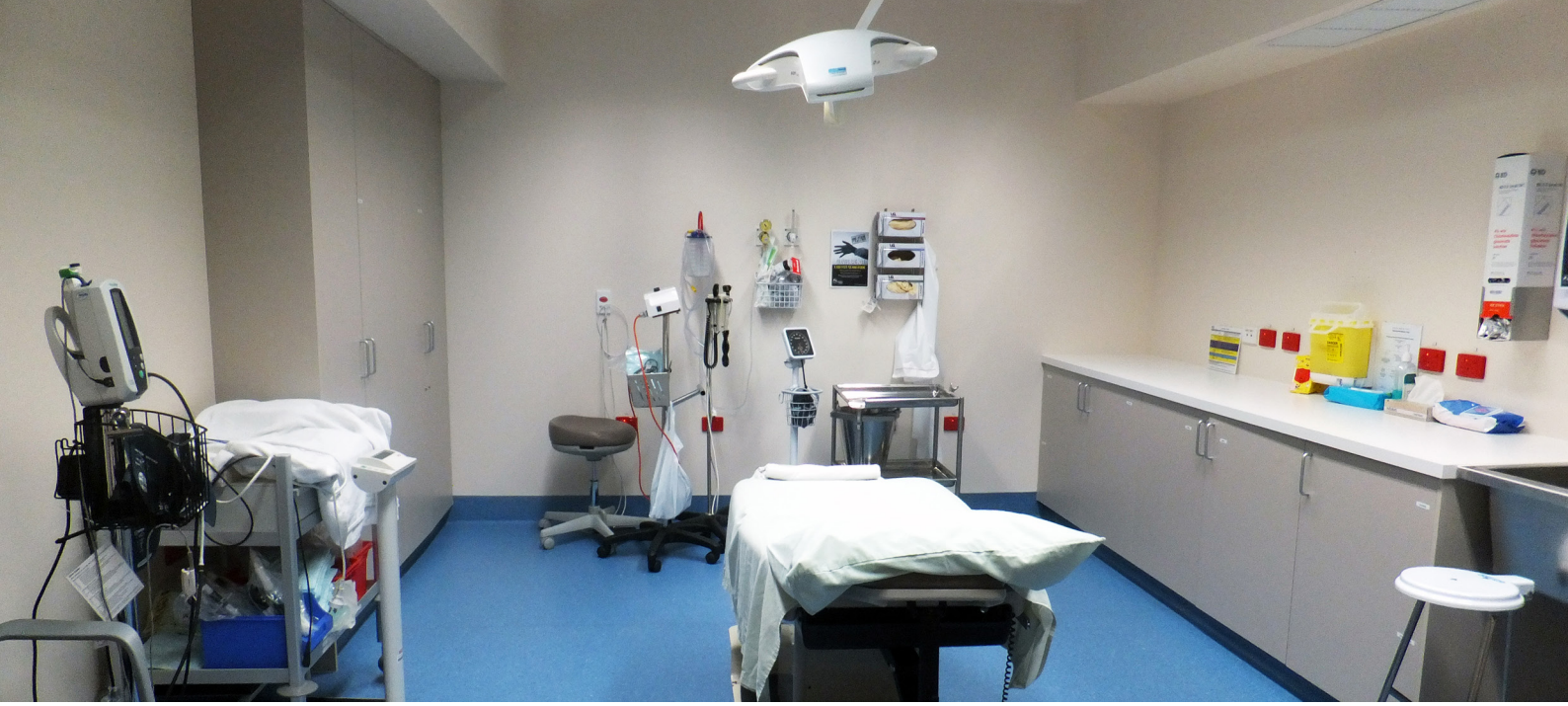
See DRHM Fellowship Pathway Regulations, section 3.3.

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 16):

1. 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.

2. 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.

3. 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.

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.

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Resuscitation skills courses

Registrars must complete the following resuscitation skills courses:

- Emergency Management of Severe Trauma (EMST) or Advanced Trauma Life Support (ATLS).
- Advanced Cardiac Life Support (ACLS). This needs to be a New Zealand Resuscitation Council (NZRC) Certificate of Resuscitation and Emergency Care (CORE) Advanced course and taken through an RNZCGP-endorsed provider. The Primary Response in Medical Emergencies (PRIME) course can be taken as an alternative.
- Advanced Paediatric Life Support (APLS) or Paediatric Advanced Life Support (PALS).

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 courses are invaluable – well-structured and educationally sound. Collectively, they cover the early management of most major medical problems. They teach 'the modern language of emergency care' needed to communicate effectively with specialist colleagues, and they are a chance to learn alongside doctors from other scopes.

From the perspective of the Division's BoS, the courses are a way to learn and apply a set of recognised standards to rural hospital emergency care.

The Division recommends you consider taking ALSO (Advanced Life Support in Obstetrics), BASIC (Basic Assessment and Support in Intensive Care), ELS (Emergency Life Support), and PROMPT (Practical Obstetrics Multi-Professional Training). These are not compulsory but are excellent courses that add to your training.

(See Fellowship Pathway Regulations, section 3.6.)

Course contact details

EMST

Early Management of Severe Trauma

Run by the Royal Australasian College of Surgeons, it tends to have a long waiting list – often more than a year – so enrol early. The certificate is **valid for five years**, at which time you take a refresher course.

Register online.

APLS

Advanced Paediatric Life Support

The certificate is **valid for five years**, at which time you repeat the course.

Contact: Jo Jones
E: jo@apls.org.nz
T: 07 312 9574

ACLS

Advanced Cardiac Life Support

The course you do must be at the Advanced level of the New Zealand Resuscitation Council standard and endorsed by the College. If you are unsure where to find a course, ask the DRHM senior education coordinator for an up-to-date list of providers. ACLS courses remain **valid for three years**.

ALSO

Advanced Life Support in Obstetrics

Visit www.amare.org.au for course dates and information.

BASIC

Basic Assessment and Support in Intensive Care

Designed to teach practical management of critically ill patients, particularly doctors working in smaller units. Topics include the assessment of the seriously ill patient, mechanical ventilation, severe trauma, severe sepsis and septic shock, interpretation of arterial blood gases, sedation and analgesia.

Contact: Sandra Bee (Course coordinator)
T: 06 878 8109 extn 4567
M: 027 245 3692
E: sandra.bee@hbdhb.govt.nz

ELS

Emergency Life Support

The ELS course provides two days of instruction on medical emergencies and covers a broader content area than other resuscitation skills courses.

www.elscourse.com.au

PROMPT

Practical Obstetrics Multi-Professional Training

This is an evidence-based multi-professional training package for obstetric emergencies.

www.promptmaternity.org

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.

The clinical leaders for the RHM training programme are:

Dr Amanda van Zyl

drhmcl1@rnzcgp.org.nz

021 187 2100

Dr Jared Green

drhmcl2@rnzcgp.org.nz

021 865 335

Dr Stephen Ram

drhmcl3@rnzcgp.org.nz

021 159 3070

Dr Jack Haywood

drhmcl4@rnzcgp.org.nz

027 329 9175

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.

You should 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. Ideally, at least two of these meetings will be face-to-face and two will be by telephone or video-calling. It is likely you will have a meeting at the New Zealand Rural General Practice Network conference. One of you may need to travel for the second face-to-face meeting.

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.

Once a year your EF will provide a report to the BoS on your progress based on your discussions and meetings throughout the year.

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

You will have a rotational supervisor for each attachment. This will normally be the specialist to whom you are clinically responsible. 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 for the run. You should successfully complete one Mini-CEX every three months during the relevant runs (i.e. one Mini-CEX 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 End of Attachment and Mini-CEXs reports to the DRHM senior educational coordinator as soon as a run is completed.

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 your EF four times 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 training 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.

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 cases you managed, skills you learnt, what you observed your supervisors doing.
- 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.

You and your EF 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.

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.

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.

You should review your skills logbook when you meet with your EF 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.

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.

It is the registrar's responsibility to submit their academic result as soon as they pass each paper. However, you can consent to the College receiving your academic results directly from the university. The consent form is available on Te Ara.

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

Mini-CEX

The Mini-CEX is a practice-based assessment undertaken by your rotational supervisors or appropriately qualified doctors delegated by your rotational supervisor. It is an important formative assessment tool.

You need to get your rotational supervisor to undertake four Mini-CEX examinations a year, normally one every three months except in the elective year. They will observe you taking a history, conducting an examination, and then ask about diagnosis and management. They will assess competency in communication skills, history taking, physical examination, clinical judgment, organisation and efficiency, and overall clinical competence. They will provide you with immediate feedback and complete a rating form. Please ensure that your rotational supervisor includes comments for all the comment boxes of your Mini-CEX form.

You need to keep the results of your Mini-CEX examinations in your portfolio and review them with your EF and send copies to the DRHM senior education coordinator.

You must pass 12 Mini-CEX examinations to qualify for Fellowship. A maximum of two outstanding Mini-CEX examinations can be undertaken at the time of the Fellowship assessment visit, with the prior approval of your Fellowship assessor.

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, and appropriate paperwork must be provided for the two assessments.

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 completed during this time credited towards the Mini-CEX requirement of the RHM training programme. A maximum of four Mini-CEXs (two per 12 months of RPL) may be credited with approval from the Division BoS or delegate.

The 12 Mini-CEXs are a crucial tool 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.

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 as soon as the run is completed.

Educational facilitator reports

Your educational facilitator (EF) will be asked to complete a report on your performance and progress annually based on your meetings and discussions during that year. These also form part of your formative assessment.

It is the registrar's responsibility to initiate the meeting arrangement with their EF. It is important that you keep your EF updated with your plans and intentions.

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. Candidates remain in one place while the examiners (all in one location) rotate around the candidates.

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.

StAMPS will be undertaken no earlier than 12 months before the end of training. There are limited places available for the StAMPS examination. If you wish to complete StAMPS, you will need to book into an examination session directly via ACRRM's website. Please notify the DRHM senior education coordinator and clinical leaders **before** you apply online to sit the StAMPS examination.

Registrars can choose to travel to Australia to do the examination in person or undertake it in New Zealand by videoconferencing.

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 developed by the Royal Australasian College of Physicians. 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.

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 two Mini-CEX examinations that can be conducted on the day and 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.

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
- Registrar training agreement.

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.

At-risk registrars

Registrars will be identified as 'at risk' if they:

- are not making adequate progress
- have reports that flag concerns
- have failed any summative components.

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.

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.

You are welcome to request an assessment summary sheet from the DRHM senior education coordinator where applicable.

The New Zealand Rural General Practice Network and Conference

All rural hospital doctors, including registrars, are welcome to join the New Zealand Rural General Practice Network. Membership is also open to rural GPs and nurses. Join online at www.rgpn.org.nz.

Attendance at the New Zealand Rural General Practice Network conference is part of the training programme, so it is recommended that you make every effort to attend. 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, which is usually preceded by sessions specifically for rural hospital medicine registrars.

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. More details at: www.rgpn.org.nz

Your employer should give you adequate leave to attend.

Fees

Like other hospital-based vocational training programmes, the rural hospital medicine programme is funded by Health Workforce New Zealand (HWNZ). HWNZ has contracts with DHBs that cover the costs of your training, such as release time for formal and informal teaching, consultant 'slow down time' related to teaching, and external costs such as university and college fees.

The Division also charges fees for its contribution to your training and for associate membership of the College and the Division. See the website for current rates.

Refer to the University of Otago and The University of Auckland for fees for academic papers.

In most cases, fees can be legitimately claimed back from your employer.

The government also offers Voluntary Bonding Scheme scholarships for rural hospital medicine registrars. This used to apply only to registrars working in some hard-to-staff DHBs and hospitals but has been extended to apply to rural hospital medicine registrars working in any community. More information at: www.moh.govt.nz/bonding.

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