VOCATIONAL TRAINING
FREQUENTLY ASKED QUESTIONS

GENERAL TRAINING PROGRAM

Q. To undertake training towards a FACRRM, what do I have to do?

A. You must become a registrar member of ACRRM and enrol with ACRRM. There are two forms on the website which can assist you with this. These are the Membership Form and the Enrolment Form.

Q. Can a registrar do both qualifications at the same time?

A. Yes, but requirements for completion of training are different between FACRRM and FRACGP. Candidates seeking both Fellowships will need to refer to each College's completion of training requirements, including formative and summative assessment.

Q. Does a FACRRM candidate have to undertake all training in rural areas?

A. Training must be undertaken in ACRRM accredited training posts. Predominately these are located RRMA's 4 – 7. There are some instances where a post may be able to be accredited when it is in RRMA's 1 – 3, provided that it provides the range of extended clinical learning opportunities and the opportunity to gain experience in emergency medicine, after hours work and extended care responsibilities such as home visits, nursing home and hospital visits outside the practice premises. Core Hospital Training may be undertaken in accredited hospitals, which can be metropolitan. Advanced Specialised Training (AST) may require the candidate to train in an urban post, depending on the discipline chosen.

Q. Can a candidate in the general pathway of AGPT complete a FACRRM qualification?

A. Yes. The only factor that needs to be considered in planning training is that there is the AGPT requirement for general pathway candidates to undertake 6 month's training in an outer metropolitan area. It is therefore necessary to identify an ACRRM accredited outer metropolitan post.

Q. How would a registrar enrolled with an urban-based RTP gain access to rural/remote posts?

A. This is dependent on the individual RTP. Some RTPs have arrangements in place with rurally based RTPs to facilitate access to these posts.

Q. Can registrars already enrolled in general practice training (AGPT) switch over to/enrol in the FACRRM qualification?

A. Yes. Please refer to the AGPT 2008 Registrar Guide (page 15). This Guide is available on the AGPT website.

Q. Does Small Town Rural count towards AST in FACRRM training?

A. ACRRM recognises the skill set and use of Small Town Rural Hospitals as valid training towards FACRRM. Moreover, ACRRM has **mandated** the achievement of these skills, which are documented in the **ACRRM Primary Curriculum**. In the Primary Rural and Remote component of training towards FACRRM, Rural and Remote Medical registrars are required to gain 2 year's experience in ACRRM accredited rural/remote posts. This includes any combination of appropriate Hospitals/outreach clinics, Private Practice with VMO status or Aboriginal Community Controlled Health Service practice.

ACRRM registrars are not limited to six month's 'special skills' to undertake hospital-based training as core component of Fellowship. Hospital-based training has always been important for training towards FACRRM. All FACRRM candidates **must** acquire the skills of the rural generalist, to enable the FACRRM to be seen by employers and practices as certification that doctors with this qualification are competent in providing inpatient care in a small rural hospital. (This is one of the points of differentiation between FACRRM and the FRACGP; in FRACGP, the skill set and ARSP is an optional/ post nominal extra.).

Because ACRRM requires small town rural (STR) experience for primary training, we do not recognise it (STR) for the purposes of AST per se, unless the experience can be configured to cover one or more of the ACRRM AST curriculum areas. AST requires a demonstrable extension of the skill set defined in the primary curriculum and the demonstrated applicability of those skills in rural and remote practice.

Q. Can a registrar split their AST training time in two, e.g. complete 6 months of anaesthetics in year 2 and 6 months in year 4?

A. People completing training against a JCC curriculum will need to maintain continuity in their training and will generally undertake it across one twelve month period. For the other 7 AST disciplines, ACRRM would consider each situation based on its merits. It is ACRRM's preference for a candidate to gain the benefit of 12 month's continuous training time and focus in the AST discipline. Individual cases can be considered and can be addressed by the RTP putting a request in writing to the Vocational Training Team at ACRRM.

Q. What happens if a registrar has missed out on one of the essential rotations during the core hospital year?

A. A determination of the development needs of that registrar should be made. The registrar's experience in total should be reviewed to determine whether exposure to that area has been gained through other means, e.g. intern year, PGPPP, another rotation which provides elements of the essential skills, knowledge and behaviours. If in doubt about a registrar's competence and confidence to practice in a particular area, the RTP should work with the supervisor to make an early assessment of the registrar's abilities. A detailed learning plan, together with appropriate levels of supervision, should then be tailored to suit the registrar's needs.

Q. I have heard that ACRRM do not accept training in Drug and Alcohol posts for either Primary Rural and Remote or AST. Why is this?

A. For Primary Rural and Remote Training, the training post must give the registrar the opportunity to acquire the skills and knowledge outlined in the Primary Curriculum. The scope of practice of facilities which focus solely on Drug and Alcohol, generally means that a registrar would not be exposed to the broad range of areas required in the volume required to build competence; e.g. Paediatrics, Obstetrics, Surgery, Palliative Care, and Emergency Medicine.

For AST, ACRRM currently offers 10 disciplines. Drug and Alcohol is not one of these disciplines. Depending on the post, a case may be made for the involvement of Drug and Alcohol work as a part of a Mental Health AST, as long as it was not the mainstay.

Q. Do ACRRM offer an AST in Palliative Care? If not, why not? Can Palliative Care be undertaken as a part of Primary Rural and Remote Training?

A. Palliative care is an important area of service need in rural and remote communities. However, a palliative care service position is not accreditable for primary rural and remote training, as it does not afford the breadth of experience required to meet Primary Curriculum objectives. Extended training in Palliative Care may be constructed as a component of a broader Internal Medicine AST.

TRAINING POSTS

Q. If ACRRM allows a registrar to undertake all their training in a hospital environment, how can ACRRM claim to train General Practitioners, when none of the training has to occur in an actual 'general practice'.

A. ACRRM trains registrars to function safely and independently in rural and remote environments. ACRRM believes that the type of generalist practice required in these environments can be described as:

- Management of undifferentiated acute and chronic health problems across the lifespan in an unreferred patient population;
- Providing continuing care for individuals with chronic and complex conditions;
- Undertaking preventative activities such as screening, immunisation and health education;
- Responding to emergencies including stabilisation and definitive management as appropriate;
- Providing hospital-based secondary care where required;
- Delivering obstetric care; and

- Undertaking a range of population health interventions at the practice and community level.

Rather than mandating the minimum time that is to be spent in a specific business model of primary medical care (e.g. private office-based practice), the expectations in ambulatory primary care are covered by curriculum. ACRRM's Primary and Advanced Curricula have been written to incorporate learning outcomes which would see the achievement of a set of knowledge, skills and behaviour that allows a generalist practitioner to work within this scope of practice. It also acknowledges that the office-based primary care practice that occurs in the majority of urban-based private practice environments, is usually a subset of the scope of practice that occurs in primary medical care in the rural and remote environments, with less access to specialist and other referral services.

A registrar can train towards FACRRM in any environment which is accredited to deliver training against our standards. A key quality indicator which underpins the ability of a training post to be accredited, is that the training post:

"Provides the learner with a range of clinical experiences and responsibilities that cover the spectrum of illness, conditions and situations usually encountered in rural and remote medical practice."

That quality indicator is further defined and given context and definition by ACRRM in the Primary and Advanced Curricula.

Rural or Remote hospital environments can differ substantially from their urban counterparts. There are many factors (such as lack of other health care services, lack of accessibility of generalist practitioners, geographical isolation, cultural and social influences), which can mean that a rural or remote hospital is involved in the scope of practice that ACRRM defines as its benchmark for training rural and remote registrars. The key to the involvement of a rural or remote hospital as a training post for a registrar, is its accreditability against ACRRM standards and its ability to enable the registrar to meet the learning outcomes defined in the curricula. If this standard is met, then the hospital is appropriate for training purposes.

Q. Do hospitals need special accreditation for Core Clinical Training?

A. ACRRM will accept Post Graduate Medical Council (PGMC) accredited hospitals as satisfying the requirements of Core Clinical Year. If a hospital is not accredited with the PGMC, then ACRRM will institute its own accreditation process.

Q. Can posts that are not in RRMA 4- 7 be accredited for training?

A. It depends. Each case would need to be considered on its merits. If the scope and type of practice were such that the post met ACRRM's standards, then it would be able to be accredited.

Q. Is a dedicated room essential for registrars - does it mean the registrar always must work out of the same room?

A. It is ideal for the registrar to have their own room on a continuing basis. ACRRM recognise that the nature of some practice environments means that all practitioners, not just the registrar, need to move rooms from day to day. As long as the registrar has a fully equipped room in which to consult with patients, we are satisfied.

Q. Are there any requirements for in-practice teaching time?

A. The ACRRM standards do not mandate or prescribe an amount of teaching time. Instead, it is our view that the individual needs of registrars should inform negotiations between the supervisor, RTP and registrar to determine the amount of teaching time needed. ACRRM's standards for remote supervision (where the supervisor is not insitu in the registrars practice) do prescribe a minimum of two, one hour sessions per month of educational instruction by telephone or videoconference, augmented by weekly teleconference, to amount to a minimum of 1.5 hours per week.

Q. What cover/back up supervision is required by ACRRM?

ACRRM has two sets of requirements, depending on whether supervision is remote or not. In normal circumstances, ACRRM requires the supervisor to be accessible and available to the learner, either on site or delegated, or by telephone or radio, in accordance with the requirements outlined by the RTP. In remote contexts, the supervisor should be accessible and available to the learner by telephone or radio 80% of the time the learner is working, or on call to provide appropriate advice and backup. At times when the supervisor is unavailable, the supervisor organises for a nominated deputy supervisor or the education provider broker to perform this role.

Q. How does ACRRM accreditation for Royal Flying Doctor Services and Aboriginal Community Controlled Health Services work?

A. In the same way and against the same standards as other training posts.

Q. What happens if an RTP thinks a practice should not be accredited?

A. The RTP should provide evidence, in writing, detailing the reasons for this stance.

Q. Where a practice provides support to a local hospital, does that hospital also have to be an accredited post or do we rely on the accreditation at its source?

A. The post is accredited as a total 'package' that would take into account the nature of engagement with other facilities (such as on-call, emergency department shifts, inpatient care, nursing home care), rather than require each of these settings to be separately accredited.

Q. The standards outline the need for the learner to take on extended continuity of care responsibilities such as home visits, nursing home visits, hospital visits and other visits outside the practice premises. Is after-hours hospital involvement mandatory or is it acceptable for a practice to simply be involved in home visits or nursing home visits?

A. To meet accreditation standards, the post would generally need to include negotiated access to hospital and after-hours care. Exceptions for individual registrars can be made on a case-by-case basis where this experience can be demonstrated to be made up in other posts/rotations.

RECOGNITION OF PRIOR LEARNING (RPL)

Q. If a registrar changes from the RACGP program to the ACRRM program at a point during their training, what processes are required from an RPL point of view and what RPL is likely to be awarded?

A. Apart from completing the necessary forms to enrol in the ACRRM program, as soon as is practicable, the registrar should submit an application for RPL to ACRRM, so that their experience can be assessed against ACRRM's standards. The extent of RPL likely to be awarded will depend on the extent to which their experience has occurred in training posts that are accredited, or are likely to be capable of being accredited by ACRRM. Other issues which will impact are whether they have undertaken any training time which fits within ACRRM's paradigms for Core Clinical, Primary Rural and Remote or Advanced Specialised Training.

Q. Will overseas experience count towards RPL?

A. It depends on the context and content of that experience. For example, rural and remote generalist practice in countries such as Canada, the United States, New Zealand and South Africa would be considered relevant. Specialist experience in an overseas context can be considered on a case-by-case basis.

Q. If someone has previously worked as a specialist in a non generalist discipline, how will this be treated for RPL purposes?

A. Depending on the speciality and its alignment with the 10 ACRRM AST disciplines, recognition could be granted for an AST year partially or in its entirety. Credit may also be awarded against aspects of the Primary curriculum and training time reduced. This can depend on the context in which the work was undertaken. For example, a FACEM with 5 year's experience in a metropolitan ED would be granted credit for an AST in Emergency Medicine and possibly/probably some Primary Rural and Remote Training time. These applications would need to be judged on a case-by case-basis.

COMPLETION OF TRAINING

Q. When does a candidate fill out a completion of training form?

A. When all training time, assessment components and mandatory requirements are complete.

Q. How long does it take to achieve Fellowship once a Completion of Training Form is submitted?

A. If all documents and evidence are included with the form, it will take between 3 and 9 weeks to process.