Placement allocation guidelines for hospitals

Note: this guide is intended to be read with the QRGP Prevocational training program framework and Training outcomes statements.

Every prevocational clinical placement is unique. When allocating clinical placements, we encourage medical administration and education units to consider the experience available during a clinical placement (area of practice, type of experience, caseload, complexity, workload) through the lens of the National Framework for Prevocational Medical Training (NFPMT) and the QRGP's training objectives and desired outcome statements.

Every Rural Generalist trainee's 2-year prevocational program is also unique. Care must be taken to ensure that the combined clinical experiences fulfil the NFPMT and QRGP desired outcome statements by the end of PGY2.

The following guidelines are provided to assist training hospitals to allocate the 4 AMC clinical experiences in a way that reinforces the training objectives of the both the NFPMT and our prevocational training program. Coloured text boxes represent NFPMT descriptions of desired training outcomes. All prevocational doctors are required to undertake clinical experiences in category A – D in PGY1, and category A – C in PGY2, as outlined on page 4.

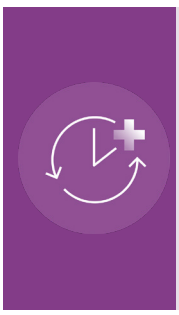
A | Undifferentiated illness care
Prevocational doctors must have experience in caring for, assessing and managing patients with undifferentiated illness. Learning activities include admitting, formulating and assessment, presenting and clinical handover. This means the prevocational doctor has clinical involvement at the point of first presentation and when a new problem arises. This might occur in a range of settings such as in an emergency department or in general practice.

Emergency medicine and general practice are the most appropriate source of undifferentiated care experience for rural generalist prevocational doctors.

Inpatient undifferentiated care experiences (e.g. ward call, or an acute admission unit) provide useful supplementary experience but do not by themselves provide the broad ambulatory caseload required for rural generalist prevocational training.

Community-based medical practice involves a high degree of clinical uncertainty, especially in rural practice where the full spectrum investigative and specialist support may not be immediately available.

Vocational trainees need to be comfortable with and have the diagnostic and problem-solving skills required to accommodate uncertainty and tackle presenting problems that may not always be well understood or managed within a traditional biomedical paradigm.



B | Chronic illness care
Prevocational doctors must have experience in caring for patients with a broad range of chronic illnesses and multi-morbidity, with a focus on incorporating the presentation into the longitudinal care of that patient. Learning activities include appreciating the context of the illness in the setting of the patient's co-morbidities, social circumstances, and functional capacity. Experience should include working with multidisciplinary care teams to support patients, complex discharge planning and a focus on longitudinal care and engagement with ongoing community care teams. This might occur in a range of settings, such as general practice, a medical ward, outpatient clinic, rheumatology, rehabilitation, or geriatric care.

General practice is the most directly relevant source of chronic care experience for prevocational trainees. Some, but not all, medical units have a significant component of chronic disease care. Careful attention must be paid to the unit's caseload to ensure the placement provides appropriate chronic care experience. A prevocational doctor's work on a clinical placement may need to be customised to ensure it fulfills NFPMT training objectives if it is to be classified as a chronic care experience.

Acute care of a patient that has underlying chronic disease, is not the same as chronic disease care.

C | Acute and critical illness care
Prevocational doctors must have experience assessing and managing patients with acute illnesses, including participating in the care of the acutely unwell or deteriorating patient. Learning activities include to recognise, assess, escalate appropriately, and provide immediate management to deteriorating and acutely unwell patients. This experience should be gained working in a wide range of settings such as acute medical, surgical or emergency units.

Emergency medicine provides acute and critical care experience for rural generalist trainees. The ability to assess the level of risk given the clinical scenario and context of care is a foundational skill for rural generalist vocational trainees. Early recognition, management, resuscitation, and when necessary, expeditious transfer of seriously or critically ill patients is a critical skill.

Rural Generalist trainees require well developed critical care experience, including airway and resuscitation experience, in addition to emergency medicine. Basic life support, advanced life support, paediatric life support, and trauma courses are strongly recommended.

Clinical experience in Intensive Care, Coronary Care, High Dependency Medical and Surgical units are valuable supplementary sources of critical care experience. Acute general medical and surgical units provide necessary experience in the acute care of adult patients.

Clinical placements on subspeciality medical units do not provide the broad general experience necessary for rural generalist prevocational training and are discouraged. However, general medical units that have a special interest but accept admissions from all patients presenting for medical or surgical admission are acceptable.

A mental health placement is highly desirable for rural generalist trainees. The high incidence of mental health problems exacerbated by the relative of lack of suitable services in rural communities mean that rural generalists and vocational trainees play an essential role in the initial diagnosis, management, referral, advocacy for, and access to mental health services.

D | Peri-operative/ procedural care
Prevocational doctors must have experience in caring for patients undergoing procedures, including pre-, peri-, and post-operative phases of care. Clinical experiences should include all care phases for a range of common surgical conditions/procedures. Learning activities include preadmission, intraoperative care/attendance in theatre, peri-operative management, post-operative care and longitudinal outpatient follow-up. This might include working in a range of settings such as in interventional cardiology, radiology, anaesthetic units or surgical units.

A general surgery experience is the richest source of peri-operative and procedural care. While we do not require trainees to undertake a general surgical term, it is an ideal clinical experience for meeting category D in year one.

Anaesthetics, interventional cardiology, radiology, orthopaedics, and obstetrics and gynaecology provide valuable supplementary perioperative experience, but do not provide exposure to the assessment and pre-operative, operative and post-operative management of 'common surgical conditions and procedures' articulated in the NFPMT. They are not preferred as stand-alone perioperative care experiences.

Clinical placements on subspeciality surgical units do not provide the broad general experience necessary for rural generalist prevocational training and are discouraged. However, general surgical units that have a special interest but accept admissions from all patients presenting for medical or surgical admission are acceptable.

Where feasible, and where category D experience has otherwise been met in year one (refer to the table on page 4 of this document for term examples), training hospitals could consider offering a general surgical term experience in year two. This is a suggestion only and is not a requirement.

Learning opportunities – rural placements

Rural and urban/regional hospital placements have different educational properties. Advantages of rural placements include rural context, broad caseload, continuity of care and supervision and participative 'hands-on' learning in which trainees have more autonomy and responsibility. Figure 1 provides more detail.

Trainees with an active learning style benefit most from these types of placements. However, placements need to be of sufficient duration to provide the clinical exposure required and it is important to ensure that trainees do not feel disadvantaged by their rural placement[1,2].

Framework requirements

Category	PGY1	PGY2
A: Undifferentiated illness care	✓	✓
B: Chronic illness care	✓	✓
C: Acute and critical illness care	✓	✓
D: Peri-operative/procedural care	✓	

RG trainee required terms include:
- obstetrics
- anaesthetics
- emergency medicine
- paediatrics.

Highly desirable terms when available:
- rural general practice or John Flynn Prevocational Doctor Program (JFPDP)
- rural hospital placement or JFPDP
- mental health

Examples of terms that may meet the NFPMT Framework requirements (either in full or part) are outlined below:

Category	Term
A: Undifferentiated illness care	Emergency medicine, general practice, rural placement, JFPDP
B: Chronic illness care	General practice, medical/paediatric outpatient clinic, rural placement, mental health, JFPDP
C: Acute and critical illness care	General medicine, CCU/ICU, rural placement, paediatrics, mental health
D: Peri-operative/procedural care	Anaesthetics, O&G, orthopaedics, general surgery

Prevocational training programs and terms must be accredited by Prevocational Medical Accreditation Queensland (PMAQ). Refer to Queensland Health's list of current accredited prevocational training programs and PGY1/PGY2 terms.

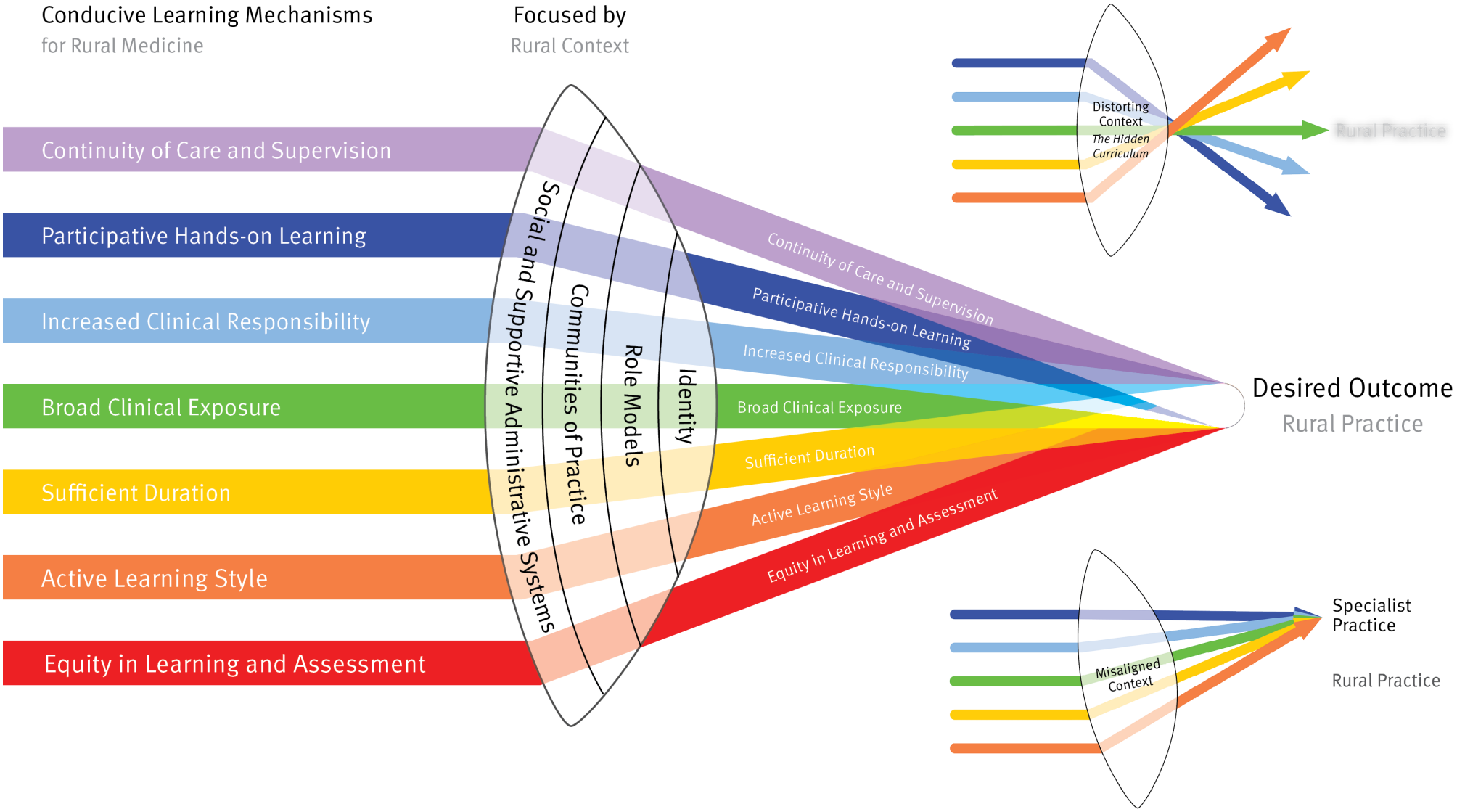


Figure 1: Figure 1: Learning mechanisms and contextual factors contributing to rural placements

Engagement with the rural community of medical practice

Rural generalism requires different knowledge, expertise and skill, but it also requires a different way of knowing, thinking and practicing clinical medicine. Our prevocational training program seeks to develop clinicians whose contribution to society cannot be purely defined by what they know and what they do, but who they are [1,3,4]. Arguably, there is a fifth level of Miller's Pyramid - *is* - that is learnt by example[4].

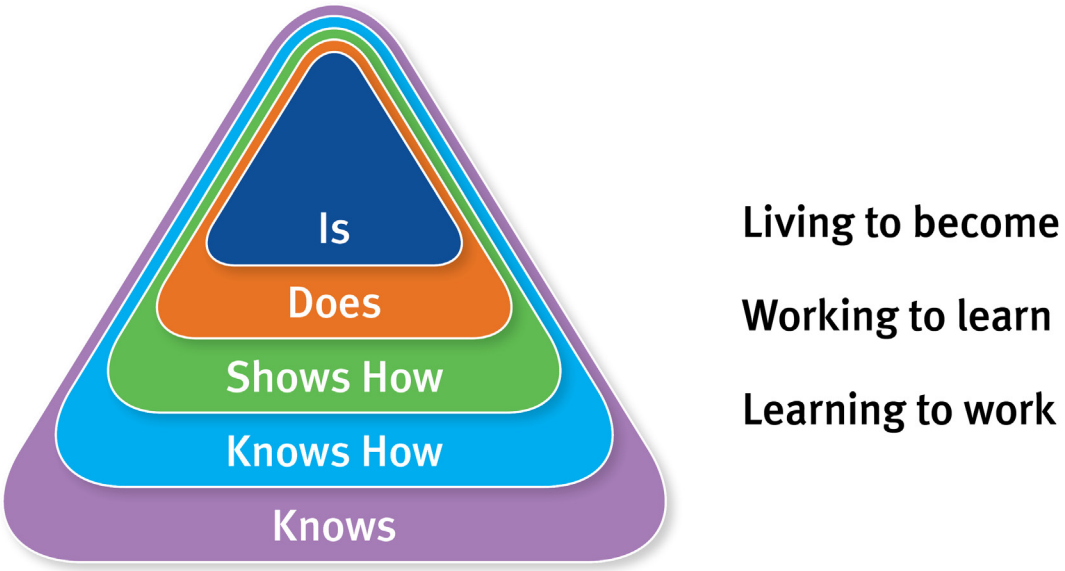


Figure 2: Modified Miller Pyramid. Cruess et al[4]

Situated learning emphasises that knowledge is constructed within the activity, context and culture in which it is learned. Trainees learn by progressively engaging in the work of a community of practice[5].

Creating opportunities for prevocational doctors to obtain rural community and hospital-based clinical experience provided by rural clinicians, educators, supervisors, mentors and role models has been shown to be important for undergraduate, prevocational and vocational training and workforce development of rural GPs and Rural Generalists[1,3,4,6,7].

We have purposefully created learning experiences in which trainees meet with their prevocational peers for training provided by Rural Generalists and become increasingly involved in, and part of, Queensland's rural community of medical practice. Where possible, we encourage prevocational training hospitals to consider how best they can facilitate the desired educational and contextual outcomes for Queensland's future rural medical workforce through facility clinical experience offerings and allocations.

References

1. Hanson DW, Carey E, Harter J, Bond D, Manahan D, Prevocational Integrated Extended Rural Clinical Experience (PIERCE): cutting through the barriers to prevocational Medical Education, *Rural and Remote Health*, 2020: 5437

2. Thistelwaite J, Bartle E, Chong A, Dick ML, King D, Mahoney S, Papinczak T, Tucker G, A review of longitudinal community and hospital placements in Medical Education: BEME Guide No 26, *Medical Teacher*, 2013, 35: e1340-e1364

3. Barnett R. *The limits of competence: knowledge, higher education and society*. Buckingham: Society for Research into Higher Education & Open University Press, 1994.

4. Cruess RL, Cruess SR, Steinert Y. Amending Miller's Pyramid to include professional identity formation. *Academic Medicine* 2016; 91(2): 180-5

5. Lave J, Wegner E. *Situated Learning: legitimate peripheral practice*. Cambridge: Cambridge University Press, 1991.

6. Australian College for Rural and Remote Medicine, ACRRM, Followship training program Handbook version 6.3, ACRRM, Brisbane, 2021, https://www.acrrm.org.au/docs/default-source/all-files/handbook-fellowship-training.pdf?sfvrsn=bdb27590_39, accessed 23rd of March 2023.

7. Royal Australian College of General Practitioners, RACGP Rural Generalist Fellowship Training Handbook 07 02 2023, RACGP, Melbourne, 2023, https://www.racgp.org.au/getattachment/b2b1a845-1b87-4f9b-b6f3-bf45a2c7bdc2/RACGP-Rural-Generalist-Fellowship-Training-Handbook.aspx, accessed 23rd of March 2023