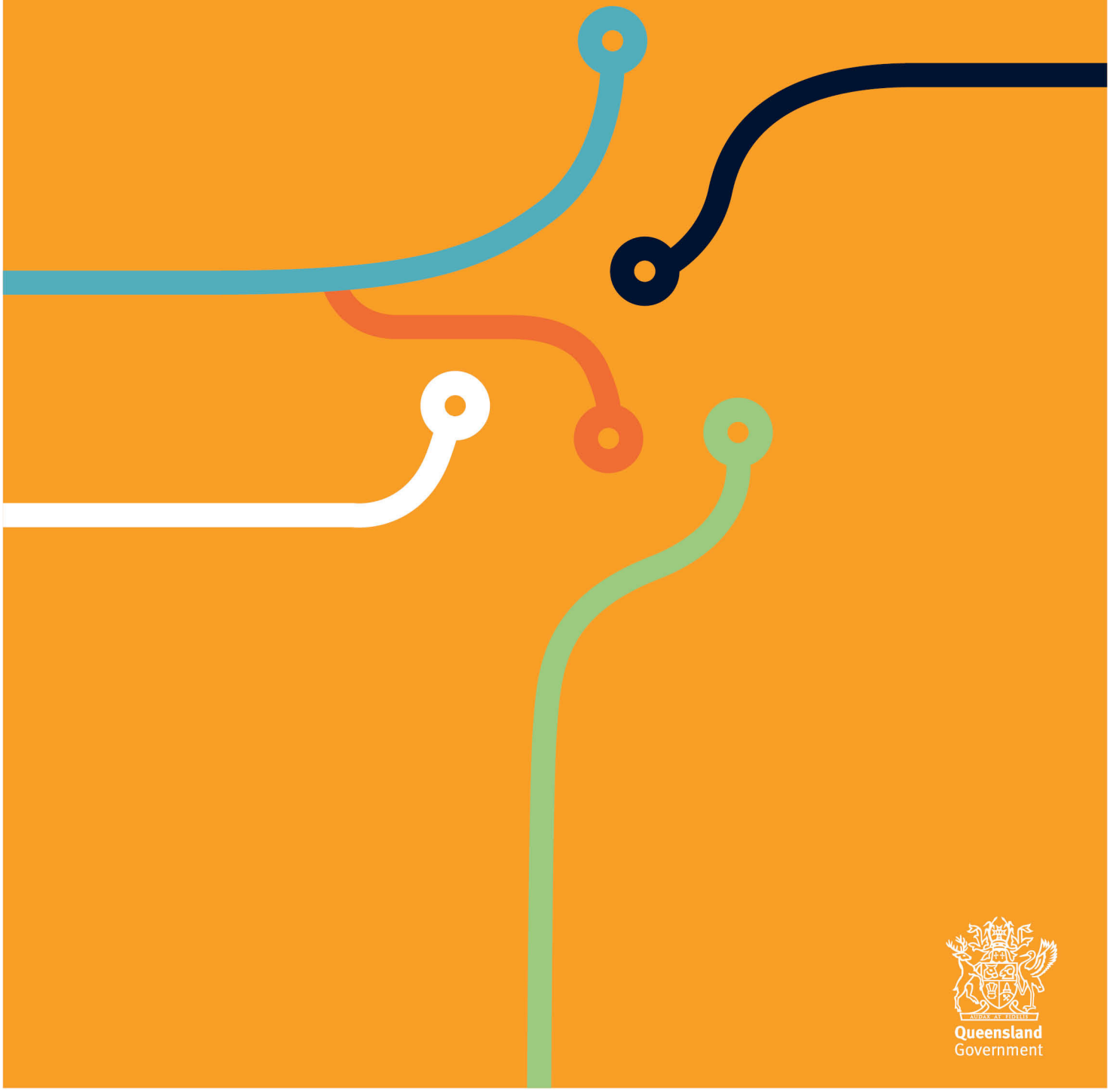
Queensland Rural Generalist Pathway

find your calling

Prevocational training program framework

Version 2.00 | January 2025



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Executive summary

Rural Medicine is not urban medicine practiced in a rural context. The Collingrove Agreement outlines the scope of practice of a Rural Generalist (RG) as defined by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP)[1]. Four domains of medical practice are needed to provide comprehensive health care in a rural community:

- primary care
- emergency medical care
- inpatient care
- advanced skill.

The Queensland Rural Generalist Pathway (QRGP) implemented Rural Generalist Medicine Prevocational Certification in 2007. The implementation of the Australian Medical Council's National Framework for Prevocational (PGY1 and PGY2) Medical Training (NFPMT) in 2024 presented an opportunity to refine and contemporise our prevocational training program.

Our program is based on the Collingrove Agreement's four domains of practice and ACRRM and RACGP fellowship training requirements. It comprises:

- emergency medicine
- exposure to key generalist disciplines:
  - anaesthetics
  - obstetrics and gynaecology
  - paediatrics
- rural placement (primary care and hospital placements are highly desirable).

This wide-ranging skill base requires systematic development over the course of prevocational training. Comprehensive, broad-based, generalist training, in multiple settings (community and hospital) at different service levels (urban, regional, and rural) involving patients of all ages and genders (male, female, adult and child) are essential for the ongoing professional development of rural generalist trainees. Basic and Advanced Life Support skills and basic prevocational procedural skills are a prerequisite for rural practice.

The NFPMT provides a solid structure in which to deliver these training objectives. We strongly support the rationale and objectives of the Framework and are keen to continue to support RG training hospitals with the educational structures, knowledge, expertise, and rural and general practice training opportunities required for the Framework to be successfully implemented as intended.

While rural generalism requires different knowledge, expertise, and skill, it also requires a different way of knowing, thinking and practising clinical medicine. It is critical that rural generalist prevocational trainees are exposed to rural clinicians, educators, supervisors, mentors and role models, and progressively become more and more involved in the rural community of medical practice.

Introduction to the National Prevocational Training Framework

National review of intern training

To address concerns about whether prevocational training was meeting community expectations to provide a medical workforce fit for purpose, the Australian Health Ministers Advisory Council (AHMAC) commissioned a review of prevocational training in 2013. The report authored by Professor Andrew Wilson and Dr Anne Marie Feyer was published in 2015. They concluded that:

> *Our consultation reinforced the value of a structured, supervised transition to practice that enables medical graduates to assume increasing responsibility for patient care as their capability matures.*
>
> *However, while stakeholders generally do not consider the internship to be totally broken, it is clearly not performing as well as it should. A number of important health system changes, together with structural deficiencies in the current model, mean it no longer fits the purpose of meeting the long-term health needs of the community.*
>
> *The internship for the majority of graduates remains almost exclusively focused on the public hospital, acute care system. While important, health care is increasingly provided in other settings. Not only does this mean that the experience doesn't reflect modern health care, it impacts negatively on the quality of the learning experience. The combined effect of incremental changes in the hospital environment, such as new models of care, shorter lengths of stay, improved governance of patient safety and shorter working hours, has unintentionally diluted the learning experience in many settings.*

Prevocational training in its previous form was not adequately meeting the health workforce needs of the Australian community or the training needs of prevocational doctors, especially those entering general practice, rural general practice and rural generalist vocational training.

Acute, rapid, high turn-over hospital admissions, shorter lengths of stay, shorter working hours, and increased administrative burden, have changed the caseload, the nature of the caseload, and the nature of prevocational training. The resultant lack of an authentic clinical role and decision-making responsibility have undermined the development of the clinical judgement and confidence required for ongoing professional development. Training is mostly provided by urban or regional teaching hospitals, a social system that provides and teaches acute hospital-based specialist care. There are few if any opportunities for prevocational doctors to work in other healthcare sectors (e.g. community or rural).

The Australian Government has made significant investments in undergraduate and vocational medical training resulting in a substantial increase in the number of doctors being trained. Despite this, the maldistribution of medical graduates towards hospital-based specialist medicine is increasing while critical workforce shortage in general practice and rural medicine persists. Medical schools have responded by expanding training settings beyond the traditional teaching hospital, as has GP vocational training. However, prevocational training has been slow to respond.

The challenge is to reconnect prevocational training with vocational training in Rural Generalism and General Practice.

NFPMT overview

After an extensive period of consultation (2019 to 2022), the AMC implemented the National Framework for Prevocational Medical Training (NFPMT) in 2024 for interns and 2025 for PGY2.

The framework aims to:

- better align prevocational training with community health needs
- strengthen the Aboriginal and/or Torres Strait Islander and Māori peoples' health component of prevocational training
- provide broad generalist experience in PGY1 and PGY2
- increase focus on clinical work
- improve supervision and feedback
- improve national program consistency
- replace the previous term by term approach with a longitudinal approach to building skills across each year
- increase the emphasis on prevocational doctor wellbeing.

Prevocational training is a transition from medical school to specialty training and independent practice, focusing on safe, high-quality patient care. Prevocational doctors should receive practical work-based training under the supervision of senior colleagues, including support, feedback, teaching and assessment. The prevocational years provide opportunities for graduates to apply, consolidate and expand their clinical knowledge and skills, and progressively increase responsibility for patient care.

Broad generalist clinical experiences aim to prepare trainees for future vocational training and meet the health care and medical workforce needs of the Australian community.

It is expected that the majority of desired learning outcomes can be met by prevocational doctors simply doing their job.

To address the perceived imbalance of prevocational training towards acute hospital-based care, the framework places more emphasis on undifferentiated, chronic and community-based care. Ideally, training should take place in a variety of health care settings (metropolitan, regional and rural) including hospitals, general practices and community-based medical services.

Rather than solely rely on mandatory clinical placements to deliver the desired outcomes the framework has provided a clearer statement of prevocational training objectives, including:

- desired outcomes and capabilities
- program content
- training environment
- educational experiences
- delivery contexts.

Prevocational training hospitals are expected to design clinical rotations, learning and assessment programs that enable prevocational doctors to achieve these outcomes. The

outcomes statements provide clinical supervisors and training directors with clear criterion for determining progress and completion. Achieving the outcomes is a requirement for general registration at the end of PGY1.

AMC Prevocational Training Framework desired outcomes

The AMC prevocational outcome statements describe 4 broad capabilities that prevocational trainees are expected to achieve by the end of their prevocational training:

Domain 1 **Practitioner**	The work expected of prevocational doctors in assessing and caring for patients including appropriately communicating, documenting, prescribing, ordering investigations, and transferring care.
Domain 2 **Professional and leader**	The professional dimension of the doctor. It includes the importance of ethical behaviours, professional values, optimising personal wellbeing, lifelong learning and teamwork.
Domain 3 **Health advocate**	The doctor who applies whole-of-person care and partners with their patients in their care. The doctor recognises that broader determinants of health have tangible effects on their patients and takes account of their context as well as broader systemic issues.
Domain 4 **Scientist and scholar**	The doctor who applies and expands their medical knowledge and evaluates and applies relevant evidence to their clinical practice.

Entrustable Professional Activities (EPAs)

Entrustable Professional Activities (EPAs) are activity-based educational conversations undertaken in the context of a clinical episode of care. The NFPMT has identified 4 everyday clinical tasks performed by prevocational doctors that are suitable for an EPA.

- EPA 1: Clinical assessment
- EPA 2: Recognition and care of the acutely unwell patient
- EPA 3: Prescribing
- EPA 4: Team communication – documentation, handover, and referrals

EPAs are the practical clinical manifestation of prevocational training. It is expected that prevocational doctors should be able to demonstrate most of the capabilities required by the NFPMT by undertaking EPAs. They will generally be assessed by a clinical supervisor and take place during normal clinical work.

The NFPMT EPAs are mapped to the prevocational training outcome statements.

EPA assessments are not pass/fail. It is an assessment of trust (hence, En***trust***able Professional Activity). Specifically, the supervisor is asked to express a judgement about the level of supervision required by the trainee to complete the task effectively and safely. This will vary according to the complexity of the case and the seniority of the doctor. A case that is difficult in PGY1 may be less so in PGY2. More is expected in PGY2 than in PGY1, at the end of the year than the beginning of the year, and at the end of the term than the beginning of the term. It is to be expected that not all cases will achieve a set standard of entrustability. What matters is progress, not an arbitrary number of 'passed' EPAs.

There are 3 levels of entrustability in the NFPMT:

- requires direct supervision – the supervisor needs to directly observe the work
- requires proximal supervision – the supervisor needs to be easily contacted and available to provide immediate and detailed review of the work
- requires minimal supervision – the supervisor trusts the prevocational doctor to complete the task.

AMC prevocational training program

To reset the balance of training that was historically dominated by acute hospital-based differentiated care the NFPMT has introduced 4 mandatory clinical experiences:

Undifferentiated illness care	Prevocational doctors must have experience in caring for, assessing and managing patients with undifferentiated illnesses.
Chronic illness care	Prevocational doctors must have experience in caring for patients with a broad range of chronic diseases and multi-morbidity, with a focus on incorporating the presentation into the longitudinal care of that patient.
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.
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 care should include all care phases for a range of common conditions/procedures.

Clinical experience in all 4 elements will be required in internship (PGY1). Terms in emergency medicine, medicine and surgery are no longer mandatory. Clinical experiences in undifferentiated care, chronic care and acute care are required in PGY2. Perioperative care may be included in a PGY2 training program, but it is not an AMC requirement.

	PGY1	PGY2
Length	Minimum 47 weeks	Minimum 47 weeks
Structure	Minimum 4 terms (of at least 10 weeks)	Minimum 3 terms (of at least 10 weeks)
Specialties	Maximum 50% any specialty and 25% subspecialty	Maximum 25% subspecialty in a year
Embedded in clinical teams	At least 50% of the year	At least 50% of the year
Service terms - relief and nights	Maximum 20% of the year	Maximum 25% of the year
Program content - clinical experiences *The primary focus of the clinical experience that you are engaged with during the term.*	Undifferentiated illness Chronic illness Acute and critical illness Peri-operative/procedural	Undifferentiated illness Chronic illness Acute and critical illness

A clinical placement may combine up to a maximum of 2 clinical experiences. For example:

- a surgical placement might be classified as either providing perioperative experience, or both perioperative and acute care experience depending on caseload
- an Emergency Department (ED) placement typically provides both undifferentiated and acute care
- a General Practice (GP) placement might provide all four clinical experiences, but only the two most prominent experiences can be classified.

While a clinical placement must be a minimum of 10 weeks, no duration is specified for the 4 clinical experiences, nor should they be strictly interpreted in this way[*]. Queensland Health will continue to offer five 10 to 12-week terms. While the NFPMT specifies that a clinical placement must be a minimum of 10-weeks in duration, one short 5 to 7-week clinical placement is allowable per year to accommodate rostered leave[†]. Short placements may be expedient for rostering, but they are less desirable educationally[‡]. The better approach is to extend one term to 15-weeks. However, this is not always possible.

E-portfolio

The e-portfolio will be implemented in 2026 and will provide a national, standardised electronic record of clinical placements, supervisor assessments, EPAs, courses attended

[*] A few examples help explain why this is the case:
- in an ED placement (providing experiences in undifferentiated and acute care) most presentations would be both undifferentiated and acute - effectively providing 10-weeks of experience in both
- in a medical placement (providing experiences in acute and chronic medicine) some patients may present with either acute or chronic problems (50:50).

[†] This is to accommodate the scheduling of rostered leave.

[‡] Trainees prefer longer placements. It takes 5 weeks to settle into a placement, understand the job and supervisor expectations, and develop sufficient self and supervisor confidence to meaningfully contribute to the work of the unit. Where possible, the optimum solution to a five-week roster gap is to create a longer placement (15 week), rather than short term.

and other educational experiences. All prevocational trainees will be required to maintain their e-portfolio. A review of the e-portfolio is part of the final assessment of satisfactory completion of training.

Supervision

Prevocational doctors must be supervised at a level appropriate to their experience and responsibilities. Supervision arrangements should be clear and explicit. There may be more than one supervisor, each with different responsibilities:

- **Term supervisor**
  The person responsible for term orientation and assessment, who may also provide primary clinical supervision for some or all of the term.
- **Primary clinical supervisor**
  A consultant or senior medical practitioner with experience managing patients in the term's discipline. The person in this role may change during the term and could also be the term supervisor.
- **Day-to-day clinical supervisor**
  An additional supervisor who has direct responsibility for patient care, provides informal feedback and contributes information to assessments. The person in this role should remain relatively constant during the term and should be at least PGY3 level, such as a registrar.

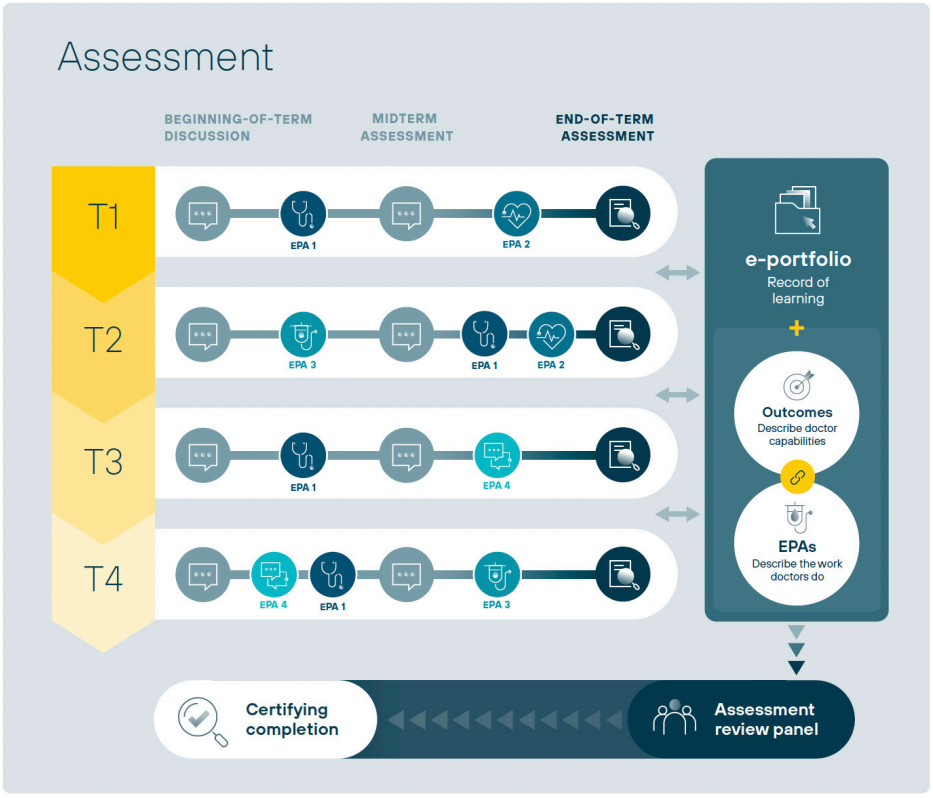
Assessment

Continuous work-based training and assessment is the backbone of the NFPMT. The NFPMT uses 2 key strategies to assess a trainee's progress and performance:

1. Supervisor assessment:
   - Midterm assessments provide timely feedback, identify any special learning needs and discuss how they can be met.
   - End of term assessments provide global feedback on a trainee's overall performance for the term.
2. EPAs provide feedback on an observed episode of everyday clinical practice and contribute to the overall term assessment and the end of year global assessment.

   The NFPMT requires:
   - 10 EPAs per year or two per term
   - EPA1 is required every term
   - a minimum of two EPA2, 3 and 4 over the course of the year.

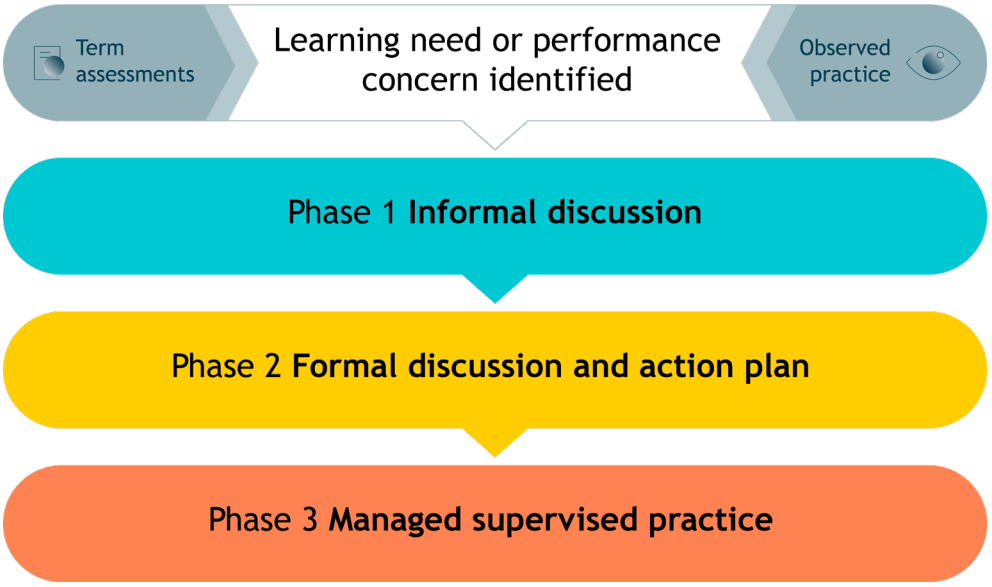
   An example of a trainee annual assessment program is provided below.



Improving performance

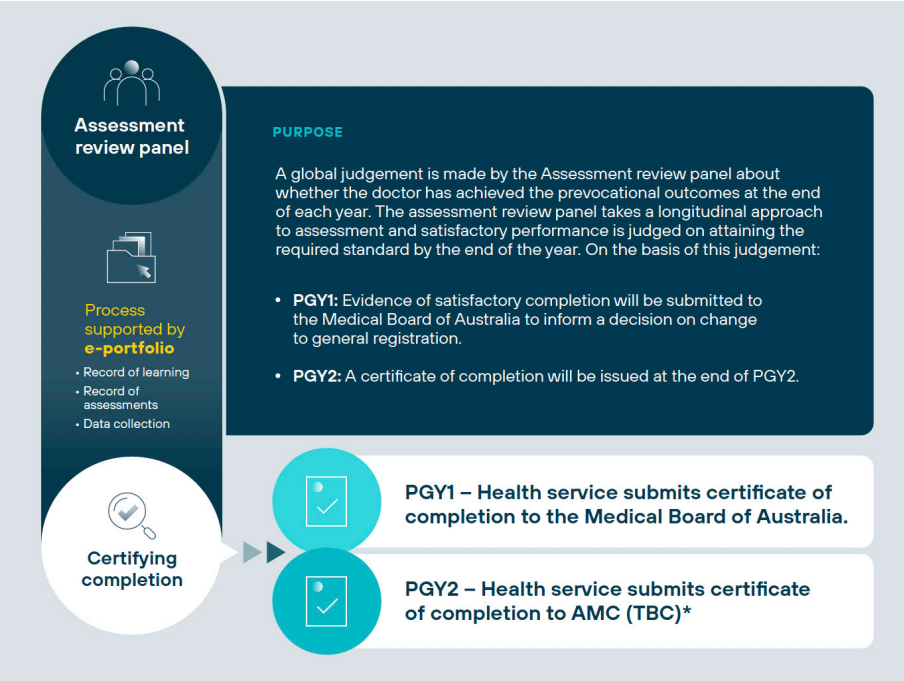
The NFPMT has a strong emphasis on assisting prevocational trainees who are experiencing difficulties that impact on their clinical performance or career progression. These difficulties may be social, workplace related or concerned with clinical performance. The focus is on early identification, feedback and support.

Multiple factors can impact performance, including individual skills, wellbeing, and the work environment. Longitudinal program and performance issues will be managed by the prevocational doctor, Director of Clinical Training (DCT) and term supervisor(s) in a 3-phase process outlined below.



Certifying completion of PGY1 and PGY2 training

At the end of each year the hospital assessment review panel makes a global judgement on whether to recommend progression to the next stage of training. The requirements for certifying completion of PGY1 and PGY2 are different. Satisfactory completion of PGY1 is the point at which the Medical Board of Australia decides to grant general registration.



National Standards for Prevocational Training Programs

Individual health services develop and deliver prevocational training programs. Health services have a responsibility to provide adequately resourced, quality prevocational training and education to:

- protect the wellbeing and safety of their staff and their patients
- support the professional development of their staff to promote best practice in their hospital
- contribute to the development of the medical workforce required by the wider Australian community.

The prevocational training hospital's overall prevocational training program, and the individual terms within their programs must be accredited. Training hospitals are assessed against 5 standards:

Standard 1	Organisational purpose and the context in which prevocational training is delivered
Standard 2	The prevocational training program – structure and content
Standard 3	The prevocational training program - delivery
Standard 4	The prevocational training program – prevocational doctors
Standard 5	Monitoring, evaluation and continuous improvement

The responsibility to comply with and promote national prevocational training standards applies to all training environments - teaching hospital, rural hospital, and primary care. From 2025, PGY2 clinical programs must be accredited and compliant with the AMC National Standards for Prevocational Medical Training (National Standards)[6]. Accreditation is an external peer review process against the National Standards undertaken by state and territory Postgraduate Medical Councils (e.g. Prevocational Medical Accreditation Queensland – PMAQ). The National Standards outline the minimum standards expected for prevocational training, including program structure, governance, content and delivery, clinical experience, supervision support, feedback, and assessment.

The National Standards operationalise the Medical Board of Australia (MBA) registration standards in 2 important ways:

- General registration: The AMC National Standards for PGY1 (intern) align with the MBA registration standard for the granting of general registration as a medical practitioner in Australia and New Zealand upon successful completion of intern training.
- CPD exemption for mandatory registration standards: PGY1 doctors (from 2023) and PGY2 doctors (from 2025) are exempt from the MBAs continuing professional development requirements that came into effect from 1 January 2023.

Implementation

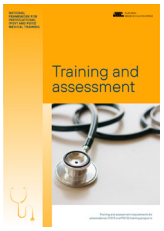
PGY1 components of the NFPMT were implemented in 2024 and PGY2 components of the NFPMT will be implemented in 2025.

The National Prevocational Training Framework and QRGP Prevocational Training

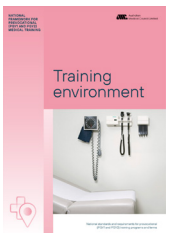
We strongly support the rationale and objectives of the NFPMT and are keen to continue to support RG training hospitals with the educational structures, knowledge, expertise, and rural and general practice training opportunities necessary for the framework to be successfully implemented as intended.

Foundation documents

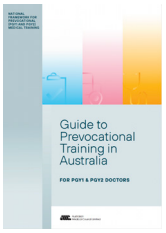
Our program resources should be read in conjunction with the following AMC documents. Our prevocational training program is compliant with and is undertaken within the processes and structure of the AMC PTF.



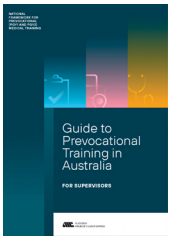
Training and assessment requirements for prevocational training programs[5]
https://www.amc.org.au/wp-content/uploads/2022/07/Training-and-assessment---Training-and-assessment-requirements-for-prevocational-PGY1-and-PGY2-training-programs.pdf



National standards and requirements for prevocational training programs and terms[6]
https://www.amc.org.au/wp-content/uploads/2022/12/Training-environment---National-standards-and-requirements-for-prevocational-PGY1-and-PGY2-training-programs-and-terms.pdf



Guide to Prevocational Training in Australia for PGY1 & PGY2 Doctors
https://www.amc.org.au/wp-content/uploads/2023/07/Guide-to-Prevocational-Training-in-Australia-for-PGY1-and-PGY2-Doctors.pdf



Guide to Prevocational Training in Australia for Supervisors
https://www.amc.org.au/wp-content/uploads/2023/07/Guide-to-Prevocational-Training-in-Australia-for-Supervisors.pdf

What is a Rural Generalist?

A Rural Generalist's scope of practice has been defined by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP)[1].

> *A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.*
>
> Collingrove Agreement[1], January 2018

Rural Generalists have the unique opportunity, experience and skill required to coordinate and deliver comprehensive holistic, community-based, patient-centered care across all domains of clinical practice in a rural context (primary care, emergency care, inpatient care, and an advanced skill).

Queensland Rural Generalist Pathway

Rural Generalist Medicine was founded in Queensland in 2005 by a group of key stakeholders who convened in Roma to develop the concept of a supported training pathway to a career in rural medicine[2].

As a result of that historic agreement, Queensland has benefited from an established and successful rural generalist pathway which has provided support and placement opportunities for rural generalist doctors in training for nearly 20 years.We currently support around 300 trainees across Queensland and nearly 300 Fellows have trusted us to be by their side while they complete their training.

We support our trainees to acquire the skills they need to meet the diverse health needs of regional, rural and remote Australians. It seeks to provide a rural and regional focus that encourages adaptability to different community contexts and provide opportunities for training and skills development supporting the needs of regions and towns. It embraces Aboriginal and Torres Strait Islander understandings of health, healthcare and decision-making. Find out more about the pathway.

Rural Generalist vocational training

Two medical colleges support Rural Generalist training in Australia:

- The Australian College of Rural and Remote Medicine (ACRRM)[3]
- The Royal Australian College of General Practitioners[4]

Both training programs require the trainee to have achieved general registration (i.e. completion of internship) prior to College training formally commencing from PGY2 (at the earliest). Training is undertaken in 3 phases:

- PGY 2 - a second year of prevocational training, generally undertaken in a regional hospital setting (one year as a minimum, however trainees may elect to undertake an extra PGY3 prevocational year if they wish)
- Advanced skills training - generally but not always undertaken in a regional hospital setting (one year)
- Vocational training - intended to be undertaken in a rural hospital and general
- practice setting (2 years).

Both training programs share many essential features, however training requirements, structure and detail vary between colleges. Table 1 provides more detail.

Table 1: ACRRM and RACGP training structure overview

ACCRM[3]	**RACGP[4]**
Prevocational training	
PGY1 – Internship (undertaken prior to college commencement)	
PGY2 Core generalist training – General clinical experience including: • Paediatrics • Obstetrics and Gynaecology • Anaesthetics	PGY2 hospital training – General clinical experience including: • Paediatrics
Advanced Specialised Training (AST)	Additional Rural Skills Training (ARST)
12 months training in one of the following: • Aboriginal and Torres Strait Islander Health • Academic Practice • Adult Internal Medicine • Anaesthesia • Child Health • Emergency Medicine • Mental Health • Obstetrics and Gynaecology • Palliative Care • Surgery (2 years) • Population Health • Remote Medicine	12 months training in one of the following: • Aboriginal and Torres Strait Islander Health • Academic Post • Adult Internal Medicine • Anaesthesia • Child Health • Emergency Medicine • Mental Health • Obstetrics • Palliative Care • Surgery (2 years)
Vocational Training	Vocational Training
• Primary care – 6 months • Secondary care – 3 months • Emergency care – 3 months • Rural and remote practice – 12 months (MM 3 to 7)	• Emergency medicine (core EMT) – 6 months • General practice training – 18 months • A minimum of 12 months must be in a rural general practice setting (MM 3 to 7)

Rural Generalist prevocational training

Rural medicine is not urban medicine practiced in a rural context. The economic and social context of rural communities, their health issues, differences in access to health services, and health professionals necessarily change the way medicine is practised.

The Collingrove Agreement identifies 4 domains of medical practice needed to provide comprehensive Rural Generalist health care for a rural community:

- primary care
- emergency medical care
- inpatient care
- an advanced skill (an area of medical specialist care provided in both hospital and community settings as outlined in Table 1).

This wide-ranging skill base requires systematic development. The implementation of the NFPMT in 2024/25 has provided an opportunity to refine and contemporise our prevocational training program.

The goals of the NFPMT and our program are well aligned as outlined in Figure 1, however a proactive approach is required to achieve these goals. It is imperative that the challenges of implementation do not distract focus away from the intended educational and social outcomes of prevocational training. The NFPMT is a means to an end, not an end in itself. Its purpose is to improve the consistency, quality and relevance of prevocational training and better align prevocational training with community health needs.

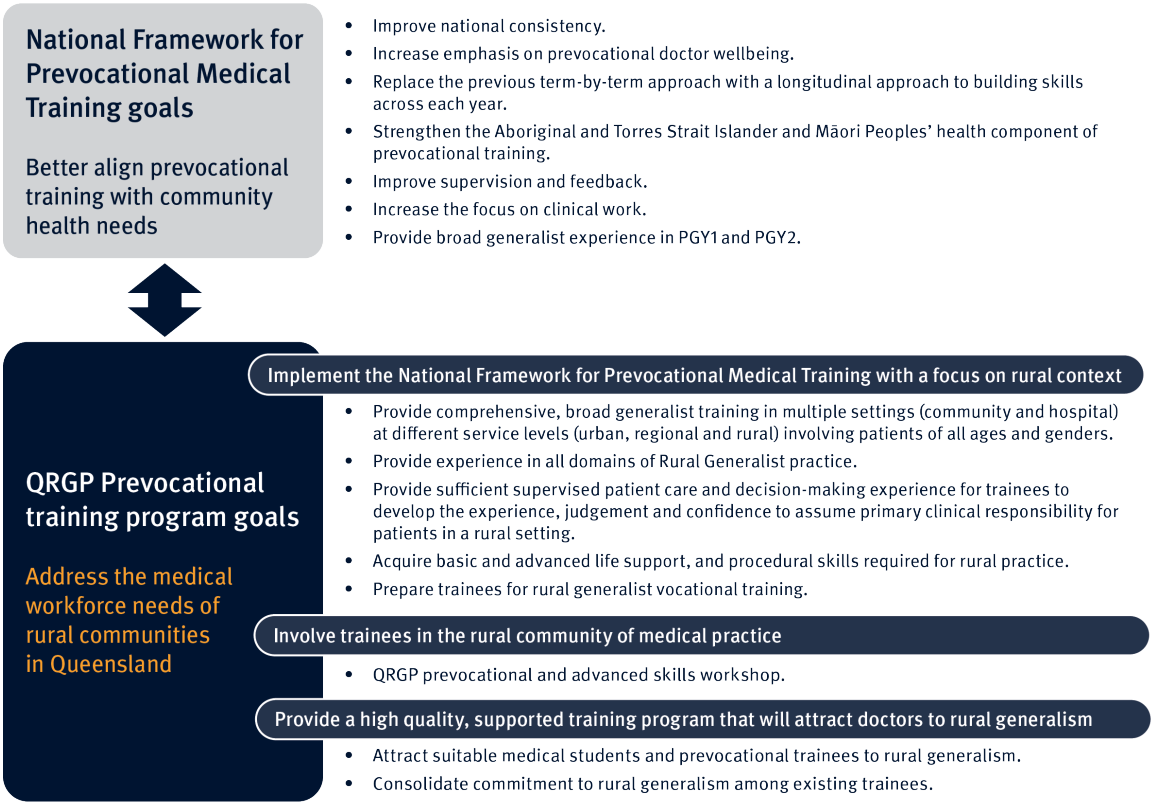


Figure 1: NFPMT and QRGP prevocational training program goals

Comprehensive, broad, generalist training, in multiple settings (community and hospital) at different service levels (urban, regional and rural) involving patients of all ages and genders (male, female, adult and child) is an essential foundation for our prevocational doctors' ongoing professional development.

Sufficient supervised patient care and clinical decision-making experience is required for our prevocational doctors to develop the experience, judgement and confidence needed to assume primary clinical responsibility for patients in a rural setting where there may not be immediate access to the full range of support and referral services available for doctors working in urban or regional tertiary hospitals. Basic and Advanced Life Support skills and basic prevocational procedural skills are a prerequisite for rural practice.

The QRGP Prevocational Training Program as outlined in Figure 2 is a comprehensive rural prevocational medical training program that seeks to reinforce the NFPMT by assisting QGRP training hospitals to develop the structures, knowledge, expertise, and training opportunities required for the NFPMT to be successfully implemented as intended. By facilitating the introduction of community-based rural medicine into their prevocational medical training programs it seeks to better prepare QRGP trainees for vocational training in accordance with college training requirements, and by providing quality training experiences, strengthen QRGP prevocational trainees' commitment to a career in Rural Generalism.

Rural Generalism requires different knowledge, expertise and skill, but it also requires a different way of knowing, thinking and practising clinical medicine. It is critical that rural generalist prevocational trainees are exposed to rural clinicians, educators, supervisors, mentors and role models and progressively become more and more involved in the rural community of medical practice.

Introducing rural context into prevocational training

Community based holistic care

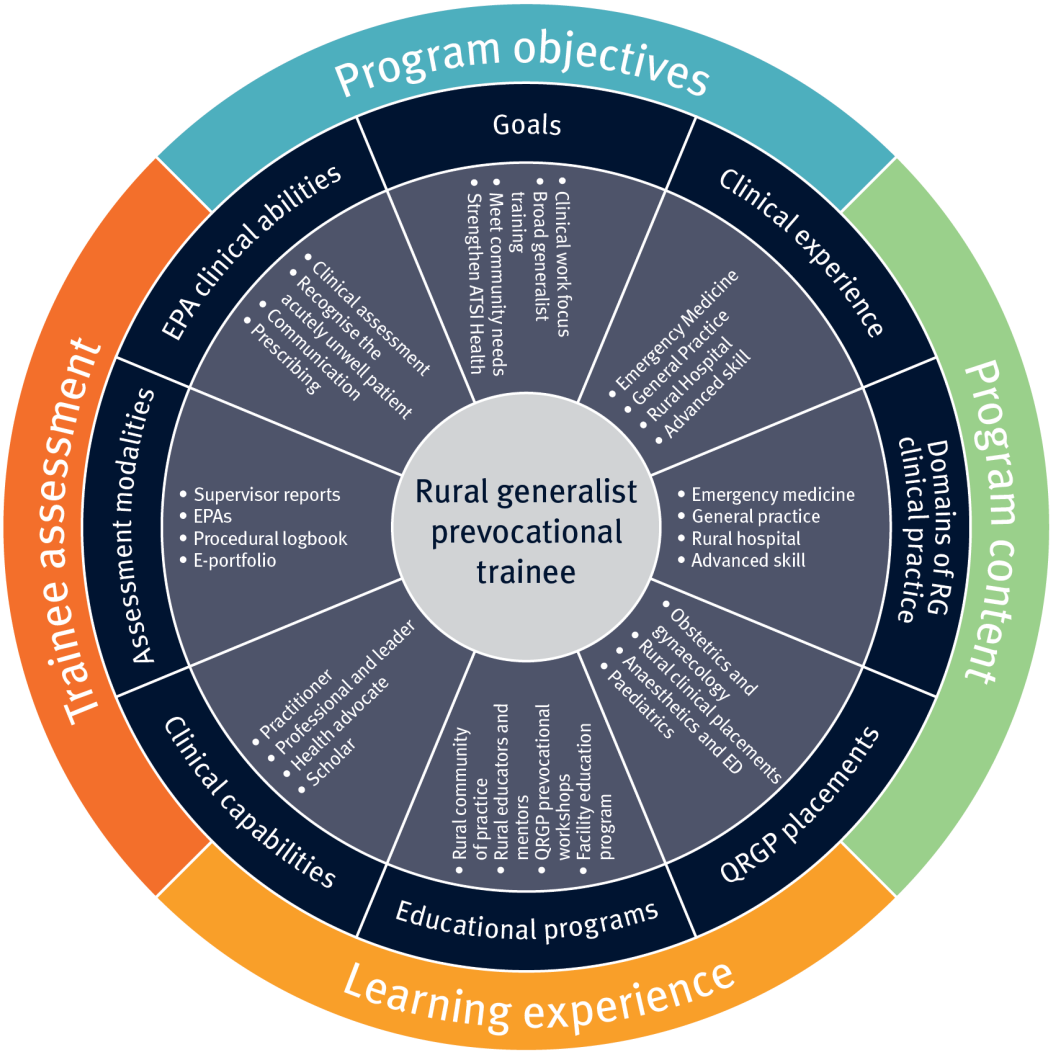


Figure 2: Introducing rural context into prevocational training

QRGP Prevocational training program desired outcomes

Our prevocational outcome statements build on the NFPMT focusing on capabilities particularly required for Rural Generalist vocational training.

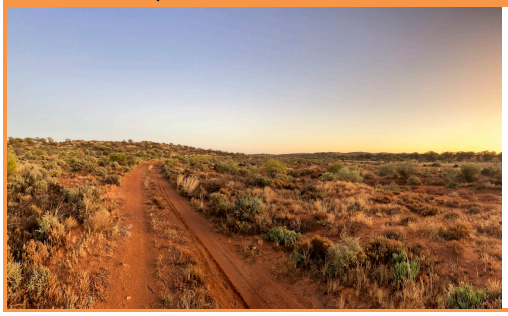
Domain 1 | Practitioner

A Rural Generalist is able to assess and care for patients of all ages and genders, appropriately communicating, investigating, documenting, and managing their health care needs, facilitating safe care in the most suitable setting given the level or risk and the availability of the expertise and resources required.

Domain 2 | Professional and leader

A Rural Generalist demonstrates ethical behaviours, professional values, and the wise use of limited health resources, optimising personal wellbeing, lifelong learning, and teamwork.

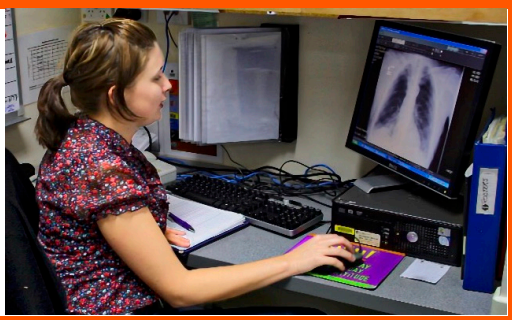
Domain 3 |Health advocate



A Rural Generalist applies whole of person care and partners with patients under their care, taking into account the contextual and systemic issues that affect heath, wellbeing and the delivery of health care, recognizing that broader determinants of health have tangible effects on their patients and the communities in which they live and work.

Domain 4 | Scientist and scholar

A Rural Generalist applies and expands their medical knowledge and evaluates and applies relevant evidence to clinical practice in a rural context.



More detailed descriptions of the desired learning outcomes are provided below.

Domain 1: The prevocational doctor as a practitioner

The doctor is able to assess, investigate, diagnose, communicate, negotiate, manage, document, prescribe and care for patients of all ages and genders presenting for either ambulatory or inpatient care in all settings (rural, community and hospital), cognisant of clinical, geographic, social and situational risk and able to identify scenarios requiring transfer for definitive care to secondary and tertiary facilities. It is expected that prevocational training will equip doctors with the broad skills they need to continue their education and practice in a range of settings.

On completion of training, prevocational doctors should be able to:	
1.1 Place the needs and safety of patients at the centre of the care process, working within statutory and regulatory requirements and guidelines. Demonstrate skills including effective clinical handover, graded assertiveness, delegation and escalation, infection control, and adverse event reporting. 1.2 Communicate sensitively and effectively with patients, their family and carers, and health professionals, applying the principles of shared decision-making and informed consent. 1.3 Demonstrate effective, culturally safe interpersonal skills, empathetic communication and respect within an ethical framework inclusive of Indigenous knowledges of wellbeing and health models to support Aboriginal and Torres Strait Islander patient care. 1.4 Perform and document patient assessments, incorporating a problem-focused medical history with a relevant physical examination, and generate a valid differential diagnosis and/or summary of the patient's health and other relevant issues.	1.5 Recognise, assess, communicate and escalate as required, and provide immediate management to deteriorating and critically unwell patients. 1.6 Request and accurately interpret common and relevant investigations using evidence-informed knowledge and principles of sustainability and cost-effectiveness. 1.7 Safely perform a range of common procedural skills required for work as a PGY1 or PGY2 doctor. 1.8 Make evidence-informed management decisions and referrals using principles of shared decision-making with patients, carers and the health care team. 1.9 Prescribe therapies and other products including drugs, fluids, electrolytes, and blood products safely, effectively and economically. 1.10 Appropriately use and adapt to dynamic systems and technology to facilitate practice, including for documentation, communication, information management and supporting decision-making.

On completion of training, *Rural Generalist* prevocational doctors should be able to:	
1.11 Assess and manage patients of all ages and genders in all settings (rural, community and hospital) presenting for either ambulatory or inpatient care. 1.12 Have the experience, confidence and judgement required to accommodate diagnostic uncertainty and manage undifferentiated patients safely in a resource-limited rural environment. 1.13 Assess the clinical, geographic, social, and situational risk of a clinical scenario. 1.14 Have the experience and judgement needed to assess the level of care.	1.15 Understand, and mobilise locally available health care resources and, when necessary, access external support, and facilitate timely transfer to an appropriate referral facility. 1.16 Effectively communicate and hand over care at key transition points between health care facilities. 1.17 Provide appropriate social and administrative support to patients and their family when referral to a regional or urban facility is required.

Domain 2: The prevocational doctor as a professional and leader

The doctor demonstrates ethical behaviours, professional values, lifelong learning, teamwork, and optimising personal wellbeing in a local community. Responsibilities of the doctor also include the wise use of limited resources in a rural context, supporting the health and wellbeing of individuals, communities, and populations now and for future generations, teaching, and promoting the environmental and financial sustainability of the healthcare system.

On completion of training, prevocational doctors should be able to:	
2.1 Demonstrate ethical behaviours and professional values including integrity, compassion, self-awareness, empathy, patient confidentiality and respect for all. 2.2 Identify factors and optimise personal wellbeing and professional practice, including responding to fatigue, and recognising and respecting one's own limitations to mitigate risks associated with professional practice. 2.3 Demonstrate lifelong learning behaviours and participate in, and contribute to, teaching, supervision and feedback. 2.4 Take increasing responsibility for patient care, while recognising the limits of their expertise and involving other professionals as needed to contribute to patient care. 2.5 Respect the roles and expertise of healthcare professionals and learn and work collaboratively as a member of an inter-professional team.	2.6 Contribute to safe and supportive work environments, including being aware of professional standards and institutional policies and processes regarding bullying, harassment and discrimination for themselves and others. 2.7 Critically evaluate cultural safety and clinical competencies to improve culturally safe practice and create culturally safe environments for Aboriginal and Torres Strait Islander communities. Incorporate into the learning plan strategies to address any identified gaps in knowledge, skills, or behaviours that impact Aboriginal and Torres Strait Islander patient care. 2.8 Effectively manage time and workload demands, be punctual, and show ability to prioritise workload to manage patient outcomes and health service functions.

On completion of training, *Rural Generalist* prevocational doctors should be able to:	
2.9 Demonstrate wise stewardship of limited local resources in a rural context. 2.10 Actively participate as a working member of and contributor to a local rural health system.	2.11 Actively participate in the local community and develop the support systems and resilience required to sustain a rural lifestyle and practise.

Domain 3: The prevocational doctor as a health advocate

The doctor applies whole-of-person care and partners with their patients in their care. The doctor recognises that broader determinants of health have tangible effects on their patients and considers the contextual and systemic issues that affect health, wellbeing and the delivery of health care in a rural setting. The doctor considers how these factors influence a patient's presentation, symptoms, ideas, concerns expectations, and behaviours. Acting as an advocate occurs as a response to acknowledgment of the disempowerment that patients may experience as they access the health system. As a health practitioner, the doctor considers their own biases and reflects on their impact on their practice.

On completion of training, prevocational doctors should be able to:	
3.1 Incorporate disease prevention, relevant health promotion and health surveillance into interactions with individual patients, including screening for common diseases, chronic conditions, and discussions of healthcare behaviours with patients. 3.2 Apply whole-of-person care principles to clinical practice, including consideration of a patient's physical, emotional, social, economic, cultural and spiritual needs and their geographical location, acknowledging that these factors can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources. 3.3 Demonstrate culturally safe practice with ongoing critical reflection of the impact of a health practitioner's knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism and discrimination.	3.4 Demonstrate knowledge of the systemic and clinician biases in the health system that impact on the service delivery for Aboriginal and Torres Strait Islander peoples. This includes understanding current evidence around systemic racism as a determinant of health and how racism maintains health inequity. 3.5 Demonstrate knowledge of the ongoing impact of colonisation, intergenerational trauma and racism on the health and wellbeing of Aboriginal and Torres Strait Islander peoples. 3.6 Partner with the patient in their healthcare journey, recognising importance of interaction with and connection to the broader healthcare system. Where relevant, this should include culturally appropriate communication with caregivers and extended family members while also including and working collaboratively with other health professionals (including Aboriginal Health Workers, practitioners, and Liaison Officers).

On completion of training, *Rural Generalist* prevocational doctors should be able to:	
3.7 Recognise and address the impact of rurality on the availability and delivery of health services, patient health and wellbeing.	3.8 Advocate to facilitate patient access to the services they need, and the support systems available to enable them to access these services.

Domain 4: The prevocational doctor as a scientist and scholar

The doctor applies and expands their medical knowledge, evaluates and applies relevant evidence to their clinical practice in a rural context. The doctor recognises that research, and quality improvement and assurance underpin continuous improvement of clinical practice, rural clinical practice, and the broader healthcare system, and conscientiously supports these activities.

On completion of training, prevocational doctors should be able to:	
4.1 Consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important presentations in a variety of stages of life and settings.	4.3 Participate in quality assurance and quality improvement activities such as peer review of performance, clinical audit, risk management, incident reporting and reflective practice.
4.2 Access, critically appraise and apply evidence from the medical and scientific literature to clinical and professional practice.	4.4 Demonstrate a knowledge of evidence-informed medicine and models of care that support and advance Aboriginal and Torres Strait Islander health.

QRGP Entrustable Professional Activities

The NFPMT EPAs and assessment program are sufficiently generic that they can be used for hospital, community and rural settings without modification. It is expected that assessment of QRGP desired outcomes can be achieved within the NFPMT EPA program and structure, namely:

- 2 EPAs per term
  - EPA1 is required every term,
  - The other EPA can be chosen from either EPA2, 3 or 4
- 10 EPAs per year
- a minimum of two EPA2, 3 & 4 over the course of the year.

EPAs are mapped to the NFPMT desired outcome statements. They are the practical clinical manifestation of the NFPMT and QRGP's prevocational training program. EPAs are a valuable professional development opportunity for our trainees to discuss a clinical case with their supervisors and obtain feedback about their clinical skills.

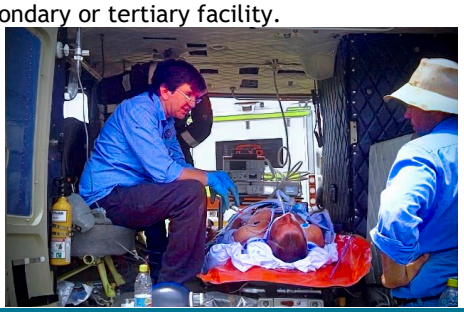
The NFPMT has identified 4 everyday clinical tasks that are suitable for EPAs. Our prevocational EPA desired outcome statements build on those of the NFPMT with identifying capabilities required for Rural Generalist vocational training.

EPA1: Clinical assessment

Conduct a clinical assessment of a patient, incorporating history, examination, investigation, and formulation of a differential diagnosis. Negotiate and communicate a management plan, cognisant of the patient's context, values and priorities.

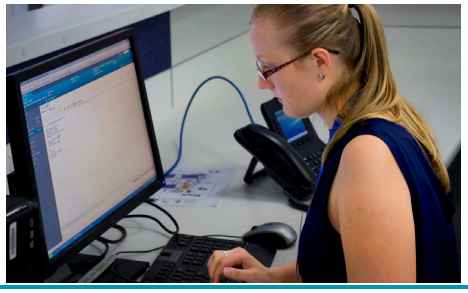
EPA2: Recognition and care of the acutely unwell patient

Recognise and assess clinical and situational risk. Provide immediate management of deteriorating, unstable and acutely unwell patients. Escalate, and when necessary, facilitate specialist support and timely transfer of care to an appropriate secondary or tertiary facility.



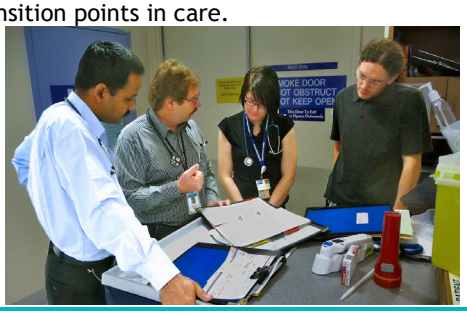
EPA3: Prescribing

Prescribe drugs, fluids, blood products and inhalational therapies, including oxygen, tailored to the patient's condition, needs, values and priorities.



EPA4: Team communication/handover

Communicate timely, accurate and concise information to facilitate high quality continuity of care within a health care team and between health care professionals and facilities at key transition points in care.



QRGP trainees are strongly encouraged to be proactive in seeking out this valuable educational opportunity, particularly for:

- cases that pertinent to the NFPMT or QRGP desired outcome statements
- unusual, classic, or memorable cases
- cases that are particularly relevant to a trainee's personal learning goals, especially if the trainee or their supervisor have identified areas that require further development.

Provided it is agreeable to both trainee and supervisor, it is acceptable for trainees to undertake more than the minimum number EPAs required by the NFPMT.

To assist trainees and supervisors achieve maximum benefit from the NFPMT EPA program, we have provided a number of example EPAs relating to common clinical scenarios, that may be used, or used as a template for other EPAs. They are not a requirement of our prevocational training program, nor are they expected to be undertaken in addition to the normal AMC EPA program. Rather, they are provided to help trainees and supervisors focus on the key learning outcomes of the QRGP prevocational training program, especially in relation to QRGP-required clinical placements.

How supervisors discuss cases, the evidence and professional values that inform clinical practice, and how they discuss and treat patients, trainees, colleagues, should reinforce the educational priorities, objectives and values of the NFPMT and our prevocational training program. Supervisor discussion and feedback for trainees should reflect the social and clinical context in which rural generalist medicine is practiced and the holistic, community-based, continuity of care medical paradigm it embodies.

Many of the items listed in the QRGP Prevocational logbook are suitable for an EPA and can serve as a valuable learning opportunity. EPAs which are not suggested in the logbook are encouraged to be undertaken. While undertaking EPAs of logook items are not a QRGP requirement, the list does provide trainees valuable guidance of the types of everyday clinical tasks that are important for vocational training and can assist to meet NFPMT EPA requirements.

We recommend undertaking 2 anaesthetic, 2 obstetrics and gynaecology (O&G), and 2 paediatric EPAs during prevocational training. These EPAs do not necessarily need to be undertaken during dedicated anaesthetic, O&G or paediatric terms. They can be undertaken in any clinical placement providing the appropriate opportunity and supervision.

The Prevocational logbook is available via rural_generalist@health.qld.gov.au

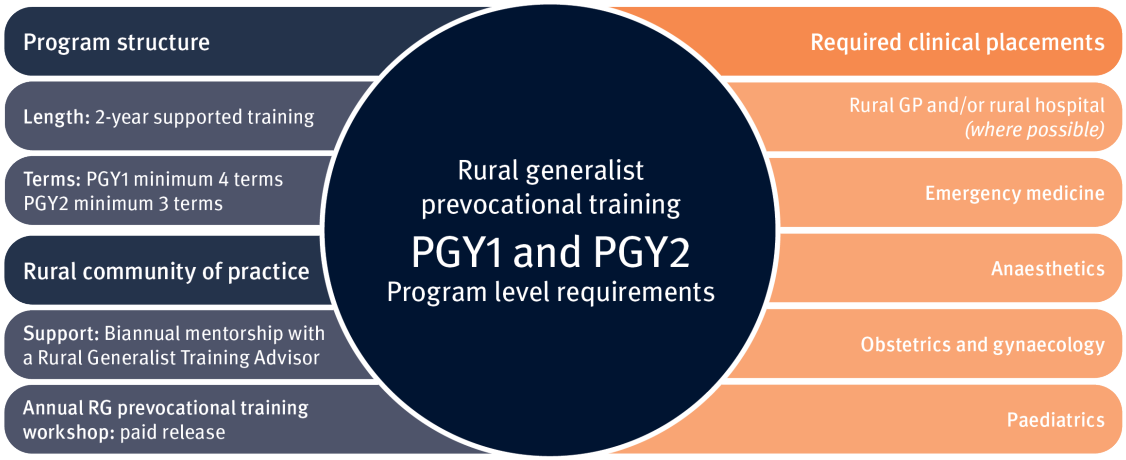
Our prevocational training program

The QRGP prevocational training program is designed to operate within the NPFMT.

The increased flexibility of the NFPMT offers more potential to provide the broad clinical experience necessary for Rural Generalist prevocational training, but a proactive approach is needed to realise this potential.

While the NFPMT provides a solid structure for the achievement of QRGP training objectives, specific clinical placements are required to ensure prevocational doctors obtain the breadth of clinical experience they need to fulfil fellowship training requirements.

Our program provides experience in all domains of Rural Generalist clinical practice to ensure trainees are adequately prepared to commence vocational training.



Queensland's rural community of medical practice

Rural generalism requires different knowledge, expertise, and skill, but more subtly, a different way of knowing, thinking, and practicing clinical medicine[7].

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[8 - 13].

We have purposefully created learning experiences in which trainees meet with their peers for training provided by Rural Generalists and become increasingly involved in, and part of, Queensland's rural community of medical practice.

Rural community of practice

RG prevocational doctors need to experience and become increasingly involved with the rural community of medical practice. Learning activities include:

- rural GP or rural hospital clinical placements
- mentoring by rural clinicians (Rural Generalist Training Advisors)
- annual QRGP prevocational training workshop facilitated by RG educators
- preparatory AST workshop facilitated by RG educators
- increasing involvement with the Queensland RG community of practice
- encourage attendance at annual Rural Doctors Association of Queensland conference
- early engagement with Rural Generalist training colleges (ACRRM and RACGP).

Rural clinical placements

When available, rural clinical placements are highly desirable training opportunities for trainees.

The QRGP, in collaboration with the Queensland Rural Medical Service, is committed to working with our training hospitals to make rural primary care or hospital placement opportunities available to all QRGP prevocational trainees at some stage in their two-year program by 2025.

Primary care placements are a highly desirable component of a Rural Generalist training program (any placement MMM 2 or above is acceptable[§]). The John Flynn Prevocational Doctor Program (JFPDP) is a strategic opportunity for QRGP training hospitals to implement primary care clinical placements in their Rural Generalist program. These placements offer authentic community-based training in ambulatory care, undifferentiated care, chronic care and continuity of care, significantly expanding the breadth of experience available within a rural generalist training hospital prevocational program.

Rural and primary care placements may be provided in either PGY1 or PGY2 in keeping with the availability of quality well supervised rural placements.

Three types of rural clinical experiences can be provided by QRGP prevocational training hospitals:

- primary care/John Flynn Prevocational Doctor Program (MMM 2 and above)
- rural hospital (e.g. Rural hospital, Rural ED, PIERCE, jDocs)
- blended community-based care/rural hospital.

§ Monash Modified Model (MMM) defines whether a location is a city, regional, rural or remote site. See link for more detail: https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

Primary care (MMM 2 or above)

RG prevocational doctors should gain experience of living and working in a rural community, and:

- consolidate commitment to a career in rural general practice/rural generalism
- develop skills in the provision of whole-of-person care in a community context, including the assessment, investigation, and management of undifferentiated patients of all ages and genders presenting with acute or chronic medical conditions
- develop the experience, judgement and confidence required to provide medical care in a rural context with limited access to health care resources.

Rural general practice experience is highly desirable if available.
This placement would be suitable for an undifferentiated or chronic care experience.

Rural hospital care

RG prevocational doctors should gain experience of living and working in a rural community, and:

- consolidate commitment to a career in rural general practice/rural generalism
- develop skills in the provision of hospital care in a rural context
- develop the experience, judgement and confidence required to provide medical care in a rural context with limited access to health care resources
- understand how systemic issues and social context affect health, wellbeing, and the delivery of healthcare in a rural context.

Rural hospital experience is highly desirable if available.
This placement would be suitable for an acute care experience.

Prevocational Integrated Extended Rural Clinical Experience (PIERCE)

RG prevocational doctors should gain experience of living and working in a rural community, while gaining anaesthetic, O&G and paediatric experience in a rural context, and:

- consolidate commitment to a career in rural general practice/rural generalism
- develop skills in the provision of hospital care in a rural context
- understand how systemic issues and social context affect health, wellbeing, and the delivery of healthcare in rural communities
- experience a broad inpatient caseload in a rural context
- have an authentic role as a member of staff of a rural hospital
- gain first-hand experience and clinical skills as required by the ACRRM Core curriculum in anaesthetics, obstetrics and paediatrics.

Rural hospital experience is highly desirable if available.
This placement would be suitable for acute and perioperative care experience.
PIERCE is a 15-week placement.

Note: Rural emergency medicine (outlined below) and PIERCE placements have been successfully combined in one RG prevocational training hospital, creating a blended 6-month rural placement in which the authentic hands-on rural clinical experience, broad case load and continuity of care and continuity of supervision is greatly appreciated by RG prevocational trainees.

Blended primary care and hospital-based care

RG prevocational doctors should gain experience of living and working in a rural community, and:

- consolidate commitment to a career in rural general practice/rural generalism
- develop skills in the provision of whole-of-person care in a community context, including the assessment, investigation, and management of undifferentiated patients of all ages and genders presenting with acute or chronic conditions
- develop the experience, judgement and confidence required to provide medical care in a rural context with limited access to health care resources
- understand how systemic issues and social context affect health, wellbeing, and the delivery of healthcare in rural communities
- experience a broad ambulatory caseload in a rural context
- develop skills in the provision of hospital care in a rural context.

Emergency medicine

Rural Generalist trainees require well developed emergency medicine skills.

Emergency medical care

RG prevocational doctors require sufficient experience in emergency medicine to:

- assess, prioritise, stabilise, investigate, and provide initial treatment to undifferentiated emergency presentations in rural hospital and community settings
- recognise the need to urgently consult with supervisors, senior staff, and external specialist services, and when indicated, expediate retrieval to definitive care
- perform emergency procedures as detailed in the QRGP Prevocational training logbook
- perform basic life support, commence resuscitation of a patient following the ABC algorithm, undertake a primary survey, and contribute to a resuscitation or trauma team
- assess, and manage acutely disturbed mental health patients.

A minimum 10-week experience in emergency medical care is required, 20 weeks is highly desirable. This placement would be suitable as an undifferentiated or acute clinical care experience.

Rural emergency medical care

RG prevocational doctors should gain experience of living and working in a rural community, while gaining experience in emergency medicine, and:

- consolidate commitment to a career in rural general practice/rural generalism
- develop skills in the provision of hospital care in a rural context
- understand how systemic issues and social context affect health, wellbeing, and the delivery of healthcare in rural communities
- experience a broad ambulatory caseload in a rural context
- have an authentic role as a member of staff of a rural hospital.

At the end of the placement the trainee should be able to:

- assess, prioritise, stabilise, investigate, and provide initial treatment to undifferentiated emergency presentations in hospital and community settings
- recognise the need to urgently consult with supervisors, senior staff, and external specialist services, and when indicated, expedite retrieval to definitive care
- perform emergency procedures as detailed in the QRGP Prevocational training logbook
- perform basic life support, commence resuscitation of a patient following the ABC algorithm, undertake a primary survey, and contribute to a resuscitation or trauma team
- assess and manage acutely disturbed mental health patients.

Rural emergency medicine experience is highly desirable if available.
This placement would be suitable for an undifferentiated and/or acute care experience.

Prevocational generalist experience

ACRRM Fellowship training requires 10-weeks of clinical experience in anaesthetics, O&G, and paediatrics (5 weeks is acceptable provided trainees undertake supplementary learning activities). RACGP Fellowship training requires a 10-week clinical experience in paediatrics.

Ten-week placements are highly recommended. While both colleges provide alternate options for trainees to acquire the prerequisite skills and capabilities expected, trainees, supervisors and training hospitals should be aware that colleges expect trainees to achieve the level of competency and capability that would be achieved during a 10-week placement regardless of the length of the placement. Trainees undertaking short 5-week placements must provide evidence that they have achieved the skills and capabilities expected. Typically:

- a log of 50-cases to document that sufficient clinical experience has been obtained
- attendance at an appropriate course, many of which have extended waiting times.

A proactive approach is required by trainees, supervisors, and the training hospital to ensure trainees acquire the clinical experience necessary to achieve college training requirements.

Anaesthetic care

RG prevocational doctors require experience in assessing and managing an airway and caring for patients undergoing an anaesthetic procedure. Learning activities include:

- preoperative assessment of patients
- prescribing analgesia
- the administration of induction, anaesthetic, sedative, local anaesthetic agents, and regional blocks
- the use and interpretation of monitoring systems
- positioning an airway and providing basic airway support, and insertion of an LMA
- bag and mask ventilation
- the provision of postoperative care.

10-week placements are highly desirable, 5-week placements are acceptable.
This placement would be suitable for perioperative care experience.

Obstetric and gynaecological care

RG prevocational doctors require experience in assessing and caring for women presenting for obstetric, gynaecological, and women's health issues. Learning activities include:

- the assessment and management of a woman presenting with gynaecological or obstetric problems
- provision of contraceptive advice
- diagnosis of pregnancy and urinary pregnancy testing
- antenatal and postnatal care
- the assessment and management of a woman presenting in labour
- palpation of a pregnant abdomen, including foetal heart detection
- vaginal and speculum examination, endocervical swab and pap smear
- breast examination.

10-week placements are highly desirable, 5-week placements are acceptable.
This placement would be suitable for perioperative care experience.

Paediatric care

RG prevocational doctors require experience in assessing and caring for children and adolescents presenting with acute, chronic or development issues. Learning activities include:

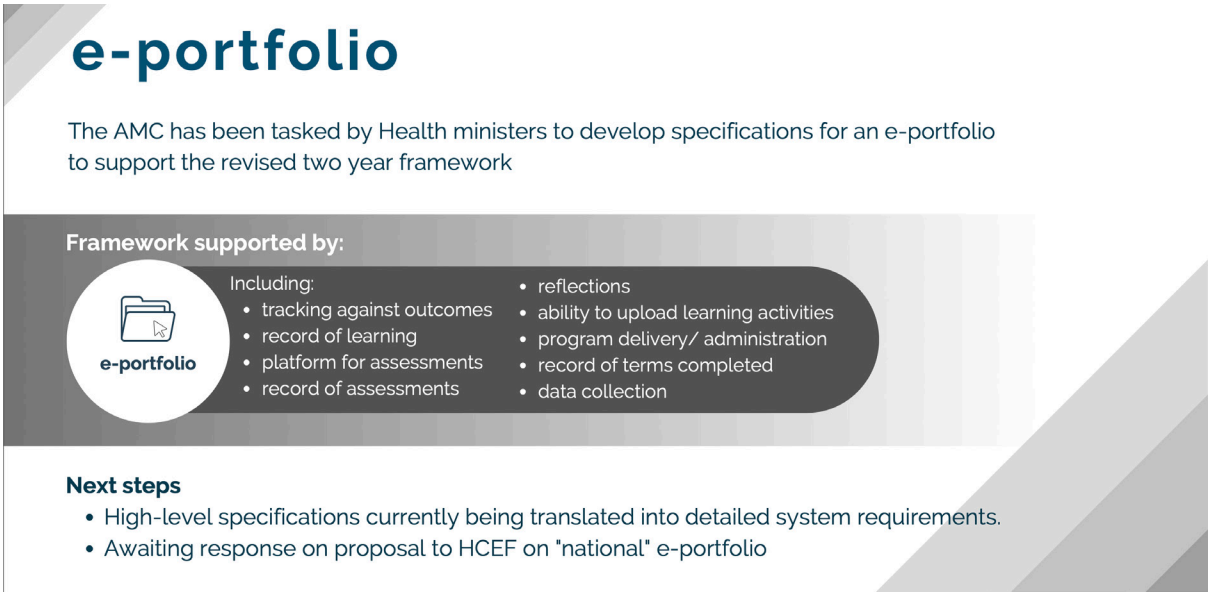
- seeing paediatric patients as the first point of contact
- exposure to paediatric emergency department attendances
- assessment and management of a child presenting with medical, surgical, developmental, or social issues
- opportunities to learn to recognise, diagnose and manage a seriously ill child
- opportunities to follow up paediatric patients, where practical, during admission and after discharge
- developmental assessment
- exposure to a broad spectrum of acute paediatric presentations
- childhood immunisation
- neonatal and paediatric resuscitation.

10-week placements are highly desirable, 5-week placements are acceptable
Depending on the scope of practice this placement may be suitable for an undifferentiated, acute, or chronic care placement.

E-portfolio

The e-portfolio will be implemented in early 2026 and will provide a national, standardised electronic record of clinical placements, supervisor assessments, EPAs, case logs**, QRGP Prevocational logbook, skills acquired, courses attended, and other educational experiences obtained.

All QRGP prevocational trainees will be required to maintain their e-portfolio. It provides an important record of prevocational training that will not only be formally reviewed by the QRGP to certify completion of QRGP prevocational training, but also, most likely, by the respective colleges at the time of formal fellowship application and ratification. This e-portfolio will be especially important for trainees who did not complete standard 10-week clinical placements in anaesthetics, O&G and paediatrics as college training advisors and censors will formally review a trainee's e-portfolio to ensure that all fellowship requirements have been met.



Prevocational logbook

The prevocational logbook is a required component of our prevocational training program. It assists trainees and their supervisors to focus on experiencing and acquiring the skills expected of junior medical officers working in rural settings.

Attainment of 80% of the procedures is required by the end of prevocational training. The logbook items also suitable for EPAs are indicated. While this is not a requirement, trainees seeking out a supervisor to sign off these logbook items, should consider asking their supervisor to undertake an EPA at the same time as this would substantially enhance the learning obtained from this episode of care.

Some logbook items are Class C activities. College standards require that they must be undertaken on real patient under direct clinical supervision. In this scenario, it would be a wasted opportunity if the case was not discussed with the supervisor and feedback provided (i.e. an EPA undertaken).

** e.g. anaesthetic, O&G and paediatric case logs for trainees undertaking 5 week clinical placements

Minimum standard required – procedure class
A: Practitioner operating independently - performed on a real patient.
B: Performed to a pass standard in a certified course in a simulated environment
C: Practitioner under supervision - performed on a real patient.
D: Practitioner assisting an independent practitioner - performed on a real patient.

Adult internal medicine

Procedure	Suitable for EPA	Minimum standard required
Non-rebreather mask		A
Spirometry & Peak Flow Measurement		A
Nebulisation therapy		A
Arterial blood sampling		A
Glasgow Coma Scale		A
Urethral catheterisation on male		A
Initiate insulin therapy	3	A
Facilitate a family meeting for discharge planning	4	A
Conduct a patient focused medication review prior to discharge	3	A

Anaesthetics

Procedure	Suitable for EPA	Minimum standard required
IV access		A
Blood transfusion		A
Oxygen saturation monitoring		A
Digital nerve block		A
Conduct pain management review for chronic pain patient	3	A
Oropharyngeal airway		B
Nasopharyngeal airway		B
Laryngeal mask		B
Endotracheal intubation		B
Bag/mask ventilation		B
External cardiac massage		B
Defibrillation		B
Synchronised DC cardioversion		B
Adult sedation		B
Rapid sequence induction	2/3	C

Child and adolescent

Procedure	Suitable for EPA	Minimum standard required
Use of respiratory med delivery devices	3	A
Use of spacer devices	3	A
Nebulisation therapy	3	A
Local anaesthesia		A
Repair of superficial skin laceration	3	A
Venous blood sampling		A
Conduct a developmental assessment	1	A
Write an asthma management plan	3	A
HEADSS assessment		A
Endotracheal intubation		B
Intravenous access		B

Mental health

Procedure	Suitable for EPA	Minimum standard required
Suicide risk assessment and safety planning	1/4	A
Mini-mental state examination	1	A
Psychiatric mental state examination and formulation	1	A
Assess a patient experiencing a mental health emergency	1/2	A

Musculoskeletal medicine

Procedure	Suitable for EPA	Minimum standard required
Soft tissue injury strapping		A
Fracture splinting		A
Fracture plaster cast	3	A
Reduction of fracture	3	C

Obstetrics and women's health

Procedure	Suitable for EPA	Minimum standard required
Urethral catheterisation in female		A
Perform urine pregnancy test *and manage the finding*	1	A
Perform foetal heart sound detection		A
Fundal height assessment		A
Conduct ante-natal visit	1/2	A
Conduct post-natal visit	1	A

Conduct well baby check	1	A
Manage post natal mental health issues	1	A
Manage shoulder dystocia		B
Manage normal delivery	1/3/4	B

Opthamology

Procedure	Suitable for EPA	Minimum standard required
Visual acuity & field assessment		A
Use ophthalmoscope		A
Topical anaesthesia of cornea		A
Staining of cornea with Fluorescein		A
Removal of corneal foreign body		A

Palliative care

Procedure	Suitable for EPA	Minimum standard required
Nasogastric tube insertion		A
Complete advanced care plan	1	A

Surgery

Procedure	Suitable for EPA	Minimum standard required
Incision & drainage of abscess		A
Repair of skin laceration including LA administration & wound debridement		A
Management of epistaxis (including anterior nasal cautery)		A
Wound dressing		A
Drainage of subungual haematoma		A
Ear toilet		A
Management of a chronic wound	3	A

Supervision during clinical placements including rural placements

It is imperative that all doctors involved in the supervision of prevocational doctors are clear about their responsibilities. Prevocational doctors must be supervised at a level appropriate to their experience and responsibilities. Doctors working in rural hospitals and primary care who are used to supervising more senior trainees, need to be particularly aware that prevocational doctors require closer supervision, especially for interns.

There may be more than one supervisor, each with different responsibilities, as outlined earlier:

- **Term supervisor**
  The person responsible for term orientation and assessment, who may also provide primary clinical supervision for some or all of the term.
- **Primary clinical supervisor**
  A consultant or senior medical practitioner with experience managing patients in the term's discipline. The person in this role may change during the term and could also be the term supervisor.
- **Day-to-day clinical supervisor**
  An additional supervisor who has direct responsibility for patient care, provides informal feedback and contributes information to assessments. The person in this role should remain relatively constant during the term and should be at least PGY3 level, such as a registrar.

Personal, social, educational and professional issues impacting on training

Our prevocational training program and the NFPMT share a strong emphasis on assisting prevocational trainees who are experiencing difficulties that impact on their clinical performance or career progression.

Multiple factors can impact performance, including individual skills, wellbeing and the work environment. Longitudinal program and performance issues will be managed by the prevocational doctor, DCT and term supervisor(s).

We respect the privacy of our trainees and understands that they may not wish to notify all workplace performance issues to the QRGP. However, our highly experienced, independent training advisors welcome contact from trainees should they wish to seek advice about how any personal, social and professional issues might impact on their career progression or wellbeing.

Certifying completion of QRGP prevocational training

Certifying completion of internship (PGY1) and prevocational training (PGY2) is a function of the training hospital Assessment Review Panel. We are not involved in this process.

However, we do have specific requirements for rural generalist prevocational training (clinical placements, workshop attendance and prevocational logbook). We will issue a *Certificate of Satisfactory Completion of Rural Generalist Prevocational Training* after review of a trainee's e-portfolio (via manual collation of evidence in the interim).

National Accreditation Standards for prevocational training programs

As noted earlier, under the NFPMT, training hospital prevocational programs and the individual terms within those programs must be accredited. Intern training programs and clinical placements already require accreditation. While PGY2 training programs have not required accreditation or a formal training program in Queensland up until now, from 2025 onwards PGY2 clinical programs and all clinical placements, including rural and general practice placements, must be accredited and compliant with the AMC National Standards for Prevocational Medical Training[6].

All clinical placements are subject to the same requirements of evaluation, reporting and quality improvement, regardless of location or type. Rural hospital, community-based and GP clinical placements are no exception and like any other clinical placement are subject to PMAQ's comprehensive accreditation process. Please see PMAQ's Policy and Accreditation standards for more information on these processes[††].

Research of both undergraduate and postgraduate rural and primary care rotations emphasise the provision of adequate support for trainees is critical to ensure the long-term success of these rotations[8 - 13]. Unless trainees feel adequately supported and not socially, educationally or professionally disadvantaged by a placement they may not fully engage and may share their discontent with their colleagues, undermining the reputation of the placement. Accordingly, accreditation standards require training providers to ensure adequate supports are in place, or can be provided, either locally or by their 'home' program.

Prevocational doctors rotating to a clinical placement outside of their 'home' HHS are still considered an employee of that HHS. All industrial protections remain in place according to the 'home' hospital's employment contract. When rotations with rural and community-based sites are being negotiated and designed, training providers must ensure that appropriate agreements are in place that specify how the quality of the clinical placement will be measured and maintained, who will take responsibility for each aspect of quality assurance and improvement programs and how those will be enforced and settled.
There are currently several GP terms accredited for PGY1s throughout Queensland. Training providers are encouraged to contact each other to share how best to set up these placements.

Implementation

PGY1 components of our prevocational training program were implemented in 2024 alongside the NFPMT. However, the e-portfolio will not be widely available until early 2026.

PGY2 components of the QRGP program will also be implemented in 2025 alongside the NFPMT.

The implementation of a rural placement of some type is highly desirable for QRGP prevocational trainees if training hospitals have suitable placements available within their programs. The QRGP, in collaboration with Queensland Rural Medical Service, is committed to working with our training hospitals to make rural primary care or hospital placement opportunities available to all QRGP prevocational trainees by 2025 at some stage in their 2-year program.

Primary care placements are a highly desirable component of a Rural Generalist training program (any placement MMM2 or above is acceptable[‡‡]). The John Flynn Prevocational Doctor Program is a strategic opportunity for QRGP training hospitals to implement primary care clinical placements in their Rural Generalist program. Hospitals interested in learning more should contact the team via JFPDP@health.qld.gov.au.

[††] https://pmaq.health.qld.gov.au/resources/policies-procedures/
[‡‡] Monash Modified Model (MMM) defines whether a location is a city, regional, rural or remote site. See link for more detail: https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

Supporting documents

- Training outcome statements
  - Rural placement
  - Emergency medicine
  - Anaesthetics
  - Obstetric and gynaecology
  - Paediatric
- Placement allocation guidelines for hospitals

References

1. Office of the National Rural Health Commissioner, "*National Rural Generalist Taskforce Advice to the National Rural Health commissioner on the Development of the National Rural Generalist Pathway*", Australian Government, Canberra, December 2018, https://ruralgeneralist.qld.gov.au/wp-content/uploads/2022/02/National-Rural-Generalist-Taskforce-Advice-to-the-National-Rural-Health-Commissioner-on-the-Development-of-the-National-Rural-Ge.pdf, **accessed 23rd of March 2023**
2. Queensland Rural Generalist Pathway, "*Roma Agreement*", Queensland Health, Brisbane, 2005, http://ruralgeneralist.qld.gov.au/wp-content/uploads/2017/07/roma_agree_4dec12.pdf, accessed 23rd of March 2023
3. 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
4. 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
5. Australian Medical Council, *National Framework for Prevocational (PGY1 and PGY2 Medical Training, Assessment and Training - Training and assessment requirement for Prevocational (PGY1 and PGY2) training programs*, Australian Medical Council Limited, Melbourne, 2022. https://www.amc.org.au/wp-content/uploads/2022/07/Training-and-assessment---Training-and-assessment-requirements-for-prevocational-PGY1-and-PGY2-training-programs.pdf, accessed,6th August 2023.
6. Australian Medical Council, *National Framework for Prevocational (PGY1 and PGY2 Medical Training, Training environment – National Standards and requirements for prevocational (PGY1 and PGY2) training programs and terms*, Australian Medical Council Limited, Melbourne, 2022. https://www.amc.org.au/wp-content/uploads/2022/12/Training-environment---National-standards-and-requirements-for-prevocational-PGY1-and-PGY2-training-programs-and-terms.pdf, accessed, 22nd March 2023.
7. Lynch JM, Thomas HR, Askew DA, Sturman N, "Holding the complex whole: Generalist philosophy, priorities and practice that facilitates whole-person care, *Australian Journal of General Practice*, 52:7, July 2023, p428
8. McGrail MR, Chhabra J, Hays R, Evaluation of General Practice Experience for Prevocational Medical Graduates, *Rural and Remote Health*, 2023:7409
9. Nichols A, Worley P, Toms LM, Johnson-Smith T, Change of place, change of pace, change of status, Rural Community Training for Junior Doctors, does it influence choices of training and career, Rural and remote Health, 2004:259
10. Best JB, Boyer SL, De Lacy CJ, Phillips JS, Welch TM, McCol GJ, Murray to the Mountains Intern Training program: involvement of small health services, MJA, 2014, 200(7):378-380

11. 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
12. 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
13. Worley P, Prideaux D, Strasser R, Magarey A, March R, Empirical evidence for symbiotic medical education: a comparative analysis of community and tertiary-based programs, *Medical Education*, 2006, 40: p109-116.