PLEASE NOTE THAT SHORT VIDEOS OF THE PROCESS OF rECTVs AND OF HOW TO USE ZOOM ARE AVAILABLE ON MEL AND THE MCCC HOME PAGE (LINKS AT END).

1. What is an rECTV?

An ECTV (External Clinical Teaching Visit) is a learning opportunity where the registrar receives direct feedback on their consultation skills. During the current COVID-19 pandemic, face to face visits have been suspended. However, to ensure continuity of training, observation and feedback, MCCC is introducing remote ECTVs. A Medical Educator or appropriately trained external supervisor (ECT visitor) will remotely observe a series of up to five (5) consultations during the visit which are live streamed on Zoom.

The purpose of the visit is to assess whether the GP registrar's (GPR) knowledge, and clinical skills and attitudes are appropriate for their level of training. The limitation of making firm conclusions as to GPR expected competency based on up to five observed consultations is acknowledged. ECTVs also provide registrars, supervisors and ECT Visitors with an opportunity to discuss practice related issues.

Standard 2.1 of RACGP standards for General Practice training state that ECTVs are:

Direct or videotaped observation of registrar consultations with verbal and written feedback to the registrar delivered by clinical teachers who are not the supervisor of the registrar.

RACGP acknowledges that these are unusual circumstances (see below) and the rECTV fits within their acceptable alternatives. Please note that if the visit ONLY consists of random case analysis then it does not meet the standards of an acceptable alternative unless the registrar has previously demonstrated at or above consultation skills.

3. Remote external clinical teaching visits

Intent of the standards:

Registrar performance in the workplace is evaluated for assessment and educational purposes

Guidelines

There is substantial educational value in observation of the registrar working with patients followed by an immediate and interactive feedback exchange between the registrar and the educator.

Examples of acceptable alternatives:

- ***Remote real-time observation by the educator of the registrar consulting with patients using a web-based video platform such as Zoom, Skype or Facetime. These real-time observations would not be recorded.***
- *Joint observation of pre-recorded registrar consultations either with patients or with simulated patients. Pre-recorded patient consultations would need to be done in a way that complied with patient privacy and record requirements.*

- *Simulated consultations role-played by the educator.*
- ***Case analysis, discussion and feedback for registrars who have previously demonstrated expected or above expected consultation skills.***

2. Allocation of an ECT Visitor

Each semester, an ECTV roster is developed by each regional MCCC team. While pandemic restrictions are in place all ECTVs will be undertaken as rECTVs.

The REAPS (Registrar Education and Practice Support Coordinator) and RHE (Regional Head of Education) will determine appropriate Medical Educators or experienced GP supervisors to undertake the visits.

Relevant Medical Educators and Supervisors (via their practice managers) will be advised via email of the registrars they have been allocated to observe, the level of the registrar and the practice details where the registrar will be working.

If the ME or visiting supervisor believes they will be unable to complete a particular allocated registrar rECTV, they should advise MCCC as soon as possible, so that it can be re allocated.

3. When are ECTVs Required?

As far as possible, the following timelines need to be adhered to.

Each GPT/PRRT1 registrar requires an ECTV prior to the end of week 6 of the semester. A subsequent ECTV is then undertaken later during the semester (approximately week 20 / must be completed by week 22).

Each GPT/PRRT2 registrar requires an ECTV prior to the end of week 8 of the semester. A subsequent ECTV is then undertaken later during the semester (approximately week 20 / must be completed by week 22).

Each GPT/PRRT3 registrar requires 1 ECTV during the semester.

Additional rECTVs may be undertaken as a teaching or assessment tool. MCCC will communicate with the practice as required to arrange these. These are called Diagnostic rECTVs. Where possible an external supervisor or medical educator will be allocated to undertake these visits.

4. Establishing the date

Where a ME (Medical Educator) has been allocated to the registrar, the ME will contact the registrar's practice manager directly to liaise regarding an appropriate date and time for the remote visit.

Where a GP Supervisor has been allocated, their practice manager will contact the registrar's practice manager to liaise regarding an appropriate date and time for the remote visit.

The visit should take place on a day when the GP registrar and their supervisor are both consulting in the clinic.

It is vital that the rECT visitor liaises with the GPR re the live streaming platform. Zoom should be used as it is the optimal streaming platform in terms of ease of use, encryption and confidentiality. The invitation to the meeting should be sent by the ME to the registrar via the MCCC Zoom account using the latest version 5.

The registrar should discuss with their PM re internet availability/access.

It may also be necessary for the practice/registrar to have a phone tripod (provided by MCCC if necessary).

The registrar must ensure that the position of the phone/iPad allows the observing ME to view the registrar and the patient.

See Appendix 1 for more details of how to access Zoom.

Once the date is confirmed, the ME or PM of the visiting supervisor MUST advise MCCC of the date via email. MCCC will confirm the date by email (including the registrar) and set up SWAN for completion of the report as required. MCCC will also ensure that the PM has access to rECTV consent forms.

On receipt of the date of the rECTV, the training support officer (TSO) will ensure that the visiting educator has the appropriate professional Zoom MCCC licence.

The rECT visitor and registrar **must** have contact via Zoom PRIOR to the visit to ensure that both can access and utilise the platform and that audio quality is sufficient for the purpose of the visit. If there are any concerns as a result of this trial, the ME should contact the regional training support officer (TSO).

It is strongly advised that the rECT visitor contact the practice 24 hours prior to a scheduled rECTV to confirm the practices is aware of the visit, to check appropriate bookings, ensure that the registrar has access to a phone tripod and to ensure that there are appropriate patient numbers.

The registrar should email their learning plan to the rECT visitor (if not available via SWAN) a week prior to the visit.

Changes or absences

If the allocated ME or visiting supervisor is unable to complete a scheduled rECTV, the registrar's practice manager should be advised as soon as possible and the date rescheduled. MCCC should be advised of the amended date.

5. Format of visit

The ECTV should take around 3.5 hours. **The registrar's practice manager is responsible for booking the ECTV in the patient appointment diary.** The format will vary based on the registrar level.

Both ECT visitor and registrar should ensure that their device is fully charged or plugged in for the duration of the remote visit.

Prior to the visit, the registrar should choose a position for their phone (on a tripod preferably) that allows a view of both the registrar and the patient.

Telehealth consultations are to be done via speaker phone or, if via video, in a format that can be seen and heard by the rECT visitor.

MCCC may amend and vary this policy and/or procedure from time to time.

Initial Assessment (first GPT/PRRT1 ECTV)

- 30 minutes before the first consultation. This is time for discussion with the GP registrar about their term so far, a review of their learning plan and to answer questions about training.
- At least 4 patients booked for 30-45- minute appointments (note: this is generally ½ hour with patient followed by some discussion time)
- For the purpose of the rECTV, it is recommended that no more than one of the consultations is via telehealth. ***NOTE:*** *this will depend on current COVID restrictions, location of practice and vulnerability of registrar. In some circumstances, observation of mostly telehealth or all telehealth will be necessary.*
- 30 minutes at the end with the registrar's GP Supervisor and the GP registrar to talk through any issues.

Further Assessment (first GPT/PRRT2 ECTV)

- 30 minutes before the first consultation. This is time for discussion with the GP Registrar about their term so far, a review of their learning plan and to answer questions about training.
- 5 patients booked for 30 -minute appointments (note: this is generally 20 minutes with patient followed by some discussion time)
- For the purpose of the rECTV, it is recommended that no more than one consultation is via telehealth. ***NOTE:*** *this will depend on current COVID restrictions, location of practice and vulnerability of registrar. In some circumstances, observation of mostly telehealth or all telehealth will be necessary.*
- 30 minutes at the end with the registrar's GP Supervisor and the GP registrar to talk through any issues.

All other routine ECTVs

- 30 minutes before the first consultation. This is time for discussion with the GP Registrar about their term so far, a review of their learning plan and to answer questions about training.
- Five (5) patients booked at half hour appointments (note: this is generally 20 minutes with patient followed by some discussion time)
- For the purpose of the rECTV, it is recommended that no more than two of the consultations are via telehealth. ***NOTE:*** *this will depend on current COVID restrictions, location of practice and vulnerability of registrar. In some circumstances, observation of mostly telehealth or all telehealth will be necessary.*
- 30 minutes at the end with the registrar's GP Supervisor and the GP Registrar to talk through any issues.

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Diagnostic ECTVs

Will be planned and allocated as required. You will be provided with information on the format at the time.

6. Consent, Privacy and Signage

In order to comply with legislative privacy policies, MCCC requires training facilities to have the following in their facility's privacy statement: 'medical records may be accessed by visiting medical educators and/or general practice supervisors from another practice for the purpose of registrar training'. This forms part of the annual practice agreement with MCCC GP Training. It is also suggested that the training facility display the prepared poster. (GP Training Accreditation/Medical Records Access poster – available on the MCCC website).

Since the consultation is live streamed, there is no recording of the consultation and so no issue of data storage.

Consent is required for each patient. The practice manager will arrange for reception staff to gain written consent for each patient being seen by the registrar during the rECTV. If a patient is booked for a telehealth consultation, staff should record verbal consent at booking having read out the consent form to them. An alternative is for the rECTV consent form to be emailed out to the patient who then emails back a signed form which is placed in the patient file.

The patient should have verbal consent confirmed at the start of the consultation (whether it is face -to - face or via telehealth) and be introduced to the rECT visitor.

7. The Visit

Initial meeting

Both rECT visitor and registrar should ensure that devices are fully charged and/or plugged in.

The rECT visitor should ensure that they are in a quiet place where they will not be interrupted for the duration of the visit and that the discussion and consultations cannot be overheard to ensure patient confidentiality.

The ME logs in to their MCCC professional Zoom account and send an invitation to the registrar.

During the first 30 minutes allocated, the visitor will discuss with the registrar the format and purpose of the visit and what the GPR hopes to achieve through the process. Visitors should also discuss the educational progress of the registrar to date, well-being and any concerns which require follow up. The rECT visitor should have already reviewed the registrar learning plan either on SWAN or via email from the registrar and this should be discussed.

The GPR should be advised that the rECT visitor is an observer and cannot participate in the consultation. Any issues which arise during a consultation and on which the GPR needs advice should be referred to the supervisor in the usual way.

The rECT visitor should also discuss the following –

- Current practice placement eg. Patient profile and range of illnesses, workload and bookings, time management and uncertainty, distressing patient experiences
- Experience of training during the pandemic (mix of telehealth vs face to face) and well- being.
- Relationships with the supervisor/s and practice staff including ability to obtain assistance with clinical concerns in a timely manner
- In practice teaching – time, process, educational activities, resources for learning
- Review of learning planner
- Exam preparation and intentions

Awareness of patient modesty is important in the observer role and the rECT visitor needs to ensure that where physical examination is required, there is no intrusion on patient privacy. In general, the remote observer will not be observing physical examination.

Should a chaperone be required or requested, the GPR should follow usual practice procedure.

Providing feedback following consultations

Following the consultation, feedback is provided on the consultation observed. In discussion, many GPRs tend to focus on those aspects of the consultations that did not progress well and the rECT visitor needs to balance this account by mentioning the more positive features.

ECTVs should have the appropriate balance of support, challenge and vision.

General principles of giving feedback include:

1. Working from the learner's agenda rather than a set framework.
2. Offering feedback based on strengths, weaknesses and areas for improvement.
3. Referring to specific instances observed in the consultation rather than vague generalities and ensuring that feedback offered relate to skills, attitudes and beliefs which can be open to modification
4. Limiting the number of teaching points in a consultation, as the impact may be lost when multiple issues are discussed.
5. Leaving the learner in a positive frame of mind, with a clear understanding of any performance issues and a plan to address any deficiencies observed.

GPRs are encouraged to reflect on the consultation in terms of the RACGP's or ACCRM's domains of general practice.

It is appropriate for rECT visitors to appraise the consultation using the Domains of General Practice (see appendix 2 and 3) and the report is constructed according to this framework. Information on GPR

MCCC may amend and vary this policy and/or procedure from time to time.

performance pertaining to domains relating to professionalism and ethical practice may need to be obtained from sources other than the consultation, such as from discussion with the GPS.

To assist rECT visitors in this respect, a worksheet has been developed for use during the time of patient observation and is included (see Appendix 4).

Supervisor, registrar, rECT visitor meeting following observed consultations

Where learning needs have been highlighted, the GPR may directly involve the GPS in the ensuing discussion about how these might be addressed and agree on further progress. If not, the rECT visitor might offer some suggestions. Any agreed learning goals should then be documented in the report of the visit.

Finally, the GPR and GPS may wish to review other educational and training issues that have arisen during the term. An rECT visitor is also in a privileged position to observe how supervision occurs within the practice and to offer feedback as a peer, to all parties involved in the educational experience.

Where significant concerns arise, these should be discussed with the GPR and GPS at the time of the visit with a clear understanding of the agreed course of action which should be documented in the subsequent report.

8. Random Case Analysis (RCA)

While RCA can be invaluable in exploring clinical reasoning, this may be difficult to achieve via remote live streaming.

In the FA rECTV, RCA is no longer mandated- but may be utilised in any rECTV if patients cancel or there are low patient numbers and the remote ME can view the registrar's computer screen and appointment book. Please note that a rECTV that *only* consists of RCA is not an acceptable alternative to an ECTV unless the registrar has been deemed to be 'at' or 'above' in consultation skills on previous assessments.

Option 1

The registrar turns their device so that the remote ME can see the clinic desktop/appointment book/patients notes.

Option 2 (preferred but requires permission from the clinic)

The registrar opens the Zoom meeting on their clinic desktop in addition to the streaming device (this must be pre-approved by the clinic) and then screen shares the clinic desktop.

In Random Case Analysis (RCA), patient records are selected at random by the rECT visitor, who reviews the record and facilitates discussion with the GPR about any issues arising. The strengths of RCA are in the assessment of clinical knowledge and reasoning, and the adequacy of the medical record.

Assessment of expected competency continues to be made on direct observation of the registrar consulting rather than RCA where practicable. However formative feedback on cases discussed during RCA can form part of the rECTV report.

The advantages of RCA are that:

1. Clinical knowledge gaps are more readily identified.
2. It allows review of an increased number and diversity of clinical presentations compared to using direct observation alone in the ECTV. (Where the record chosen is a simple problem or repeat of a previous scenario then a new record can be selected)
3. It enables an assessment of the GPR's management of a patient over time
4. It can provide the rECT visitor with an appreciation of the case load of the GPR, (too few or too many patients, or an inadequate mix of patient types)

However, RCA is of limited utility if the GPR's notes are poor, or if the GPR does not recall his or her reasoning during the consultation.

To conduct RCA, the rECT visitor asks the GPR to open the appointment book to a session within the previous week (preferably in the previous 1-2 days) and selects records from that session. The rECT visitor and the GPR discuss what was known of the patient prior to the consultation and the GPR's recall of the how the consultation proceeded. The rECT visitor then uses a range of questions to explore the domains of general practice pertaining to the consultation and to assess clinical reasoning. The ECT visitor selects questions appropriate to the case, taking care to ensure that the process is conducted as a collegiate discussion.

Further reading regarding Random Case Analysis -

https://www.racgp.org.au/afp/2013/januaryfebruary/random-case-analysis/

https://www.racgp.org.au/afp/2016/december/adding-random-case-analysis-to-direct-observation-(arcado)-%E2%80%93-updating-the-external-clinical-teaching-visit-to-improve-general-practice-registrar-assessments/

9. Issues and concerns

Issues arising during consultations

If a patient is seriously at risk of inappropriate management by the GPR, the rECT visitor may need to tactfully intervene. The patient may be required to step out of the consulting room while the rECT visitor and GPR discuss the situation. If this arises in a telehealth consult, the registrar may be asked to phone /video call the patient back at an agreed time following discussion. This incident should come to the attention of the GPS immediately and again at the end of the session when formal feedback is to be given.

Issues within the practice

The RACGP Standards 2nd edition (3) state: "Clinical teachers who perform external clinical teaching visits are uniquely placed to gather and provide information about the quality of the supervision and training within the training post." (Criterion 1.1.2.3)

At times during rECTVs, rECT visitors may become aware of issues within the practice such as non-compliance with teaching requirements by the GPS or poor relationships between the GPS and GPR. The

rECT visitor may attempt to resolve these matters through discussion with the parties involved and agreed outcomes documented. Otherwise they should be promptly referred to the Regional Head of Education (RHE) or Accreditation lead medical educator.

GPS unavailability

At times the GPS is unavailable during the rECTV, either for scheduled reasons such as annual leave or unscheduled circumstances such as illness. It may be possible to have a telephone discussion or alternatively to meet with another GPS in the practice. Failing this, a later meeting needs to be promptly arranged either by telephone or a second practice visit. The GPR should participate in all discussions.

Follow-up of underperforming GPRs

During an rECTV, a range of GPR related issues of concern may arise or be observed such as:

1. Poor communication with patients including language deficiencies
2. Significant knowledge gaps.
3. Deficient clinical reasoning/processing skills.
4. Time management
5. Unprofessional behaviour
6. Dealing with demanding patient expectations
7. Personal or health issues that may be impacting on performance.

These concerns should be discussed with both the GPR and the GPS and a plan of action formulated and documented in the rECTV report. Early identification and appropriate action is important in assisting the GPR and GPS to address such concerns.

Where the rECT visitor holds serious concerns, these should also be discussed with the Regional Head of Education. All issues of concern should be referred promptly, even if just to obtain advice on the most appropriate course of action.

Issues relating to professional behaviour should also be referred to the RHE or DMET.

10. Completion of report

The rECT visitor should document the outcomes of the visit using the designated electronic ECTV report template currently available in SWAN for RACGP registrars and on the MiniCEX Scoring form for ACRRM registrars.

The primary purpose of the report is to assist the GPR to develop further learning goals. Its secondary purpose is to inform the GPS and rECT visitors about the professional development of the GPR. While rECT visitors may adopt a range of styles in writing reports, there must be clear documentation of competencies achieved, those lacking, areas for improvement and suggested actions to achieve learning goals. This is particularly important where the GPR may have displayed professional difficulties. Matters pertaining to the rECTV, which were not discussed at that time, should not be documented. The GPS, who has access

to the GPR portfolio, is subsequently able to view the written feedback. (Note – supervisors do not have access to the practice component (Registrar in Practice Experience information) of the ECTV report.)

The rECT visitor should invite the GPR to make a written response to the subsequent report about the process of the ECTV and the issues discussed.

It is advisable that rECT visitors complete the report within two weeks, when the issues discussed and addressed during the rECTV are still clear in their minds.

11. Invoice to MCCC for time

Visiting Supervisors complete the FNF 002 Supervisors Claim Form – ECTV and submits to MCCC for payment of their time. Casual MEs complete the MCCC Approved additional hours and reimbursements form.

In addition to the 3.5 hours of the visit, ½ hour report writing can also be claimed. ie. 4 hours total.

For diagnostic EVTCs, additional report writing time is provided to a maximum of 4.5 hours for the visit and report.

12. Training new ECT Visitors

It is not envisaged that rECTVs will be conducted by new MEs or supervisors.

Associated documents

TOF 022 rECTV Patient consent

Guidance Document and summary document– rECTV processes for Practice Managers

Summary Document rECTV processes for Medical Educators and Visiting Supervisors

Summary document rECTV for registrars

The ARCADO Manual

ACRRM MiniCEX Scoring Form

Zoom Use and Security policy

Zoom how to videos on MeL

Appendices

Appendix 1 – Platform options for live streaming

Appendix 2 – RACGP Domains of General Practice

Appendix 3 – ACRRM Domains of General Practice

Appendix 4 – Template for notes

References

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Royal Australian College of General Practitioners. (2015). *Standards for general practice training* (2nd ed.). East Melbourne: The Royal Australian College of General Practitioner https://www.acrrm.org.au/training-towards-fellowship/reporting-and-assessments

Further Reading

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3. Hays R. Teaching and Learning in Clinical Settings. Abingdon, UK: Radcliffe Publishing Ltd; 2006.
4. Hays RB. Practice-Based Teaching: A Guide for General Practitioners. 2nd ed. Melbourne: Eruditions Publishing; Cowes 2006.
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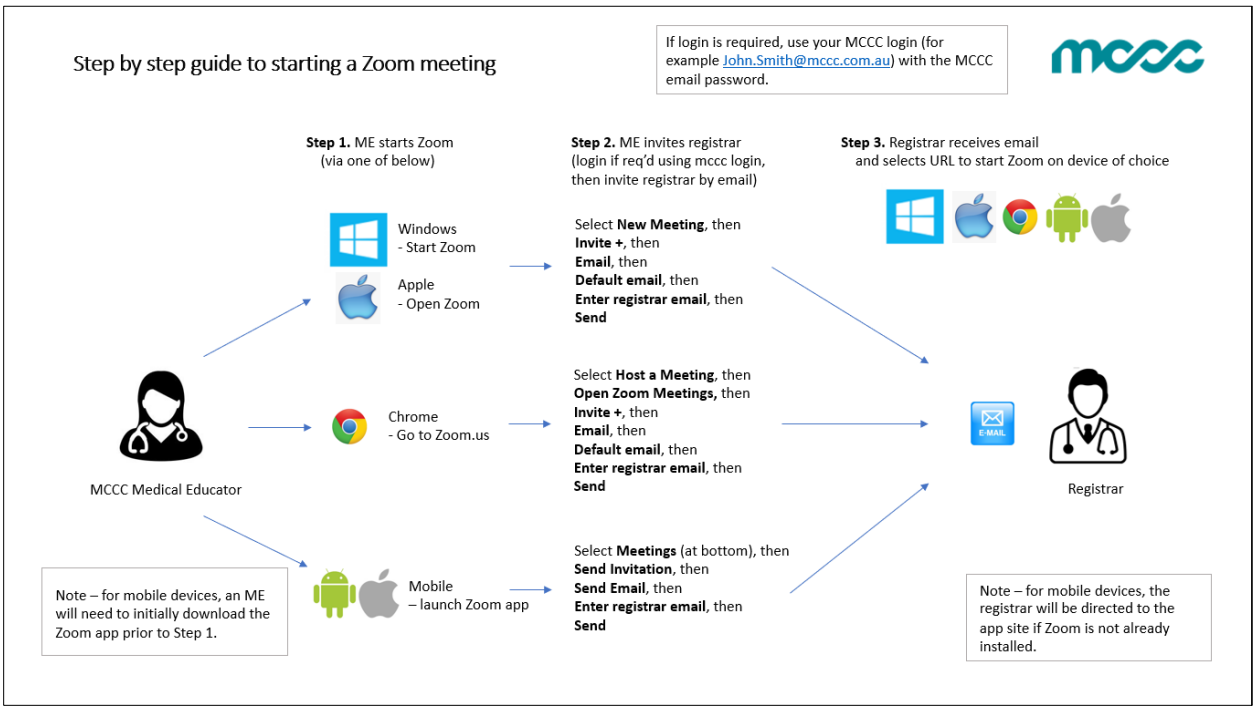
6. Kurtz SM, Silverman JD, Draper J (1998) Teaching and Learning Communication Skills in Medicine. Radcliffe Medical Press (Oxford)

7. Moorhead R, Maguire P, Thoo SL. Giving feedback to learners Aust Fam Physician. 2004;33(9):691-5.
8. Vickery A, Lake F. Teaching on the run tips 10: Giving feedback. Med J Aust. 2005; 183(5): 267-8.
9. van de Ridder JMM, Stokking KM, McGaghie WC, Ten Cate OTJ. What is feedback in clinical education? Med Educ. 2008;42(2):189-97

MCCC may amend and vary this policy and/or procedure from time to time.

Appendix 1 - Streaming platform



MEs and visiting supervisors must use the MCCC Zoom professional licence to send out the invitation for the trial, the visit and the livestreaming with the latest version of Zoom downloaded (version 5).

Appendix 2 - RACGP domains

RACGP Domains of General Practice

1. Communication Skills and the Patient Doctor Relationship
With respect to: information gathering
Is the GPR: – Sensitive to the patient's cues? – Able to elicit the patient's issues / problems / concerns / expectations (including issues of confidentiality?) – Using a bio-psycho-social-approach?
With respect to: information giving
Does the GPR – Check the patient's knowledge and understanding? – Give relevant and appropriate amount of information tailored to patient's level and needs?
With respect to: communication skills
Does the GPR – Establish rapport and empathy? – Engender confidence and trust? – Have a non-judgmental attitude? – Have good listening skills? – Use appropriate verbal communication for different situations (including use of silence)? – Use appropriate non-verbal communication for different situations (eye contact, body language, appropriate use of touch)? – Demonstrate an awareness of the patient's non-verbal communication? – Avoid jargon? – Communicate with significant others, as appropriate?
With respect to management skills

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Does the GPR – Explore options with the patient? – Have an ability to find common ground? – Negotiate a management plan (including a contingency plan and follow up in the immediate, Short and long term)? – Agree on responsibilities and limits (for doctor, patient and others)? – Capitalise on opportunities for health promotion and education (including use of pictures / models / handouts)? – Capitalise on opportunities to increase the patient's capacity for self-care?
Overall impression
– Is there structure to the consultation? – Does the consultation flow logically?
2. Applied Professional Knowledge and Skills
The presenting problem
Does the registrar demonstrate an orderly approach in – Taking a focused history appropriate to the presenting complaint? – Arriving at a diagnosis and/or management plan (including an ability to include/exclude serious conditions as part of this process)?
Physical examination
Does the GPR – Perform an appropriate and focused examination as indicated by the history? – Demonstrate competence in physical examination skills and an ability to recognize relevant – Explain the examination to the patient where necessary?
Procedural skills
Does the GPR – Demonstrate appropriate use of aseptic technique when it is required? – Have the ability to perform office procedures unsupervised? – Appropriately request assistance with procedures?

Investigations and referrals
Does the GPR – Make appropriate use of surgery tests? – Appropriately orders/doesn't order investigations? – Make appropriate and justifiable choice of investigations if ordered? – Explain nature of investigations to patient (including billing of these)? – Refer appropriately (for appropriate condition, to appropriate specialist or centre)?
Prescribing behaviour
Does the GPR – Demonstrate rational reasons for use/non-use of medication? – Ensure, when medication is prescribed, that the choice is appropriate for the patient and the Medical condition? – Follow PBS prescribing restrictions? – Explain the nature of prescribed medication to the patient? – Give adequately detailed instructions on the use and side effects of medications prescribed?

3. Population Health and the Context of General Practice
"Broader" bio-psycho-social issues
Issues which may impact on the patient's health: – socio-political – economic – work – spiritual – cultural – family & significant relationships Were any relevant? Were they elicited? Were they addressed? Was it done appropriately? Were significant opportunities missed?
Prevention, health promotion & disease screening.
– Was the opportunity taken to address these? – Was the patient involved? – Was the patient receptive? – How appropriately was it managed?
Recall / follow up
– How was it managed? – Was it explained to the patient?
Public health and safety issues
– Environmental – Safety concerns – Iatrogenic diseases (including adverse drug reactions) – Notifiable diseases (including contact tracing) – Access or equity issues Were these recognized? How were they managed?
Resources
– Is the registrar aware of what resources can be accessed in their area (referrals, community services, health services)? – Resources are finite. Is judicious use made of these resources? – How is the situation managed when these resources are lacking or inadequate?

MCCC may amend and vary this policy and/or procedure from time to time.

4. Professional & Ethical Role in General Practice
Duty of care to the patient
Does the GPR: – Take responsibility for the optimal care of the patient and the patient's needs (putting the patient first, follow up, reporting, advocacy)? – Recognize the importance of the doctor-patient relationship? – Respect the boundaries between doctor and patient? – Have respect for cultural values and how they impact on the doctor-patient interaction? – Have respect for patients' rights (confidentiality, privacy, full information, self-determination)?
Self-care
Does the GPR show concern for: – His/her own personal health (physical, emotional, spiritual and social dimensions)? – The needs of family and other relationships? – Maintaining a professional support network (GP's, other doctors, mentor, health professionals) for personal and clinical support?
Reflective skills
Does the registrar have: – A capacity for self-awareness, reflection and self-appraisal (personal reactions to the patient and their illness, knowledge and skills)? – The ability to determine learning needs based on self-reflection? – Time management skills (at work, outside of work)?
Maintenance of professional standards

MCCC may amend and vary this policy and/or procedure from time to time.

Does the registrar:

- Maintain defined clinical practice standards?
- Maintain professional codes and ethics?
- Have an involvement in professional development (CME, teaching, research, audit, incident analysis)?
- Interact appropriately with other staff in the clinic (medical and non-medical)
- Have a system for managing the professional expectations (e.g. paperwork) that is
- appropriate and practical
- Demonstrate appropriate professional behaviour in their approach to work

5. Organisational and Legal Dimensions

Medico-legal knowledge

Does the GPR have an awareness / knowledge of:

- Certification?
- Confidentiality (including access to records)?
- Legal report writing?
- Informed Consent?
- Prescribing (S8 drugs)?
- Duty of care?
- Litigation?

Organisational issues

Does the GPR pay attention to:

- "Best practice" with respect to clinical standards, guidelines and protocols?
- Accreditation requirements and practice standards?
- Information management (including management of medical records / information transfer
- /referrals / management of results)?
- Screening and recall systems?
- Appointment systems in the practice?

Time management and other personal skills

How does the registrar:

Liaise with other staff including reception and practice managers (Teamwork)

Deal with office policies and procedures?

Handle time management issues

MCCC may amend and vary this policy and/or procedure from time to time.

Appendix 3 - ACRRM domains

ACCRM - Domains of General Practice and relevant themes

Domain 1: Provide medical care in the ambulatory and community setting
Themes: Patient-centred clinical assessment, clinical reasoning, clinical management
Domain 2: Provide care in the hospital setting
Themes: Medical care of admitted patients, medical leadership in a hospital team, health care quality and safety
Domain 3: Respond to medical emergencies
Themes: Initial assessment and triage, emergency medical intervention, communication and planning
Domain 4: Apply a population health approach
Themes: Community health assessment, population-level health intervention, evaluation of health care, collaboration with agencies
Domain 5: Address the health care needs of culturally diverse and disadvantaged groups
Themes: Differing epidemiology, cultural safety and respect, working with groups to improve health outcomes
Domain 6: Practice medicine within an ethical, intellectual and professional framework
Themes: Ethical Practice, professional obligations, intellectual engagement including teaching and research
Domain 7: Practice medicine in the rural and remote context
Themes: Resourcefulness, flexibility, teamwork and technology, responsiveness to context

Appendix 4 - notes template

Template for Notes

Date: **Observer:**

What did the GPR do well & what more could they have done in each domain

Domains	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
	M/F Age	M/F Age	M/F Age	M/F Age	M/F Age
Communication skills & the Pt-Dr relationship					
Applied professional knowledge & Skills					
Population health & context of general practice					
Professional & ethical role					
Organisational & legal dimensions					

MCCC may amend and vary this policy and/or procedure from time to time.