



Australasian Faculty of
Rehabilitation Medicine

Discussion paper

The Rehabilitation Medicine Trainee of the Future

Shari Parker | 2015

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1. Executive Summary

1.1. Background

Rehabilitation medicine is defined as ‘that branch of medicine involved with the: prevention and reduction of functional loss, activity limitation and participation restriction arising from impairments; management of disability in physical, psychosocial and vocational dimensions; and improvement of lost function.’

Specialists in rehabilitation medicine are Rehabilitation Physicians. The RACP provides training to Australasian Medical Practitioners specialising in rehabilitation medicine via the Australasian Faculty of Rehabilitation Medicine (AFRM).

In just 40 years, rehabilitation medicine has evolved from a mere concept to a thriving specialty in Australasia, fulfilling an essential role in healthcare in Australia and New Zealand. The rate of change has perhaps been the greatest in the last decade. Rehabilitation now extends beyond the traditional subacute setting and Rehabilitation Physicians are now increasingly working alongside acute clinicians, providing early rehabilitation in the acute setting. Patients are transferred to rehabilitation with a higher acuity when acute issues are still prominent, and there is also an increasing focus on integrative models of care, with community-based rehabilitation care for those with chronic disability and health conditions.

AFRM’s stated mission is ‘to train, accredit and support medical practitioners in the management of functional loss, activity limitation or participation restriction arising out of illness and injury.’

To embrace this goal, as the specialty moves forward, the training program must be reviewed and contemporised to guarantee a sufficient supply of specialists who are suitably equipped for the evolving needs of the specialty within landscape of modern Australasian health care.

1.2. Aims

1. To evaluate the adult rehabilitation medicine training program and identify factors which need to be strengthened and those which may need to be modified
2. To identify options to equip the adult rehabilitation medicine training program to meet the future needs of the specialty
3. To conduct a detailed review of the option of restructuring the existing training program to RACP Basic Training with Advanced Training in rehabilitation medicine via the Adult Medicine Division (the ‘FRACP option’).

1.3. Method

- **Coordinator of Education:** An AFRM Coordinator of Education (the author of this paper) was appointed from July 2013 to carry out this work, in conjunction with an educationalist, who performed the curriculum mapping review.
- **Consultation:** AFRM members (Fellows and trainees) were invited to provide feedback regarding the training program to the Coordinator of Education in a range of formal and

informal formats, including face-to-face meetings, telephone, email, vigorous discussion at the 2013 and 2014 AFRM member meetings and via an online member survey.

- **Evaluation of the training program:** In response to the member consultation, an evaluation of the training program was conducted using the SWOT analysis format examining the strengths, weaknesses, opportunities and threats related to the training program.
- **Identify and evaluate options for change:** In response to the SWOT analysis, a range of options for change was identified. These relate to the specialty as a whole, as well as to specific options to modify or substantially change the training program.
- **Detailed review of the FRACP option:** The FRACP option was reviewed in greater depth: specifically the practicalities and implications of implementing such a change, contrasting it to the current training program, the specific advantages and disadvantages of such a change and how it addresses the aspects of the SWOT analysis.
- **Competency mapping:** Competency mapping analysis between the Adult Basic Training Curriculum and the Adult Rehabilitation Medicine Advanced Training Curriculum was undertaken by an educationalist (Andrew Dostine), who also delineated curriculum specifications for advanced training in adult rehabilitation medicine under the FRACP option.

1.4. Results

AFRM members were enthusiastic in providing feedback regarding the training program. In addition to vigorous discussion at the Annual Members' Meeting, one third of members provided input into the electronic survey and their demographics were consistent with the known demographics of the AFRM members, providing confidence in the collective representation of the responses.

The most important issues facing rehabilitation medicine in the coming two decades identified by respondents relate directly to the training program – its quality and content, and the importance of equipping trainees with the knowledge and skills for managing chronic disability, ageing with a disability, and rehabilitation of the older person.

1.5. Key recommendations to address identified issues

In response to each of the factors identified in the SWOT analysis, actions were identified with the purpose of reinforcing and capitalising on the positive internal and external factors, and addressing the negative factors both in the short term and in the medium to long term. The recommendations are listed below with further detail following regarding key areas.

1. Develop a vision for rehabilitation medicine in Australasia
2. Update scope of practice for adult rehabilitation medicine in Australasia
3. Perform a gap analysis between current training program and the requirements for the Rehabilitation Physician of the future
4. Review entry to training criteria
5. Curriculum review and update

6. Review teaching and learning components of Advanced Training in rehabilitation medicine
7. Improve the breadth and oversight of clinical experience in the rehabilitation medicine training program
8. Review issues identified with some specific training program elements
9. Review rehabilitation medicine workforce requirements
10. Consider the option of changing structure of rehabilitation medicine training program.

Review entry to training criteria

Many of the concerns identified regarding the training program will be mitigated by addressing the entry to training criteria for the rehabilitation medicine training program. Fundamentally, greater clarity is needed to define the characteristics of a trainee suitable for a career in rehabilitation medicine, including personal qualities, commitment to the specialty and baseline knowledge and skills. This will inform and guide the entry to training processes.

Changes to the entry to training processes could include: clearer prescription of pre-requisite experience and knowledge; review of the purpose, timing, content and structure of Modules 1 and 2 (assessments completed during the first two years of training) and with one possible option being to vary the AFRM program structure to align with that of the FRACP (the FRACP option). Consideration of the FRACP option must consider what impact this would have on the characteristics or type of trainee likely to enter into training.

Curriculum review and update

In the context of recent and projected developments within the specialty, a gap analysis of existing and predicted knowledge and skills for future specialists is needed. It is quite likely that Rehabilitation Physicians of the future will need greater foundational knowledge and skills in internal medicine. While Rehabilitation Physicians are not the primary physicians responsible for complex medical conditions, co-morbidities and complications, there is an increasing need for Rehabilitation Physicians to have a deeper understanding of the impact of conditions on the rehabilitation process, and indeed of the impact of the rehabilitation process on medical conditions. A training scheme that was more aligned with the FRACP would provide trainees with foundation knowledge and skills necessary for future rehabilitation medicine practice. Approximately one quarter of the content of the current clinical curriculum is duplicated in the Basic Training Curriculum and could be removed from the existing rehabilitation medicine curriculum as demonstrated in the curriculum mapping matrix included in this report.

Apart from these considerations the existing curriculum needs updating, with the addition of contemporary content; review of the structure and weighting of content; and to consider moving some content from core to non-core requirements.

A strategic review of the existing teaching and learning program will be encompassed in the curriculum review to ensure that trainees have consistent and equitable opportunities to address the updated curriculum. This includes allocation of adequate resources for a contemporary

approach to teaching and learning, including appraisal and enhancement of existing teaching programs and the development of innovative approaches to teaching and learning.

Improve breadth of clinical experience

Mechanisms are currently inadequate to ensure trainees' breadth of clinical experience to address key curriculum areas, which is reflected in Fellowship examination results. Approaches such as review of the term allocation process, introduction of logbooks/portfolios and development of options to facilitate a greater variety of clinical exposure would provide a more rounded training experience and knowledge/skillset.

Review training program elements

Specific comments are made regarding the utility of some aspects of training program elements to ensure that they continue to provide meaningful value to the trainees in achieving the stated goals. These recommendations are relatively minor and easy to implement, and would align well with a review of the curriculum.

Review workforce requirements

While Rehabilitation Medicine Trainee numbers are generally approaching adequacy, strategies to enhance awareness of rehabilitation medicine as a career will further strengthen competition for training places, raising the calibre of Rehabilitation Medicine Trainees, particularly if the entry to training criteria are tightened.

If the FRACP option is pursued, future workforce implications must be modelled as there is some concern that trainee numbers would fall. This is of particular concern for certain geographical areas where there are already workforce challenges.

1.6. Overview of FRACP option for adult rehabilitation medicine training

Changing the adult rehabilitation medicine program to align more closely with an RACP Advanced Training approach would address several but not all domains identified in the analysis of the rehabilitation medicine training program. There was mixed support for this model in the member survey, with 41% of respondents in favour of this change and 49% not in favour. It is, however, worth noting that this would better align adult rehabilitation medicine training with paediatric rehabilitation medicine training.

In this model, three years of adult Basic Training would precede Advanced Training in rehabilitation medicine via the Adult Medicine Division resulting in the qualification of FRACP. The Fellowship of the Australasian Faculty of Rehabilitation Medicine (FAFRM) qualification would no longer be offered.

Basic Training focuses on developing core medical skills and knowledge, introducing the specialty disciplines and providing a foundation for consolidation and further study within Advanced Training. The current Basic Training Curriculum in Adult Internal Medicine includes limited reference to rehabilitation medicine. An extensive review of the Basic Training curricula is currently underway, which may provide a natural opportunity for redressing the rehabilitation

medicine content in the Basic Training Curriculum. Some current rehabilitation Advanced Training curricula requirements could be covered through the completion of the Basic Training program.

In this model, Advanced Training in rehabilitation medicine would probably be three years in duration. Other than removal of Modules 1 and 2, no other significant alteration to the current training program components would be necessary, and indeed the other suggested improvements to the training program as previously outlined would further augment this option.

The Advanced Training Curriculum would be updated in line with the College-wide curricula renewal process, with removal of approximately 25% of content already addressed in the Basic Training Curriculum.

As with other Advanced Training programs undertaken via divisional training, governance of Advanced Training in rehabilitation medicine would sit with an Advanced Training Committee reporting to the Adult Medicine Division Education Committee. A change to this model of training would be dependent on support from the Adult Medicine Division of the College. The formation of a specialty society in rehabilitation medicine is not essential for this model, though if it existed, it could provide input into the Advanced Training Committee.

A change to this model of training would be predicated on broad-based support from AFRM members, ratification by AFRM Council, the Adult Medicine Division Council, College Education Committee and RACP Board, and approval by the Australian Medical Council and the Medical Board of Australia and Medical Council of New Zealand. Any changes to the Specialist Register in Australia require approval of Health Ministers.

If training moved to this model, current trainees' programs would be unaffected and a prospective change over date would be set. It is most unlikely that individuals currently holding an FAFRM would be automatically grandfathered to the FRACP qualification because of intrinsic differences between the training programs. Options for providing truncated Basic Training for current AFRM Fellows could be explored, though certain requirements for completing the Basic Training programs would remain, such as successfully sitting the written and clinical examinations and potentially other components introduced with the revision of the Basic Training curricula.

1.7. Next steps

Decision-making regarding the future of the Australasian rehabilitation medicine training program must be preceded by purposeful and meaningful discussion by relevant stakeholders. The Executive Summary was presented at the Annual Members Meeting on 10 September 2014, and has been made available for review by the members since that time via the website with an open invitation for comment and feedback. It was also presented to the College Education Committee in February 2015.

From here, it is expected that members of the AFRM will be invited to participate in a facilitated workshop to discuss and debate issues raised in this report as well as in the *Horizon Paper*¹. Key questions arising from the reviews will be addressed and an action plan prepared.

¹ Health Policy Analysis, 2014. *Horizon Paper*, s.l.: Australasian Faculty of Rehabilitation Medicine.

2. Background

2.1. Summary

- Rehabilitation medicine is one of the most rapidly growing specialties in Australasia and plays a vital role in the functioning of the health care system.
- Rehabilitation medicine has undergone rapid and significant evolution over the last decade, including settings, casemix, greater acuity and our role in the National Disability Insurance Scheme. These changes will result in the need for more foundational knowledge and skills in general medicine, which is traditionally part of Basic Training in adult medicine.
- The specialty itself is adjusting to these rapid changes. Full realisation and acceptance of the role of rehabilitation medicine in the broader health context is yet to be realised.
- The demand for rehabilitation medicine will increase with population growth and ageing and ageing with disability. While the supply of trainees has increased to meet demand in many settings, there is an ongoing mismatch in the geographical supply and demand for rehabilitation doctors. It is essential that any proposed changes to the rehabilitation training program take into account the potential impact on the future supply of Rehabilitation Physicians.
- The current rehabilitation medicine training program sits within the RACP educational framework as an Advanced Training faculty program. There is a high density of training program elements within the training program. Concerns have been raised informally regarding the content and quality of some aspects of training.
- In the context of rapid change within the specialty of rehabilitation medicine, and amidst other change within the College, the training program needs to be reviewed to ensure it is fit for purpose, and relevant recommendations made to increase its relevance to its stated purpose.
- These contextual factors prompt a review of the existing rehabilitation medicine training program.

2.2. *How did we get to where we are today? Brief history of rehabilitation medicine in Australasia*

Rehabilitation medicine is that part of the science of medicine involved with the: prevention and reduction of functional loss, activity limitation and participation restriction arising from impairments; management of disability in physical, psychosocial and vocational dimensions; and improvement of lost function. Specialists in rehabilitation medicine are Rehabilitation Physicians

Rehabilitation medicine arose largely in response to the needs of those injured in wartime, particularly following the Second World War. Our specialty gained momentum from the 1950s, and many of these early practitioners received training abroad. In the 1960s, a diploma course in rehabilitation was established by the Australian Postgraduate Federation in Medicine.

In Australia in 1976, the former National Specialist Qualification Advisory Committee recognised rehabilitation medicine as a principal specialty. Acknowledgment of the need to upgrade post-graduate education led to the inauguration of the Australian College of Rehabilitation Medicine (ACRM) in 1980. The first medical practitioners graduated from its training program in adult rehabilitation medicine in 1984.

By 1986, the first trainees in both paediatric and rehabilitation medicine became Fellows of the Australasian College of Rehabilitation Medicine, via a training scheme conjointly overseen by a Specialist Advisory Committee of the ACRM and RACP. In New Zealand, the medical specialty of rehabilitation medicine was officially recognised in 1995 as a separate vocational branch of medicine by the Medical Council of New Zealand.

In November 1995, Fellows of the AFRM were recognised by the then Department of Human Services and Health as Consultants in Rehabilitation Medicine under the *Health Insurance Act 1973* for the purposes of Medicare.

The report of the Committee of Inquiry into Medical Education and Medical Workforce, chaired by Professor Ralph Doherty, released in 1988, noted that disciplines with small numbers of specialists, such as rehabilitation medicine, could benefit by coming under the aegis of one of the major colleges. In accordance with the recommendations of the *Doherty Report* (1988), the College Fellowship merged with the RACP in 1993 to become the AFRM.

Because rehabilitation medicine was a relatively new field of practice at that time, and because the baseline knowledge and skills required to specialise went beyond that of internal medicine, and extended to the additional requirement of a broader knowledge of functional anatomy and surgery, rehabilitation medicine was incorporated into the RACP as a faculty, rather than as a medical subspecialty, though it was suggested that this position would be reviewed with time.

Since 1993, rehabilitation medicine training has been undertaken by the AFRM, one of three faculties within the RACP.

2.3. What we do

2.3.1. Adult Rehabilitation Medicine Scope of Practice

The AFRM's Adult Rehabilitation Physician Scope of Practice, as presented below, was published in 2011. It was written by Fellows of the AFRM to demonstrate key areas of knowledge and clinical practice of the specialty. This document has no legal standing, but outlines usual practice. It is not all inclusive, and was not designed to be restrictive. It does, however, outline the significant diversity of skill and knowledge required by the Rehabilitation Physician, and that needs to be provided by the training program.

Adult Rehabilitation Medicine Scope of Practice (AFRM, 2011)

In the current medical environment, establishing parameters within which a specialist may practice is very important. This document has been developed to define appropriate practice for physicians who specialise in rehabilitation medicine in Australia and New Zealand. The purpose of the document is to outline the scope of adult RM practice for rehabilitation physicians who hold Fellowship of the AFRM. While some adult rehabilitation physicians manage children in certain circumstances, adult rehabilitation physicians do not generally provide a full range of rehabilitation services to children, and reference should be made to the scope of practice for Paediatric Rehabilitation, which is contained in a separate document. It should also be noted that the areas of interest and expertise of rehabilitation physicians are not exclusive to holders of Fellowship of the AFRM.

Rehabilitation Medicine is a Principal Medical Specialty (Australia) and a Vocational Scope of Practice (New Zealand). Using skills developed in the AFRM training program, and in some cases post-fellowship training, rehabilitation physicians manage inpatients, outpatients and community patients with medical, musculoskeletal, neurological and neuromuscular disorders, with an emphasis on maximising functional ability and quality of life. Rehabilitation physicians engaged in adult RM practise, diagnose and treat patients from adolescence and young adulthood through to the very elderly. Rehabilitation physicians may also engage in the delivery of health services through new modalities, such as telehealth and through outreach teams.

Patients treated are those affected by function limiting and/or painful conditions involving the central and peripheral nervous systems and the cardiopulmonary and musculoskeletal systems. They also manage the rehabilitation needs of patients who experience illness or injury affecting other body systems.

Their unique blend of education, training and experience also makes the rehabilitation physician an ideal treating or consulting physician for patients who are debilitated, including older patients and those with reduced function as a result of chronic disease. Rehabilitation physicians are also well placed to manage patients with occupational or sports-related musculoskeletal or neuromuscular injuries.

Their multi-disciplinary training also makes rehabilitation physicians the most qualified specialists to lead the team of rehabilitation therapists and nurses and other medical specialists in the provision of a coordinated and patient-focused program of individual, goal-directed rehabilitative care.

Rehabilitation physicians are specially trained in therapeutic exercise and orthotic, prosthetic and other rehabilitation equipment and modalities. Therefore they are able to prescribe these precisely to meet the patient's specific needs. Rehabilitation physicians use routine laboratory and imaging studies, but they are also trained in the clinical interpretation of other diagnostic studies that evaluate musculoskeletal and neuromuscular systems such as CT, bone scan, MRI, and musculoskeletal ultrasound.

The Australasian Faculty of Rehabilitation Medicine asserts that all rehabilitation physicians who have completed Rehabilitation Medicine specialty training have adequate training in the following areas:

1. Inpatient and outpatient musculoskeletal and neuromuscular diagnosis and rehabilitation;
2. Acute and chronic pain management;
3. Injury prevention, conditioning, fitness and wellness;
4. Non-surgical spine medicine;
5. Rehabilitation management of occupational and sports injuries;
6. Therapeutic and diagnostic injection techniques, such as trigger point, soft tissue and joint injections;
7. Assessments of function, disability and impairment;
8. Prosthetic and orthotic prescription and wheelchair, mobility aid and seating prescription;
9. Rehabilitative care of patients with amputations or limb deficiency;
10. Rehabilitative care of patients with brain and spinal cord disorders;
11. Management of spasticity, dystonia and hypertonia;
12. Post fracture and joint arthroplasty rehabilitative care;
13. Tissue disorders such as burns, ulcers, and wound care;

14. Rehabilitation management of older people, including the management of geriatric syndromes;
15. Rehabilitative care of pulmonary, cardiac, and oncological conditions;
16. Rehabilitation of patients who are debilitated as a result of multi-system disease or prolonged immobilisation;
17. Rehabilitation and coordinated care and management of developmental disorders such as cerebral palsy, spina bifida and other congenital disorders;
18. Long term disability management in conjunction with the person with disability and other healthcare providers.

In addition, the Faculty further asserts that some rehabilitation physicians can demonstrate expertise that qualifies them to also practice in some of the following areas:

1. Interventional diagnostic and therapeutic spinal and peripheral pain management procedures utilising x-ray and ultrasound guidance;
2. Interventional techniques for spasticity management;
3. Electrodiagnostic medicine;
4. Manual medicine techniques and acupuncture

In summary, Rehabilitation Medicine is a diverse specialty in which its members are trained to facilitate the best possible recovery of function over the full range of common and uncommon medical and surgical conditions seen in contemporary practice. The practice of Rehabilitation Medicine is also collaborative, involving the input of a diverse range of health care professionals.

This document has been adapted from the American Academy of Physical Medicine and Rehabilitation document (Physiatric Scope of Practice), with permission.

November 11, 2011

2.3.2. Recent developments in rehabilitation medicine practice in Australasia

The last decade has seen significant development and change in the specialty of rehabilitation medicine in Australasia. It is essential to consider these changes when reviewing the future training needs for rehabilitation medicine in Australasia. These changes are likely to have an important impact on the scope of practice of rehabilitation medicine, as well as on the nature and content of the training program equipping specialists in rehabilitation medicine to practise effectively within this evolving rehabilitation medicine context.

1. More rehabilitation medicine in the acute setting

With the rising costs of health care across Australasia, there is an increasing push for greater efficiency and timeliness of health care. Indeed, Australian health dollars are directly linked to these factors through Activity Based Funding, and National Elective Surgery Targets and National Emergency Access Targets.

The need for efficiency, along with the availability of resources has seen rehabilitation commence earlier, with the blurring of the lines between the acute and subacute settings. Patients undergoing rehabilitation care increasingly have more acute medical and surgical issues.

The Australian subacute rehabilitation medicine sector received funding enhancement from 2008 to 2013 via two National Partnership Agreements (NPAs) between the federal and state/territory governments, negotiated by the Council of Australian Governments (the Hospital and Health Workforce Reform NPA, and the Improving Public Hospital Services NPA)². This substantial funding boost aided in the development of new models of rehabilitation medicine care, including the in-reach model of care, where rehabilitation commences earlier in the acute setting concurrently with acute medical or surgical care³.

To provide optimal rehabilitation care for persons with disability in these evolving contexts, Rehabilitation Physicians require greater knowledge of acute issues and their impact on the rehabilitation process, and of the impact of rehabilitation on the acute issues. There is equally a requirement for acute care clinicians to have more of a stronger knowledge base of the impact of rehabilitation on acute care.

2. Greater patient acuity in subacute rehabilitation setting

The acuity and medical/surgical complexity of patients undergoing rehabilitation care have increased over the last five years resulting in a need for Rehabilitation Physicians to have stronger knowledge and skills to manage acute issues in their patients.

It is noted that there has been a reduction in the Functional Independence Measure (FIM) scores on admission to rehabilitation, reflecting higher acuity of patients in rehabilitation (see Table 2 below). Not only are patients admitted to subacute rehabilitation units with greater medical acuity, but patients frequently remain in the subacute setting when complications/interruptions to care are experienced which would have previously seen patients transferred back to the acute setting. This trend has not yet been confirmed in Australasian Rehabilitation Outcomes Centre (AROC) data though because of inconsistencies with this specific area of data collection⁴).

² Council of Australian Governments (2008). *National Partnership Agreement of Hospital and Health Workforce Reform*. Available from: http://www.federalfinancialrelations.gov.au/content/npa/health_payments/workforce-reform/national_partnership.pdf

³ Poulos CJ, Eagar K, Faux SG, Estell J, Crotty M (2013). 'Subacute Funding in the Firing Line'. *Medical Journal of Australia* 2013; 199(2): 92:93. Available from: http://www.mja.com.au/journal/2013/199/2/subacute-care-funding-firing-line?0=ip_login_no_cache%3Dcc8481a101fb97dc5289cdd43f698cd9#7

⁴ Personal correspondence Jacquelin Cappell, AROC Research Fellow, 14 May 2014.

Table 2 – Proportion with a FIM admission score less than or equal to X each year⁵

FIM admission less than or equal to	2009	2010	2011	2012	2013
40	2.2%	2.2%	2.6%	3.1%	3.6%
50	4.7%	4.7%	5.4%	6.3%	7.5%
60	10.0%	9.3%	10.5%	11.9%	13.7%
70	17.7%	17.2%	18.3%	20.2%	22.6%
80	30.5%	29.7%	30.9%	33.0%	35.8%
90	49.8%	48.5%	48.6%	51.4%	54.2%
100	72.9%	71.8%	72.2%	74.0%	75.9%
110	91.5%	90.1%	90.6%	91.5%	92.4%
120	99.3%	98.4%	99.3%	99.0%	99.6%

3. Greater contribution of re-conditioning rehabilitation to the rehabilitation medicine casemix

Within an annual 2.2% growth of inpatient rehabilitation episodes, ‘re-conditioning rehabilitation’ episodes account for the majority of the volume of growth, with additional growth seen in the cardiac and pulmonary impairment groups (AROC, 2014).

Re-conditioning rehabilitation is required when an individual has a decline in function due to an acute medical/surgical illness, or related to a cancer diagnosis. Episodes of re-conditioning rehabilitation reported to AROC doubled from 2009 to 2013 and it continues to represent the diagnostic area of greatest growth in rehabilitation care⁶.

These trends emphasise the importance of Rehabilitation Physicians having skills and knowledge regarding the acute condition resulting in the need for re-conditioning rehabilitation, which will continue to occupy a substantial proportion of the Rehabilitation Physician’s workload in addition to the other areas of rehabilitation practice in which Rehabilitation Physicians traditionally work.

Paralleling the greater medicalisation of the role of rehabilitation medicine has been a relative reduction in the proportion of Rehabilitation Physicians involved with the traditional areas of traumatic brain injury and traumatic spinal cord injury. A lower percentage of Rehabilitation Physicians are involved in these highly specialised areas of rehabilitation medicine than ever before because of the expansion of the role of Rehabilitation Physicians in ‘general’ rehabilitation, along with a small contribution from a reduction in the incidence of traumatic brain and spinal cord injuries.

⁵ Personal correspondence, Frances Simmonds and Tara Stevemeuer, AROC, 27 June 2014.

⁶ AROC (2014). *The AROC Annual Report: the state of rehabilitation in Australia in 2014*.

<http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow190994.pdf>

The changing casemix of the work carried out by Rehabilitation Physicians has important implications for the training of future specialists in rehabilitation medicine.

4. Focus on ambulatory rehabilitation programs

Beyond the inpatient setting, the role of ambulatory rehabilitation is also expanding, with enhanced roles of the Rehabilitation Physician within domiciliary and day hospital ambulatory rehabilitation programs. There has also been expansion of the role of the Rehabilitation Physician in the rehabilitative management of the older person, and in the care of the person with disability as they age. Just under 50% of ambulatory rehabilitation episodes did not originate from a hospital episode, in other words, they originated from the community setting⁷.

At every point of the disability journey, from acute onset of disability, to longer-term management, people with disability undergoing rehabilitation management have complex medical needs. This is particularly pronounced in rehabilitation of the older person. The medical issues may relate either to pre-existing co-morbidities contributing to the disabling event, or may arise following the disabling injury or illness for which the individual is undergoing rehabilitation, or it may be the accumulation of new health issues in the person ageing with a disability.

The role of Rehabilitation Physicians in the roll out of Australia's National Disability Insurance Scheme is currently unclear because Rehabilitation Physicians work largely within the medical system but also have a key role, and specialist expertise, in the management of disability, including equipment prescription, and oversight of the management and implementation of rehabilitation and maintenance therapy in the community.

The Rehabilitation Physician's capacity to manage such patients holistically is contingent upon having the skills and knowledge regarding the health conditions and their impact on disability, and vice versa.

2.4. Who we are

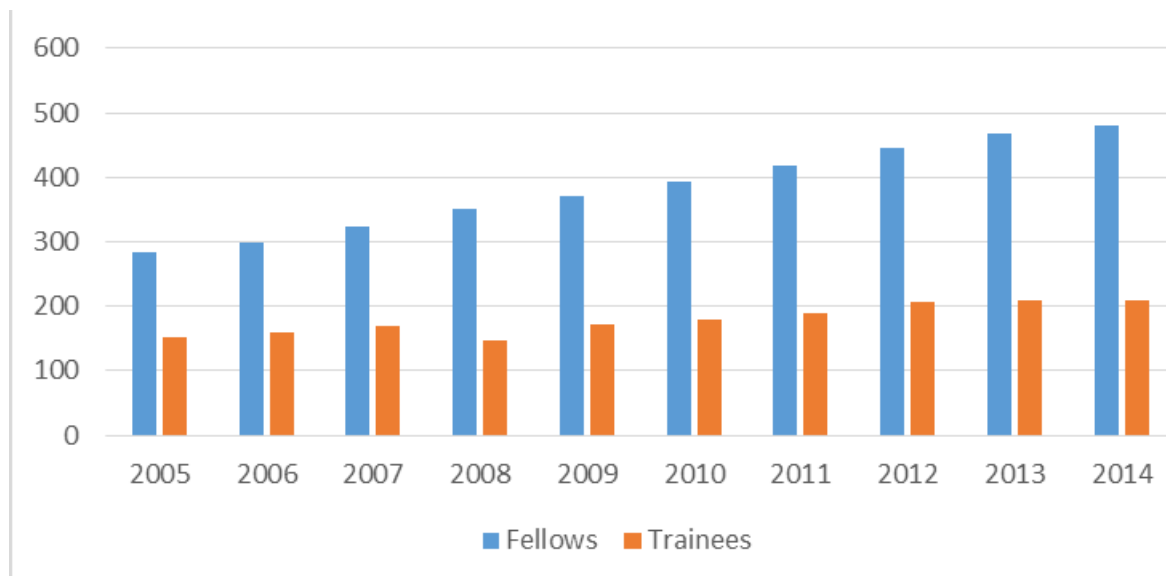
2.4.1. The Rehabilitation Physician workforce in Australasia

While it appears that the current training program is largely delivering an adequate supply of specialists, it is important to consider the market forces and geographical distribution of trainees and fellows to ensure that there will be a sufficient number of appropriately skilled Rehabilitation Physicians to service the entire population.

There are currently 542 active and honorary Fellows, and 235 trainees registered with the AFRM. Substantial growth has been recognised in the rehabilitation workforce over the last decade, fuelled by growth in the number of rehabilitation units and training positions available (See Figure 1).

⁷ AROC (2014). *AROC Ambulatory Report: Anywhere Hospital*.
<http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow191270.pdf>

Figure 1 – Growth in rehabilitation membership from 2005–2015



While there is no data collected regarding vacancy rates for vocational training posts, the rising medical school graduate numbers in Australia have anecdotally resulted in a reduction of vacancies previously seen.

Australia

Characteristics of specialists identifying rehabilitation medicine as their primary specialty in the Australian Institute of Health and Welfare's (AIHW) 2011 survey are outlined below⁸:

⁸ AIHW 2013. Medical workforce 2011. *National health workforce series*. Cat. no. HWL 49. Canberra: AIHW.

Table 3 – Specialists identifying rehabilitation medicine as their primary specialist, gender by state and territory, age and working hours, Australia 2011 *Source: AIHW, National Health and Welfare Data Set, 2011.*

		NSW ^(b)	Vic ^(c)	Qld	SA	WA	Tas ^(c)	NT ^(c)	ACT	Australia ^(b)
<i>Rehabilitation medicine</i>	Males	85	46	22	11	n.p.	n.p.	n.p.	n.p.	173
	Females	59	36	8	6	n.p.	n.p.	n.p.	n.p.	112
	Total	143	82	30	17	5	n.p.	n.p.	5	285

(a) Practitioners who spent most of their time as clinicians only.

(b) Data include medical practitioners who did not state or adequately describe their state or territory, and medical practitioners who reside overseas. Therefore, state and territory totals may not sum to the national total. In particular, the total for working overseas is noticeably higher than the sum of the state and territory figures.

		Age group					Total	Average age
		<35	35-44	45-54	55-64	65+		
<i>Rehabilitation medicine</i>	Male	6	44	66	n.p.	n.p.	173	50.8
	Female	8	41	41	n.p.	n.p.	112	46.3
	Total	14	85	107	58	21	285	49.0

(a) Practitioners who spent most of their time as clinicians only.

		Hours						Total	Average hours
		1-19	20-34	35-49	50-64	65-79	80+		
<i>Rehabilitation medicine</i>									
	Males	6	17	86	55	6	n.p.	173	44.3
	Females	14	35	39	19	n.p.	n.p.	112	36.4
	Total	20	52	125	73	n.p.	n.p.	285	41.2

(a) Practitioners who spent most of their time as clinicians only.

New Zealand

According to the 2012 Medical Council of New Zealand Health workforce survey⁹, there were 30 doctors who listed rehabilitation medicine as their primary area, of whom 12 were registered vocational trainees. They worked an average of 44.1 hours per week, and had an average age of 41 years. Of the rehabilitation specialists, 36% were female.

2.4.2. Where we work

Traditionally, clinicians working in rehabilitation medicine have been based in a subacute inpatient setting.

With the development of new models of care, the setting of our work is increasingly extending beyond the walls of the traditional rehabilitation unit, expanding into non-traditional locations, including the acute hospital setting units, community-based health maintenance/hospital

⁹ Medical Council of New Zealand (2012). *The New Zealand Medical Workforce in 2012*. Available from: <https://www.mcnz.org.nz/assets/News-and-Publications/Workforce-Surveys/2012.pdf>

avoidance programs, home and community based rehabilitation programs, and the use of telehealth¹⁰.

The last five years have seen a dramatic increase in the number of ambulatory rehabilitation units across Australia submitting data to AROC.

Despite these observations and predictions, there is no current data pertaining to the actual mix of clinical practice settings in which Rehabilitation Physicians work. To assist with future planning of our specialty, it is strongly recommended that this work be undertaken.

2.4.3. Projected workforce demands for Rehabilitation Medicine Fellows

Australia

The Australian Workforce survey of 2012¹¹ predicts an oversupply of 307 rehabilitation specialists by 2025. The calculated growth rate in need for specialists in rehabilitation medicine was 2.1% per annum. This growth rate was based on historical hospital separation and Medicare data. They applied a constant linear growth rate for various age/gender cohorts.

Despite this gloomy prediction for the future clinical need for Rehabilitation Physicians, there are additional factors which deserve consideration. Firstly, there has been a notable recent expansion in the roles and settings for rehabilitation as previously described which could not have been accounted for in these predictions.

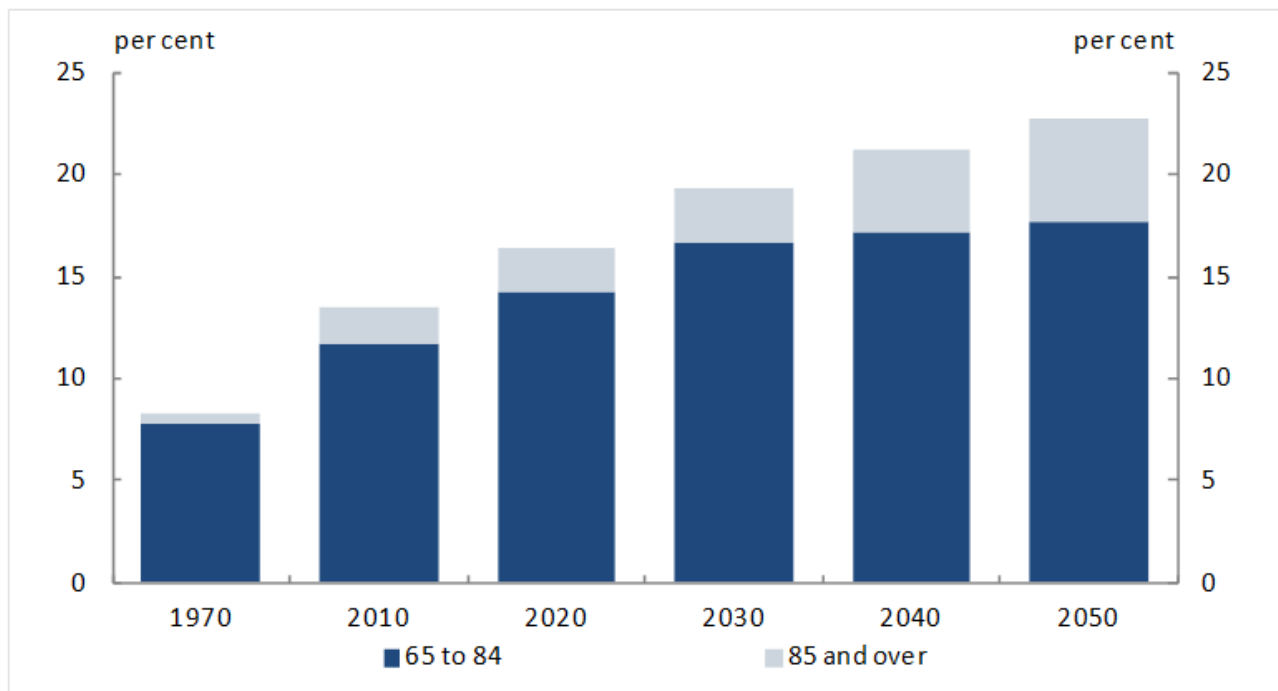
Additionally, these predictions may not have accounted for the particular areas of clinical need relevant to rehabilitation medicine. Significant growth is predicted for the coming century. In June 2012, Australia's population was 22.7 million people. In 2061, the projected population is between 36.8 and 48.3 million people, and in 2101¹² between 42.2 and 70.1 million people. Over time, the rate of population increase will be particularly notable for the older populations.

¹⁰ *Health Workforce Australia 2012: Health Workforce 2025 – Volume 3 – Medical Specialties*. Available from: https://www.hwa.gov.au/sites/uploads/HW2025_V3_FinalReport20121109.pdf

¹¹ Health Workforce Australia [2013]: *Health Workforce Australia Annual Report 2012–13*.

¹² [http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3222.0main+features32012%20\(base\)%20to%202101](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3222.0main+features32012%20(base)%20to%202101)

Figure 2 – Proportion of Australia population aged 65 and over¹³



Higher rates of disability will come with population ageing. It is expected that there will be a 70% increase in the number of older people with profound disability over the coming three decades, due to disorders in the musculoskeletal, nervous system, circulatory and respiratory conditions and stroke¹⁴.

With population growth, ageing of the population and the rise of chronic disease, risk factors for chronic disease (such as obesity), greater disease survival, resulting burden of disability and expansion of rehabilitation settings, it is anticipated that there will be growth in the need for Rehabilitation Physicians in the coming years, and a resultant higher demand for training of specialists in rehabilitation medicine.

New Zealand

In New Zealand, it has been reported that the rehabilitation workforce faces recruitment and retention issues¹⁵. The New Zealand Medical Workforce Pipeline project¹⁶ gives a ratio of Rehabilitation Medicine Trainees to specialists just over 0.2, which is just above the 'at risk' level.

¹³ Australian Government (2010). *Intergenerational Report 2010*, Australian Government, Canberra. Available from: <http://www.ncoa.gov.au/report/appendix-vol-1/9-1-age-pension.html>

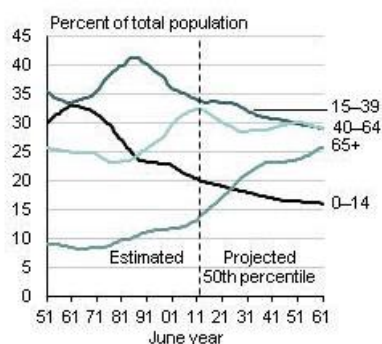
¹⁴ Giles LC, Crotty M and Cameron ID. 'Disability in older Australians: projections for 2006–2031'. *Medical Journal of Australia* 2003; 179 (3): 130-133.

¹⁵ Health Workforce New Zealand (2011). *Rehabilitation Workforce Service Review Final Report*. Available from: <http://www.health.govt.nz/system/files/documents/pages/rehabilitation-workforce-service-forecast.docx>

¹⁶ Health Workforce New Zealand (2014). *Medical Workforce Pipeline Update 28 May 2014*. Available from: <http://healthworkforce.health.govt.nz/medical-workforce-pipeline-update>

Despite this weaker baseline workforce position, population growth, population ageing and rising disability rates are also predicted for New Zealand making the future need for the training of Rehabilitation Physicians even stronger. New Zealand's population in 2012 was 4.4 million, and is predicted to rise to 5.4 million in 2036 and to 6.0 million by 2061. The proportion of people aged over 65 years will increase from 14% in 2012 to 23% in 2036 and to 26% by 2061 (see Figure 3 below).

Figure 3 – Age distribution of population 1951–2061



Source: Statistics New Zealand

2.5. Rehabilitation medicine training in Australasia

2.5.1. Introduction

Rehabilitation medicine training in Australasia is undertaken by the AFRM, and is one of the primary functions of the faculty. This section will outline the structure and nature of the training program as the basis for an analysis of the training program in its current format.

The training program sits under the umbrella of the RACP, which itself is undergoing substantial educational reform and modernisation.

While the training program is generally held to be of excellent standards and quality, as reflected by its ongoing accreditation through the Australian Medical Council (AMC), fluctuations in Fellowship examination results in recent years have prompted concerns regarding some aspects of the training program. These concerns need to be explored and addressed where necessary.

Within the context of change in the landscape of rehabilitation medicine across Australasia and other College reforms, along with informal concerns regarding the training program's fitness for purpose, a thorough review of the rehabilitation medicine training program is indicated to ensure that remains relevant and effective in carrying out its key purpose.

2.5.2. The College of Physicians – the ‘parent’ organisation of rehabilitation medicine in Australia and New Zealand

The College trains, educates and advocates on behalf of more than 15,000 Fellows and 7,500 trainees across Australia and New Zealand. The College is responsible for the training and assessment of doctors who have completed their medical degree and hospital internship, and

wish to practise as physicians or paediatricians in a certain field of medicine, including rehabilitation medicine.

The College structure and training pathways will be briefly outlined as an understanding of this pertains to a discussion of the training program in rehabilitation medicine, where it fits within the current College structure, and other potential avenues for training.

2.5.3. College structure

The College is comprised of the following:

1. Divisions

The College has two divisions:

- i. Adult Medicine Division
- ii. Paediatrics & Child Health Division.

Division training programs result in the qualification of Fellowship of the RACP (FRACP), and consist of Basic Physician Training, followed by Advanced Training via one of the divisions.

2. Faculties

A faculty is an **independent body** within the College which offers its own vocational training programs. The College's three faculties are:

- i. Australasian Faculty of Occupational & Environmental Medicine
- ii. Australasian Faculty of Public Health Medicine
- iii. Australasian Faculty of Rehabilitation Medicine (AFRM).

3. Chapters

The College has four chapters which support groups of practitioners working in specific areas:

- i. Australasian Chapter of Addiction Medicine (Adult Medicine Division)
- ii. Australasian Chapter of Palliative Medicine (Adult Medicine Division)
- iii. Australasian Chapter of Sexual Health Medicine (Adult Medicine Division)
- iv. Chapter of Community Child Health (Paediatrics and Child Health).

4. Specialty societies

Specialty societies are medical/scientific societies that bring together research and clinical scientists and physicians who are actively involved in the study of a particular specialty, e.g. cardiology, geriatric medicine.

Each society is run independently from the College. The College has formed partnerships with some specialty societies through the Advanced Training Committees responsible for **developing and supervising** Advanced Training programs for those specialty areas. Advanced Training continues to be provided by the RACP. Training programs supervised by Advanced Training Committees, and are attached to one of the Divisions, result in the qualification of FRACP. Not all

Advanced Training programs have specialty societies, most notably one of the largest Advanced Training programs, general paediatrics.

Rehabilitation Medicine Society of Australia and New Zealand Ltd

It is noted that the Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ) was formed in 2014. This society has not yet formed a formal partnership/memorandum, of understanding with the College because training in rehabilitation medicine continues under the auspices of the AFRM. Should the structure of rehabilitation training change in the future, there is scope for formal partnership to be undertaken.

The objects of the Society are the following¹⁷:

1. To advance the practice of rehabilitation medicine
2. To promote and advance the study of rehabilitation medicine
3. To foster the highest standards of training, practice, teaching and research in the field of rehabilitation medicine
4. To promote, improve, encourage and provide education or training in rehabilitation medicine by instituting and conducting courses of study for the benefit of those desiring to increase and improve their knowledge of rehabilitation medicine and related disciplines to the highest possible level based on the best available evidence
5. To provide a forum for medical practitioners engaged in the practice of rehabilitation medicine and any of its special Interests and related disciplines for the furtherance of standards of medical care and rehabilitation
6. To liaise with the AFRM and the RACP and other relevant bodies regarding training, certification and recertification programs via a formal memorandum of understanding
7. To work collaboratively with the RACP/AFRM and the Council of the RACP and all its boards and committees on matters concerning rehabilitation medicine
8. To nominate from time to time representatives (to be selected by the RMSANZ Council) to the AFRM and RACP for membership of the Specialist Training Committees or any other committees of AFRM or RACP as deemed appropriate by RMSANZ Council
9. To represent the views of consultants in rehabilitation medicine (Rehabilitation Physicians) to other relevant bodies
10. To maintain ongoing liaison with federal and state governments of Australia, the New Zealand Government and other relevant bodies to promote the development of healthcare and disability programs for people with disability
11. To hold meetings for the discussion of clinical, academic, administrative, industrial and political subjects relating to rehabilitation medicine and related disciplines
12. To establish Regional Committees, including but not restricted to state and New Zealand Branches and special interest groups of RMSANZ for the benefit of its members and the furtherance of its objects

¹⁷ RMSANZ (2015). RMSANZ: About us – FAQ. Retrieve 24 November 2015 from: <http://www.rmsanz.net/about>

13. To provide such educational activities RMSANZ thinks fit for its members and for trainees in rehabilitation medicine of the AFRM and RACP and hold regular scientific meetings for its members
14. To promote research into medical and related problems of people with disability
15. To provide encouragement and support to advanced trainees during and after their period of training in rehabilitation medicine
16. To do all such other things as are incidental or conducive to the attainment of the above objects.

College training programs

The College is an accredited provider of specialist medical education for doctors who wish to practise as physicians or paediatricians. College trainees have completed their medical degree and an internship at a hospital, and undertake further training through the College in order to specialise in a certain area of medicine.

The College offers Basic and Advanced Training programs

- 1. Basic Training programs** – these are offered under the following divisions:
 - a. Adult Medicine
 - b. Paediatrics & Child Health.

The purpose of Basic Training is to develop core skills and knowledge, introducing each of the disciplines and providing a foundation for consolidation and further study within Advanced Training. Completion of Basic Training plus Advanced Training via the divisions is the only mechanism for being awarded the FRACP.

2. Advanced Training programs

- a. **Divisional Advanced Training programs** – The divisional Advanced Training programs follow Basic Training and build on and further contextualise the knowledge and clinical skills gained during basic training within a chosen specialty. Successful completion of the relevant divisional Advanced Training program results in the qualification of FRACP. Advanced Training divisional training programs following Basic Training are offered in the following specialty fields:
 - cardiology
 - clinical genetics
 - clinical haematology
 - clinical immunology and allergy
 - clinical pharmacology
 - community child health (via Basic Training in paediatrics and child health)
 - dermatology (New Zealand only)
 - endocrinology
 - gastroenterology
 - general and acute care medicine (via Basic Training in adult medicine)

- general paediatrics (via Basic Training in paediatrics and child health)
- geriatric medicine (via Basic Training in adult medicine)
- infectious diseases
- medical oncology
- neonatal/perinatal medicine (via Basic Training in paediatrics and child health)
- nephrology
- neurology
- nuclear medicine
- palliative medicine
- respiratory medicine
- rheumatology
- sleep medicine.

Joint training programs – The College also offers three joint Advanced Training programs between the divisions (after completion of Basic Training) and other institutions, which result in dual Fellowships after the requirements are completed for both institutions:

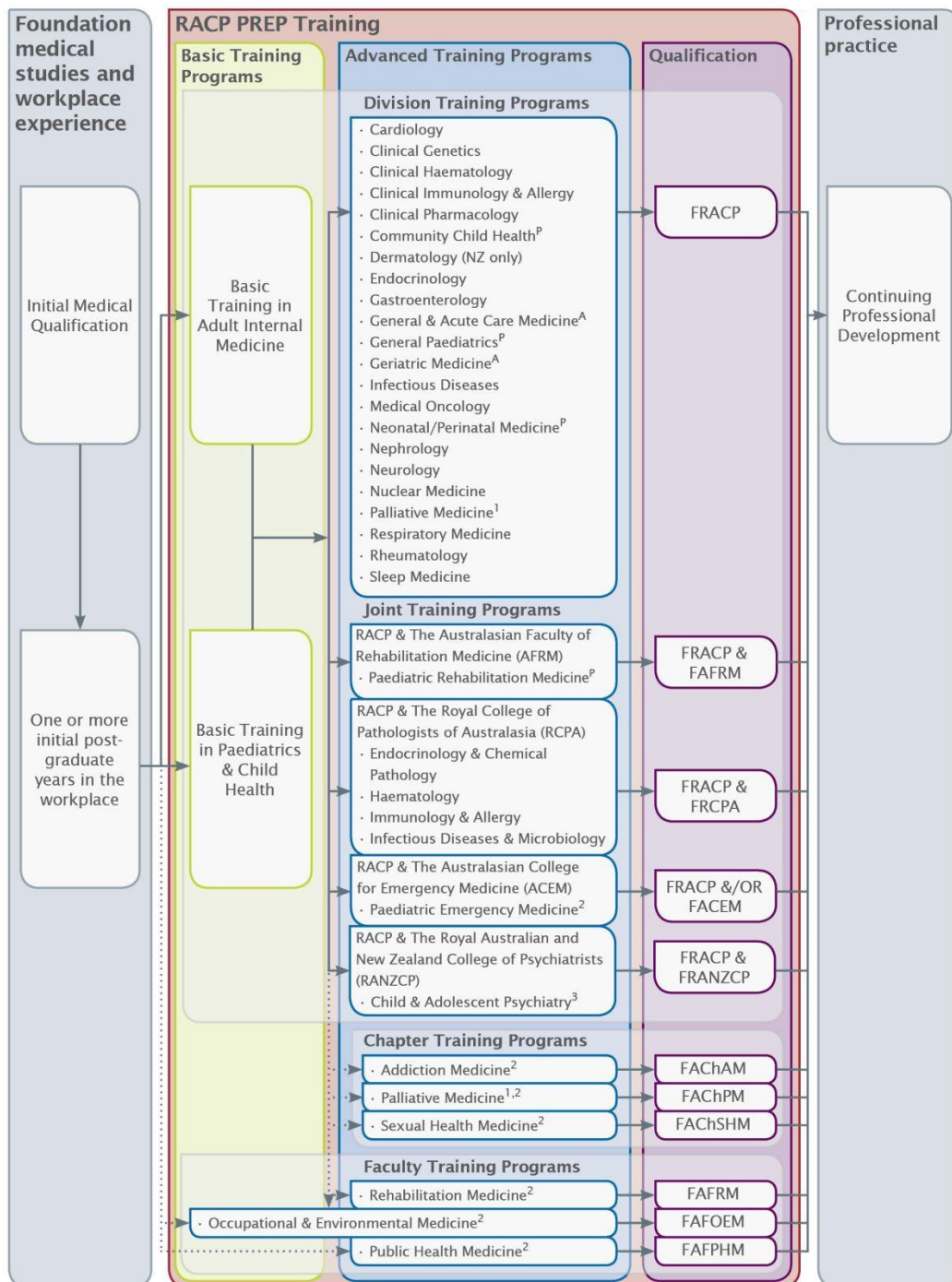
- The Australasian College for Emergency Medicine (ACEM) – paediatric emergency medicine (FRACP and/or FACEM)
- The Royal College of Pathologists of Australasia (RCPA) – endocrinology and chemical pathology, haematology, immunology/allergy, infectious diseases and microbiology (FRACP and FRCPA)
- The Australasian Faculty of Rehabilitation Medicine (AFRM) – paediatric rehabilitation medicine (FRACP and FAFRM).

b. **Faculty training programs** – Faculty Advanced Training programs are offered in: occupational and environmental medicine, public health medicine, and rehabilitation medicine. Further details regarding AFRM's training program will be presented in the following sections.

Undertaking a Basic Training program by the RACP is **not** a pre-requisite for undertaking Advanced Training with the faculties, other than for paediatric rehabilitation medicine, where Basic Training in paediatrics and child health is a pre-requisite, and which results in dual fellowship qualifications as previously outlined.

c. **Chapter training programs** – these are not required to be preceded by a period of Basic Training, and are offered in: Addiction Medicine, Palliative Medicine, Sexual Health Medicine. The majority of trainees undertaking chapter training programs either enter directly to the training program, or have fellowship from another college (e.g. general practitioners).

Figure 4 – Relationship between the various College training programs that lead to Fellowship and reinforce the link between initial medical training, post-graduate workplace experience, Basic/Advanced/Faculty/Chapter training and continuing professional development



^P Trainees must complete Basic Training in Paediatrics & Child Health to enter this program.
^A Trainees must complete Basic Training in Adult Internal Medicine to enter this program.
¹ Trainees who have entered Advanced Training in Palliative Medicine via an RACP Basic Training Program will be awarded FRACP upon completion and may subsequently be awarded FACHPM. Trainees who have NOT entered Advanced Training in Palliative Medicine via a RACP Basic Training Program will only be awarded FACHPM upon completion.
² Alternative entry requirements exist for these training programs; please see the corresponding PREP Program Requirements Handbook for further information.
³ The Child & Adolescent Psychiatry Joint Training Program with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) is currently under review by the RACP and RANZCP and closed to new entrants at present.
 NB1: This diagram only depicts training programs that lead to Fellowship. Please see the RACP website for additional RACP training programs.
 NB2: For further information on any of the above listed training programs, please see the corresponding PREP Program Requirements Handbook.
 NB3: The Medical Board of Australia has approved a time-limited pathway to FRACP without a field of specialty practice. This pathway is for trainees who commenced Advanced Training in Intensive Care Medicine prior to 1 July 2012, following successful completion of Basic Training in Adult Internal Medicine or Paediatrics & Child Health.

2.5.4. The Australasian Faculty of Rehabilitation Medicine – the peak professional organisation for rehabilitation medicine in Australia and New Zealand

As previously outlined, the AFRM is an independent body within the RACP.

The faculty's role as a higher educational institution is central to its mission 'to train, accredit and support medical practitioners in the management of functional loss, activity limitation or participation restriction arising out of illness and injury'¹⁸.

AFRM's key purposes are¹⁹:

1. Education – training specialists and overseeing ongoing professional development for specialists
2. Advocacy – advocating for persons with disabilities and for rehabilitation medicine
3. Setting standards for rehabilitation medicine – for both trainees and specialists
4. Peer support – individual and workforce sustainability.

This report will focus on the AFRM's key role of education.

2.5.5. Goals of the training program

The primary goal of the rehabilitation medicine training program is the education and training of individual Rehabilitation Physicians. The specific competencies expected at the completion of training are outlined in the Rehabilitation Medicine Training Handbook.

It is important to note that the functions of the AFRM's training program go beyond the training of the individual Rehabilitation Physician, and there are additional unstated responsibilities related to the adequate supply of Rehabilitation Physicians to meet future demand of society.

In order to meet the requirement for adequate supply, the training program must therefore have the features and appropriate marketing to attract adequate trainee numbers. Features of the training program and profession (including training duration, assessments, content, quality, structure, standards and reputation) directly influence self-selection into the specialty. These factors must be considered if any modifications are contemplated to the training program.

2.5.6. Evolution of the current structure of rehabilitation medicine training

The training program originated under the ACRM was three years' duration, and included Part 1 and Fellowship examinations. At that time, the Royal Australasian College of Surgeons, Royal

¹⁸ Australasian Faculty of Rehabilitation Medicine (2015). Australasian Faculty of Rehabilitation Medicine. Retrieved 24 November 2015 from: <https://www.racp.edu.au/about/racps-structure/australasian-faculty-of-rehabilitation-medicine>

¹⁹ Australasian Faculty of Rehabilitation Medicine (2010). Faculty of Rehabilitation Medicine Statement of Strategic Intent. Retrieved 24 November 2015 from: <https://www.racp.edu.au/docs/default-source/faculties-library/AFRM/afrmsosi.pdf?sfvrsn=2>

Australian College of General Practitioners and RACP provided exemption from the ACRM Part 1 examinations.

In 2001, ACRM training was replaced by the Rehabilitation Medicine Vocational Training Program, which received full accreditation with the AMC in 2004. From 2011, this training program was reconfigured in the Physician Readiness of Expert Practice (PREP) training framework.

2.5.7. Overview of Adult Rehabilitation Medicine Advanced Training

The AFRM has a four-year training program, which results in the post-nominal qualification of Fellow of the Australasian Faculty of Rehabilitation Medicine.

Training occurs in prospectively approved training programs in rehabilitation medicine units during which trainees acquire the professional qualities and specialty specific competencies necessary to practise as a Rehabilitation Physician.

To register, a trainee must have completed at least two years of general clinical experience or general practice. AFRM trainees are self-selected. In order to have a training program approved and become a registered trainee, a doctor must obtain employment or other supervised work that is accepted as appropriate training by the faculty. Each year, applicants must obtain positions that enable appropriate training. Applications for these service positions are managed by employing bodies.

The faculty is not directly involved in the selection of trainees into employment positions. However, each year some members of the faculty, as hospital employees, may be involved in interviews and placement of doctors into some registrar positions for the following 12-month period. The faculty recommends that official faculty representatives attend these interviews.

As well as ongoing assessment requirements and successful completion of the fellowship examinations, admission to fellowship of the faculty requires satisfactory completion of all training requirements as follows:

1. Four years of supervised clinical training in rehabilitation medicine in an accredited training program
2. Completion of training modules in clinical research, clinical neuropsychology, administration and management of rehabilitation services and behavioural sciences

The faculty accredits facilities considered suitable environments for training in rehabilitation medicine, although individual trainees' proposed training programs, not posts, are approved annually whether undertaken at non-accredited or accredited facilities. The criteria facilities should fulfil for accreditation are listed in the AFRM Manual for Trainees and on the website.

Specific aspects of the training program are outlined in the sections that follow. Additional details regarding the Adult Rehabilitation Medicine Advanced Training Program can be found in the Training Program Handbook²⁰.

2.5.8. Qualification

The specialist medical education pathway provided by the AFRM leads to the post-nominal qualification Fellowship of the Australasian Faculty of Rehabilitation Medicine (FAFRM).

2.5.9. Framework

As with all College programs, rehabilitation medicine training is conducted under the PREP training framework²¹, which includes both rehabilitation medicine training as well as continuing professional development (CPD).

2.5.10. Duration

The Adult Rehabilitation Medicine Advanced Training Program is of 48 months' duration, with a minimum of 36 months' training in rehabilitation medicine, and a maximum of 12 months' in non-core training. This has been determined by the minimum amount of time it would take a trainee to complete all of the requirements of training as well as obtain the experience necessary to practice in rehabilitation medicine as a Consultant Physician.

2.5.11. Structure

The entirety of the training is termed 'Advanced Training', without a preliminary period of Basic Training. This is in contrast to FRACP training via the divisions, where BPT of three years' duration is undertaken, which includes written and clinical assessments, and is undertaken prior to Advanced Training in an area of specialty (e.g. neurology).

It is noted that the structure for training in paediatric rehabilitation medicine is different from that of adult rehabilitation medicine where a period of Basic Training in paediatrics precedes advanced training in paediatric rehabilitation training. Paediatric training has **compulsory** joint training and results in the double qualification of FAFRM and FRACP. This may be a useful model for adult rehabilitation medicine to pursue.

²⁰ AFRM (2015). *2015 Physician Readiness for Expert Practice Advanced Training in Rehabilitation Medicine 2015 Program Requirements Handbook*. Retrieved 24 November 2015 from:

<http://members.racp.edu.au/index.cfm?objectid=139B6E80-D0B3-5740-2E93AD1AFEC7C65C>

²¹ The key principles of PREP are: a supportive learning environment, trainee-centred physician-led approaches, and reflective practice, with various elements, include: curricula, program requirements, accreditation of settings, elearning environments, teaching and learning tools, assessments, supervision, certification of training, and evaluation.

2.5.12. Selection into training

Adult rehabilitation medicine training can be commenced in the third year after graduation without a period of BPT. Trainees need to have completed two years of post-graduate supervised training in general medical and surgical areas. There is no further stated detail regarding the nature or setting of neither pre-requisite experience, nor how recent that post graduate training was. While there are allowances for formal AFRM trainee selection interviews²², these are rarely undertaken. The faculty advises successful candidates of their eligibility to submit an annual registration form to apply for approval to become a registered Advanced Trainee in Rehabilitation Medicine, which is contingent upon approval of a suitable training program.

It is noted that the College approved a new selection into training policy in 2015, and is currently planning the staged implementation of the new policy from 2017. Consultation on the policy followed comprehensive scoping activities which took place throughout 2013, and detailed development work by a specially convened development working group of Fellows and trainees throughout 2014. At the time of writing, there has not yet been a definitive plan released to change selection to training criteria for adult rehabilitation medicine or other College training programs.

The proposed criteria for entry into training are outlined below (RACP, October 2014):

The candidate demonstrates a commitment to pursuing a career as a physician

The candidate demonstrates the appropriate level of ability, and willingness to progress toward competence, in each of the following domains of the RACP standards framework.

Medical expertise

Medical expertise is central to the function of physicians and draws on the competencies across all domains of the RACP Standards Framework.

Physicians possess a defined body of knowledge, clinical skills, procedural skills and professional attitudes, which are directed to patient-centred care. They apply these skills to collect and interpret information, make clinical decisions, and carry out diagnostic and therapeutic interventions. They do so within the boundaries of their discipline, personal expertise, the healthcare setting and patients' preferences and context. Their care is characterised by up-to-date, resource-efficient clinical practice and effective communication.

Communication

²² From AFRM Training Manual: 'Formal trainee selection interviews are only required in special circumstances. Such circumstances may occur if an applicant wishes to undertake training but has not met the Selection Criteria. The purpose of the interviews would be to review the applicant's training portfolio and clinical experience, and to discuss the objectives and requirements of training in Rehabilitation Medicine.'

In order to provide high-quality care for patients, physicians establish and foster relationships with patients and their families, professional colleagues and systems.

Physicians develop and utilise a range of communication-related skills including diplomacy, confidence and assertiveness. This enables them to obtain and synthesise information from, and discuss relevant issues with, patients and their families, professional colleagues, and systems. Communication skills are characterised by trust, respect, empathy and confidentiality. Communication skills facilitate ability to research, evaluate and disseminate information.

Quality & safety

Quality and safety guidelines uphold the care of patients. Physicians consider quality and safety in every aspect of their practice, from their interactions with patients, to managing and reporting risks and hazards.

Teaching & learning

Physicians engage in continuing personal, professional and educational development. This maintains and extends professional knowledge, clinical skills and technical expertise. This is especially important within the context of growth in knowledge and medical advancements.

Research

Physicians actively contribute to the further research, development, appraisal, understanding and dissemination of health care knowledge among their professional colleagues, students, patients and the broader community.

Cultural competence

Physicians understand the impact of culture on health outcomes. They endeavour to understand cultural perceptions of illness, family, and attitudes toward death held by their patients.

Ethics & professional behaviour

Ethics pervade every aspect of clinical practice, from communication to critical reflection and professional standards. Physicians understand the relationship between health law and practice, and the distinction between law and ethics. Physicians cultivate ethical behaviour and reflection through awareness of ethical principles, health law, and the limits of science on behaviour.

Physicians maintain a professional attitude in their daily practice, striving to meet a high standard of integrity, honesty, positivity, diplomacy, confidence and assertiveness.

Judgement & decision-making

Physicians have a distinct body of knowledge, skills, attitudes and behaviours which enable them to provide clinical care to the highest standards of excellence. The physician's role is to apply reasoning to make complex clinical decisions.

Leadership, management & teamwork

Physicians manage and make decisions about the allocation of personal, professional and organisational resources. They employ communication and professional skills to work within or lead teams of allied health professionals, junior doctors and other colleagues.

Health policy, systems & advocacy

Physicians think beyond the health of the immediate patient. Physicians identify, analyse, respond to, promote, and advocate for, the social, environmental, biological and political factors that determine and impact upon health.

Physicians encourage and educate patients to achieve healthier lifestyles, and prevent injury, ill health and disease. Familiarity with risk factors affecting population subgroups, disease-prevention services and legislation are essential.

2.5.13. Training positions

Faculty trainees are responsible for obtaining suitable training positions with clinical supervisors, by direct application to the relevant employing institution. The faculty and College are not responsible for trainee recruitment.

2.5.14. Local recruitment processes

Each year in August/September some of the faculty branch committees are involved with hospital or regional advisory committees to assist the employing hospitals to interview and place suitable doctors into Rehabilitation Registrar positions for the following 12-month period. There is much variability between regions and states/countries regarding these processes. These interviews are not faculty trainee selection interviews. There is a clear separation of employment (with Health Department doctors as interviewers) and educators (AFRM capacity). Training sites and supervisors are accredited by the faculty. Training programs are prospectively approved.

2.5.15. Approval of training program

At the beginning of each year of training, trainees submit a proposed training program on their annual registration forms, for prospective approval by one of the faculty's training committees. These proposals cover the next two six-month terms. Programs are submitted annually by the trainee and the Teaching and Learning Committee is responsible for their approval.

2.5.16. Oversight of training programs

There is no global governance of the structure/content of the training program terms undertaken by the individual trainee. Recommendations for training in a particular area may be made for trainees in whom an area of inadequacy is noted through an independent review of training process. While it is stated that the Faculty Education Committee (FEC) encourages experience in more than one hospital unit or training setting during the four years of Advanced Training, this is not enacted, unless a trainee's performance comes to formal review.

2.5.17. Training setting accreditation

The faculty accredits settings as suitable for training in rehabilitation medicine, rather than requiring separate applications for each training position available. A setting seeking accreditation must demonstrate to the Accreditation Sub-Committee of the AFRM Education Committee that it has suitable staff, work and caseload facilities available for faculty trainees to permit training in rehabilitation medicine. There are five general standards for accreditation. In order to achieve formal accreditation and two-yearly reaccreditation, facilities are required to complete and submit a training facility accreditation questionnaire. A desktop audit is then conducted. Site visits are conducted on a seven-year cycle.

2.5.18. Teaching and learning

All trainees should have access to informal bedside teaching, as well as at least one hour face-to-face teaching each week from their supervisor, who should be on site at least 50% of the working week, and available by telephone at other times. Trainees in the private sector report that their access to informal and bedside teaching is sometimes restricted compared to training positions in the public setting as supervisors tend to be on site less frequently, often after hours.

All trainees should have access to the monthly two hour bi-national training program via webinar, which covers various aspects of the curriculum in a structured manner. Relevant courses, seminars, conferences and other learning opportunities are noted in the AFRM's weekly e-bulletin, which is an excellent resource.

Individual states and regions also offer additional formal and informal teaching opportunities, including structured support, clinical teaching, examination preparation courses, and trial examinations. Two recent initiatives are identified. The impact of these is yet to be evaluated. They may form useful templates for the future enhancement of teaching and learning at a national or bi-national level:

- Rehabilitation medicine training in Victoria has recently established a Victorian Training Directorate, with the support of the Victorian Department of Health, which has employed a Training Director and a Project Officer and has developed a range of stated aims²³. A website has been established (www.rmtv.org.au), which includes various education resources open only to Victoria trainees and Rehabilitation Physicians.
- A rehabilitation medicine clinical examination preparation course was offered in Sydney for the first time in 2014. This was run independently from the AFRM or RACP. Entry to the course was based on academic success in an online knowledge based examination with the stated aim of ensuring that trainees have the required baseline level of knowledge. All

²³ Victorian Rehabilitation Medicine Training Directorate aims (personal correspondence, Rob Weller and Merrilyn Diverall, November 2013):

1. Increase the quality of rehabilitation medicine training, ensuring consistency with current educational principles
2. Improve the quality of trainees entering the rehabilitation medicine training program
3. Centrally coordinate rehabilitation medicine training opportunities to ensure that trainees have exposure to appropriate training rotations
4. Ensure that regional training positions are filled, thus encouraging Rehabilitation Physicians to move to rural areas once their training is completed
5. Increase awareness and promotion of rehabilitation medicine education and training opportunities amongst medical undergraduates and doctors-in-training.
6. Consider opportunities to integrate rehabilitation medicine training with geriatric medicine and palliative medicine
7. Provide leadership for other stakeholders

trainees who attended the course were successful in the 2014 Fellowship Clinical Examination²⁴.

2.5.19. Supervision

A supervisor is nominated for each term of training. An approved supervisor is normally a Fellow of the faculty, who is a consultant or specialist in rehabilitation medicine, and who is accredited by the FEC to act as a supervisor for Advanced Training in rehabilitation medicine. The primary role of the supervisor during the year is to provide formative assessment (regular feedback on performance). The supervisor also has the responsibility to provide summative assessment (formal determination of competence) to the Education Committee at the end of the term. This report is the faculty's most important means of evaluating the trainee's performance.

The supervisor and trainee meet at the beginning of the term to plan a program of training for the term that is: consistent with the training requirements, appropriate for the stage of training and appropriate to the trainee's needs.

Advanced Trainees must be supervised directly by their nominated supervisor, who is expected to be present on site for at least 50% of the working week (i.e. at least 17.5 hours in inpatient settings) and to be available for advice by telephone or email during the rest of the week. The supervisor is required to provide each trainee with a minimum of at least one hour of dedicated face-to-face teaching time on site each week, separate from the informal teaching conducted during ward rounds and clinics.

An RACP trainee in difficulty support policy to support trainees and supervisors²⁵ will be implemented in 2016. In the meantime, the College has developed two interim pathways and supporting information guides for trainees in difficulty: *Unsuccessful Attempts at Exams* and *Work Based Difficulties*.

Rehabilitation Medicine Supervisors receive support via the RACP's Supervisor Professional Development Program (SPDP), which consists of three components: Three face-to-face workshops, each three hours in length²⁶, online learning and resources and support from Fellows as coaches and Medical Support Officers.

2.5.20. Professional Development Advisors/mentors

²⁴ Personal correspondence, Associate Professor Steven Faux, Course convenor, 18 August 2014.

²⁵ RACP (2015). Trainee support. Retrieved 24 November 2015 from: <http://members.racp.edu.au/page/educational-and-professional-development/trainee-support>

²⁶ The three workshops are facilitated by trained, leading facilitators in regional workshops and at annual scientific meetings throughout Australia and New Zealand. There will be a staged release of these workshops throughout 2013–16.

The FEC suggests that trainees seek a mentor for their three years of Advanced Training, though this is not a program requirement, as it was in the past when all trainees had a centrally appointed mentor. This person should have an understanding of the training requirements and curriculum so they can provide career advice, support, and assistance in seeking training positions.

The mentor's role is to complement that of supervisors, by providing advice and support when required and impartial consideration of conflict situations, should they arise. A mentor should be perceived by a trainee as a senior colleague, aware of the local, specialty and College requirements for training, to which the trainee could turn for professional advice and support at any time during training. The mentor's duties are further detailed in the *Rehabilitation Medicine Training Handbook*.

2.5.21. Governance of training in rehabilitation medicine

The FEC oversees Advanced Training in rehabilitation medicine. The FEC reports to the AFRM Council and the College Education Committee, who in turn report to the College Board.

The FEC is a diverse representative body with physicians and paediatricians from most Australian states and New Zealand. Membership consists of the Chair and the Coordinator of Education, and Chairs of the training committees and working parties responsible for accreditation of settings and supervisors, assessment, the training programs in rehabilitation medicine and paediatric rehabilitation medicine, as well as a member representing New Zealand and one trainee representative.

The FEC formally meets three times per year and, through its committees and working parties, works on matters including accreditation of training sites, accreditation of supervisors, curricula and assessments for Advanced Training, teaching and learning activities for trainees and Fellows, trainee issues and educational policy. College staff members provide support to the FEC and its committees and working parties,

Trainees also have active participation in the governance of training via representation on both the AFRM Trainee Committee (with representation for both the College Trainee Committee, and thus to the RACP Board) as well as to the AFRM FRC and to the AFRM Council.

2.5.22. Rehabilitation medicine curricula

Throughout the training, trainees acquire professional qualities and specialty specific competencies necessary to practise as a Rehabilitation Physician. These competencies are outlined in the two relevant curricula:

Rehabilitation Medicine Advanced Training Curriculum (adult and paediatric)

This curriculum outlines the broad concepts, related learning objectives and the associated theoretical knowledge, clinical skills, attitudes and behaviours required and commonly used by Rehabilitation Physicians within Australia and New Zealand.

Within two key domains (physician competencies and clinical curricula), learning objectives are set out, along with associated knowledge and skills, which describe the clinical competencies and attitudes that are developed via the training program, as summarised below. It is noted that there is currently no guidance regarding weighting within the clinical curriculum to guide trainees regarding the relative time that should be spent on each area of the curriculum.

<p>Domain – clinical competencies</p> <p>Themes</p> <ol style="list-style-type: none"> 1. Patient evaluation 2. Patient management 3. Administration and leadership 4. Prevention 5. Continuing medical education 6. Clinical research 7. Quality management
<p>Domain – clinical curricula</p> <p>Themes</p> <ol style="list-style-type: none"> 1. Cardiac disease 2. Chronic pain 3. Developmental and intellectual disability in adults 4. Injury and illness of the child and adolescent 5. Illness and injury in older people 6. Lower limb amputation 7. Lymphoedema and related disorders 8. Musculoskeletal medicine 9. Neurological disease 10. Occupational injury 11. Spinal cord injury and disease 12. Traumatic brain injury 13. Upper limb amputation

Professional Qualities Curriculum

The Professional Qualities Curriculum is relevant to all of the training programs offered by the College. It covers non-clinical/non-discipline-specific knowledge, skills, attitudes and behaviours required of, and commonly used by, all physicians and paediatricians regardless of specialty or area of expertise. It includes nine domains: communication, quality and safety, teaching and learning, cultural competency, ethics, clinical decision making, leadership and management, health advocacy and the broader context of health.

2.5.23. RACP curricula review

In 2013, The RACP commenced a review of its Basic Training Curricula. While this significant body of work pertains specifically to the Basic Training programs, the model which is developed

and adopted has direct implications for Advanced Training and therefore on training in adult rehabilitation medicine.

Seven important principles are guiding the renewal of College curricula.

1. **Relevant.** Curricula will focus on actual performance in the workplace, recognising on the job experiences.
2. **Flexible.** Curricula will provide guidance on recommended teaching and learning experiences, and avoid restricting innovation at a local level through the over prescription of mandatory learning requirements.
3. **Supported.** Curricula will be user-friendly and supported through technology, teaching and learning resources and professional development.
4. **Current.** Curricula will be subject to ongoing evaluation and renewal to ensure currency of content and embedding of best-practice approaches for physician training.
5. **Continuous.** Curricula will provide milestones to guide trainee progress, and articulate how training programs fit within the continuum of lifelong learning.
6. **Integrated.** Curricula will integrate professional practice domains with medical expertise in recognition of the full scope of competence for effective physicians.
7. **Aligned.** All assessment, teaching and learning, and program evaluation activities will align with curricula standards.

It is anticipated that the revised Basic Training Curricula will be in place from 2018.

Key outputs of the review are outlined below:

Standards framework

A standards framework is an overarching scaffold of defined domains of competence, or standards, common to all members of the profession to which it is applied. Overarching standards frameworks are a common and essential component of competency-based medical education programs. In clearly stating the performance standards expected at each level of training for each domain of the standards framework, the continuum of learning across the domains is defined from Basic Training to Advanced Training and through to Fellowship.

It is an evolution of the standards frameworks already in use at the College, rather than a brand new framework. Standards are listed for each domain, forming a set of competencies common to all graduates of RACP training programs. The standards framework will underpin the curricula for

all RACP training programs. The standards framework sets out the 10 domains of professionalism for physician training:

1. Medical expertise
2. Communication
3. Quality and safety
4. Teaching and learning
5. Research
6. Cultural competence
7. Ethics and professional behaviour
8. Judgement and decision making
9. Leadership, management and teamwork
10. Health policy, systems and advocacy

Broad outcomes will be defined for each domain, forming a set of competencies common to all graduates of RACP training programs.

Figure 5 – RACP Standards Framework



Entrustable professional activities

Renewed curriculum content will focus on two important aspects of the daily practice of expert physicians:

1. The integration of knowledge, skills and attitudes
2. The integration of professional skills with medical expertise

Entrustable Professional Activities are a relatively new educational concept that focuses on real-life performance of work tasks, and the requisite range of medical and professional knowledge, skills and attitudes that support these. Entrustable Professional Activities will form a key

component of the new curricula, and will focus on the most important work tasks of each training program.

Each Entrustable Professional Activity will reflect real-life practice, in that performance of the task requires the synthesis of skills from a range of domains of physician practice, as set out in the RACP standards framework.

For example, an Entrustable Professional Activity may be to “*Conduct a clinical handover*”.

In order to safely conduct clinical handovers with minimal supervision, a trainee will need to draw on a range of standards described in multiple domains of the RACP standards framework, such as *Medical Expertise, Quality and Safety, Ethics and Professional Behaviour* and more.

The Basic Training Curricula Review Working Groups have drafted a number of Entrustable Professional Activities in preparation for broad consultation on new curricula components.

2.5.24. AFRM specific training program components

Specific components of the training program which pertain to discussions which follow are outlined below. Further details regarding the Rehabilitation Medicine Training Program and program requirements can be found here: [http://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/rehabilitation-medicine-\(general\)](http://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/rehabilitation-medicine-(general))

It is noted that, relative to other training programs, there is a high density of program requirements compared to other programs, including both entry and exit examinations.

1. Modules 1 and 2

Module 1

Module 1 is a written two-hour summative assessment consisting of 100 ‘Type A’ Multiple Choice Questions (MCQs), which is held twice each year. Module 1 is offered twice a year (March and September).

Module 1 is an assessment of knowledge based on basic and clinical sciences and includes a broad range of clinical and basic science areas, including: clinical pharmacology, clinical surgery, anatomy, physiology and pathology. Trainees are expected to be familiar with advances in physiology and biochemistry applicable to internal medicine. A detailed curriculum is **not** issued, but trainees are expected to be familiar with the material in current text books of internal medicine, and with the relevant aspects of basic sciences that are applicable to internal medicine and therapeutics.

Questions are sourced from a question bank, which consists of questions from a range of sources, including the past RACP Basic Training question bank, though access to the updated version of this question bank is limited.

Module 2

The objective of the Module 2 summative assessment is to examine the trainee's ability to perform a competent clinical examination and to interpret general medical and surgical problems and other data relevant to Rehabilitation Physicians in the management of rehabilitation patients. The expected standard is 'that expected of a competent post-graduate year three doctor'. It consists of seven stations, with a mixture of live and static and the total duration is approximately 90 minutes.

Trainees are encouraged to sit Modules 1 and 2 during their first year of training, though this is not a requirement. Trainees cannot, however, progress to third year of training until Modules 1 and 2 are successfully completed

Content of Modules 1 and 2

As with the Fellowship examinations, Modules 1 and 2 are prepared and conducted by working parties consisting of Fellows of the AFRM according to detailed procedures, ensuring consistency in the quality and conduct of the examinations. Examinations are extensively reviewed and trialled in detail prior to the examinations to ensure the suitability, relevance, consistency and quality of the assessments and marking schemes. These examinations are large undertakings by the faculty and College staff and consume considerable expense and unpaid volunteer time by dozens of Fellows.

2. Long case assessments

Two in-training long case assessments (ITLCA) are completed for each six-month term, other than in the first and last six months of training (12 in ITLCA in total).

An ITLCA encounter involves a comprehensive review of clinical cases between trainees and assessors. Trainees consult with a patient and complete a written consultation summary sheet, giving consideration to short-term and long-term rehabilitation management plans. Trainees then discuss their patient assessment and proposed management plans with an assessor.

Trainees are given feedback across a range of areas relating to clinical knowledge, clinical decision-making and patient management from an assessor immediately after the interview.

An ITLCA encounter evaluates trainees in real-life settings and assesses their level of professional expertise and judgement exercised in clinical cases.

An ITLCA is designed to:

- Guide trainees' learning through structured feedback
- Help improve communication, history taking, clinical decision making, clinical knowledge and patient management
- Provide trainees with an opportunity to discuss their approach to the case and identify strategies to improve their practice

- Be a teaching opportunity enabling assessors to share their professional knowledge and experience.

Cases for consultations and discussion are chosen by the assessor, with trainees to complete encounters on a range of cases. Each encounter should represent a different clinical problem. Trainees should have had no previous contact with the patient. Trainees are responsible for ensuring that adequate encounters are completed and that most assessable areas outlined in their respective Advanced Training curriculum are covered.

ITLCAs are similar to the case-based discussion, used in the College's Divisional Advanced Training Programs. These are formative assessments.

Additionally, two formal long case summative assessments are completed in the final year of training and are carried out under examination conditions by two Fellows of the AFRM, one of whom must be an accredited Long Case Assessor. Their purpose is to evaluate the level of professional judgement exercised by the trainee in managing common clinical problems in rehabilitation medicine, and the trainee receives no feedback regarding their performance.

There has been extensive work on calibrating and standardising ITLCA through long case calibration sessions which are held regularly, including at the AFRM Annual Scientific Meeting.

Long case assessments were previously part of the Fellowship Clinical Examinations of the AFRM until 2002. They were removed because they were shown statistically to be a poor discriminator for candidates as the pass rate was high.

3. External training Modules 3 to 6

There are four external training modules, which are assignment-based courses marked by correspondence. Other than Module 5, all must be submitted by 1 April in the year Fellowship Examinations are first attempted (third or fourth year of training).

External training Module 3 – Clinical Research

Trainees can either complete this summative assessment requirement or complete the research project requirement.

The objective of this course is to familiarise trainees with the main stages of the clinical research process, so that they will be able to:

- Clinically evaluate the experimental design, methodology and statistical analysis of published research on rehabilitation medicine
- Design and undertake a limited clinical research project.

After accessing and reading critical appraisal guidelines, trainees are required to evaluate two published research articles and write 600-word reports describing the methodology and results for each one. Trainees will also be required to design and implement a limited clinical research project. The final presentation of the project should be in a format suitable for journal publication, and be no longer than 3,000 words.

External Training Module 4 – Clinical Neuropsychology

The objective of the course is to provide the trainees with a neuropsychological perspective of brain impairment, and to introduce some of the major neuropsychological syndromes encountered in patients referred to a rehabilitation medicine unit.

Five essay type answers of approximately 600 words each must be submitted for each of the following topics:

- Severe traumatic brain injury
- Mild traumatic brain injury
- Dementia
- Disorders of frontal lobe dysfunctioning
- Apraxia/agnosia/visuoperceptual problems.

External Training Module 5 – Health Services Administration and Evaluation

The objective of the course is to provide the trainees with the necessary knowledge and skills to attain competency in administration and leadership and quality management for Rehabilitation Physicians. The competencies required of a Rehabilitation Physician are outlined in the Rehabilitation Medicine Advanced Training Curriculum.

At the conclusion of this module, trainees should be able to:

- Demonstrate sound knowledge of the administration of a rehabilitation service, including skills in leadership and management of an interdisciplinary team
- Understand current quality management practices and be able to assess the quality of rehabilitation programs and outcomes.

Two written assignments (2,000 words each) must be selected and submitted from topics such as: administration and leadership of a rehabilitation service, safety and quality in healthcare, using evidence-based research to improve health outcomes.

OR

An accredited workshop on management or leadership for clinicians (of at least two days) must be completed.

External Training Module 6 – Behavioural Sciences

The objective of the course is to provide the trainees with an understanding of psychological and sociological theories and research relevant to the understanding of how people experience disability and rehabilitation.

At the completion of this course, trainees will be able to:

- Employ relevant behavioural sciences concepts to describe and/or explain issues in rehabilitation

- Use selected examples of the behavioural sciences literature to explore psycho-behavioural and psychosocial aspects of rehabilitation
- Write about contemporary issues in rehabilitation medicine in a manner that displays knowledge of, and readings in, the behavioural sciences
- Identify and understand that rehabilitation is influenced by geographical, social and cultural factors.

Trainees will have the opportunity to relate concepts and processes in rehabilitation medicine to psychological, behavioural and social sciences literature, theories and research, and to develop an understanding of theories and research in behavioural sciences relevant to:

- People with disability in society
- A person's experience of becoming and being disabled
- Psychological, social and cultural factors influencing rehabilitation
- Rural and remote communities.

Trainees are required to submit four written assignment papers of 2,000 words each.

Section A consists of one topic (The biopsychosocial model of medical care) which is a compulsory assignment for all trainees.

Trainees must then choose one assignment from the topics listed in each of the following sections:

Section B – *The process/experience of rehabilitation*

Section C – *The process/experience of disability*

Section D – *Rural, remote and culturally appropriate rehabilitation.*

Assignments are to be written in formal academic style, including a comprehensive list of references presented in the form used in the reading list.

4. Fellowship Written Examination

The Fellowship Written Examination can be attempted in the third or fourth year of training. There are two papers, the short answer paper, and the multiple choice paper. These were conducted on the one day but, since 2013, they have been 'unbundled' as they are considered as separate assessment outcomes. Consistent with the PREP guidelines, there is a three-attempt limit on Fellowship examinations.

The short answers paper includes eight guided scenario short answer questions, which take the form of an emerging scenario, with multiple questions. The examination's stated objectives are to:

- Evaluate and assess complex problems of a clinical or administrative nature
- Communicate relevant information in a clear written form, within the limited time available

- Demonstrate an awareness of the judgement of priorities, and the importance of sensitive interdisciplinary planning and liaison
- Adopt an orderly, logical and mature approach to current areas of debate and controversy in disability management.

The current written examination has evolved from a paper which previously consisted of eight traditional essay questions in which candidates formulated a management plan in the context of a detailed clinical scenario. The number of traditional essays has progressively gone down, and since 2014, the paper has consisted wholly of guided emerging scenario questions.

The multiple choice paper consists of 130 'Type A' MCQs which cover the breadth of the clinical curriculum.

5. Fellowship Clinical Examination

The Fellowship Clinical Examination can be attempted in the third or fourth year of training after completion of external training modules other than Health Service. Consistent with the PREP guidelines, there is a three attempt limit on Fellowship examinations.

As stated in the *2014 Rehabilitation handbook*, the objective of this assessment is to evaluate the trainee's competence when dealing with clinical problems and tasks relevant to the practice of rehabilitation medicine, as set out in the Rehabilitation Medicine Advanced Training Curriculum.

It takes the form of a standardised clinical examination, with 12 stations over a period of two and a half to three hours. In accordance with the pre-determined criteria set for each station, candidates are required to demonstrate a satisfactory performance across all areas of the Fellowship Clinical Examination. Each station presents a different clinical scenario and sets out a specific written task or problem. Each station is eight minutes long, with a short (three-minute) break between stations.

Both the Fellowship Written Examination and Clinical Examination are prepared and conducted by working parties consisting of Fellows of the AFRM according to detailed procedures, ensuring consistency in the quality and conduct of the examinations. Examinations are prepared with constant reference to the curricula and are extensively reviewed and trialled in detail prior to the examinations to ensure the suitability, relevance, consistency and quality of the assessments and marking schemes. These examinations are large undertakings by the faculty and consume considerable expense, and unpaid volunteer time by dozens of Fellows.

6. Learning Needs Analysis

Trainees complete a Learning Needs Analysis in conjunction with their supervisor at the commencement of each six-month term. It involves the trainee creating a learning plan that outlines their learning objectives and goals for their current rotation. Trainees refer to this throughout their training term. At the conclusion of each training term, the trainee evaluates their learning plan to determine whether they have achieved their desired goals, and identify additional areas to focus on in the future.

The Learning Needs Analysis tool is linked to both the Rehabilitation Medicine Advanced Training Curriculum and the Professional Qualities Curriculum to allow trainees to use the learning objectives determined within these curricula as a basis for their learning plan.

7. *Supervisor's Report*

The Supervisor's Report is a summative assessment of the trainee's period of training completed by their supervisor(s).

If the supervisor has not directly supervised the trainee throughout the term, the supervisor should obtain individual reports from those who have directly supervised the trainee, and provide a composite report.

Progression to the next year of training cannot occur until two Supervisor's Reports have been received and assessed as satisfactory by the Training Committee of the FEC.

It is the trainee's responsibility to pass their Supervisor's Report on to the next year's/rotation's supervisor. This is a new requirement which is included in the current AFRM training handbook for 2014. The College may provide subsequent supervisors with copies of past reports (and any other documents deemed relevant to the trainee's training).

8. *Trainee term evaluation*

The Trainee Term Evaluation Form is completed for each rotation, and should be completed before the trainee leaves the training setting for that term. It provides feedback to the faculty about a trainee's training experience for each six-month period. Progression to the next year will not occur until the trainee has submitted two Trainee Term Evaluation Forms:

Before recommendation to Fellowship, all required Trainee Term Evaluation Forms must have been submitted.

Along with the Supervisor's Reports, the Trainee Term Evaluation Form provides the principal basis upon which certification of the training program is determined.

All information provided is treated as confidential, with a College staff administrator and the New Fellow Representative being the only persons with access to the completed Trainee Term Evaluation Forms.

Information provided is de-identified and added to a training settings database that is accessed as part of the review cycle for accreditation of training settings.

Trainees are required to rate their actual experience in the following areas:

- Orientation
- Workload
- Teaching and learning on the job
- Leadership opportunities
- Additional training opportunities
- Skills supervision.

If the feedback indicates that a trainee has had significant concerns or difficulties, the New Fellow Representative will contact them to discuss possible follow-up action

9. Supervisor meetings

The supervisor should meet formally with the trainee at the commencement of each new term in order to discuss and clarify the trainee's learning goals, and the roles and responsibilities of both the supervisor and the trainee. This is when the Statement of Responsibilities in Advanced Training should be discussed and signed.

Formative assessment interviews should then be held after two months and four months for each six-month training term, to discuss the progress being made by the trainee with regard to the agreed objectives of training and the specific training term.

Trainees are encouraged to evaluate themselves before each meeting in order to benefit from the opportunity for collaborative reflection and goal-setting.

Both positive and negative aspects of the evaluation should be discussed at the interviews. Where performance in any area has been unsatisfactory, the supervisor must indicate and document any agreed remedial action to be taken. The next meeting should address the effectiveness of such action, and the need (if any) for further action.

Expectations must be congruent with the level of training and the trainee's past clinical experience.

10. Functional Independence Measure (FIM™) training course

FIM™ is an important tool for Rehabilitation Physicians, and most staff members in rehabilitation units are expected to be FIM™ credentialed. From January 2011, completion of formal FIM™ training is a mandatory requirement for all new trainees commencing Advanced Training in Rehabilitation Medicine, and is highly recommended for all existing faculty trainees. The FIM™ instrument is a functional assessment scale for collecting uniform measurement and data on disability and rehabilitation outcomes.

It should be noted that final certification for Fellowship may be delayed unless the FEC is satisfied that all the requirements for the training program have been adequately met.

3. Aims and Methods

Rehabilitation medicine is one of the most rapidly growing specialties in Australasia and plays a vital role in the functioning of the health care system. Rehabilitation medicine has undergone rapid and significant evolution over the last decade, including settings, casemix, greater acuity and our role in the National Disability Insurance Scheme. The demand for rehabilitation medicine will increase with population growth and ageing and ageing with disability. The specialty itself is adjusting to these rapid changes. Full realisation and acceptance of the role of rehabilitation medicine in the broader health context is yet to be realised.

The current rehabilitation training program sits within the RACP educational framework as an Advanced Training faculty program. There is a high density of training program elements within the training program. While the supply of trainees has increased to meet demand in many settings, there is an ongoing mismatch in the geographical supply and demand for rehabilitation doctors.

In the context of rapid change within the specialty of rehabilitation medicine, and amidst other change within the College, the training program needs to be reviewed to ensure it is 'fit for purpose', and relevant recommendations made to increase its relevance to its stated purpose.

3.1. *Aims*

These contextual factors prompt a review of the existing rehabilitation medicine training program, which is the purpose of this body of work, with the following stated aims:

1. To evaluate the adult rehabilitation medicine training program and identify factors which need to be strengthened and those which may need to be modified
2. To identify options to equip the adult rehabilitation medicine training program to meet the future needs of the specialty
3. To conduct a detailed review of the option of restructuring the existing training program to RACP Basic Training with Advanced Training in rehabilitation medicine via the Adult Medicine Division (the FRACP option).

3.2. *Method*

1. **Coordinator of Education**

An AFRM Coordinator of Education (the author of this paper) was appointed for 12 months from July 2013 to carry out this work, in conjunction with an educationalist, Andrew Dostine, who performed the curriculum mapping exercise.

2. **Consultation**

AFRM members (Fellows and trainees) were invited to provide feedback regarding the training program to the Coordinator of Education in a range of formal and informal options, including face-to-face meetings, telephone, email, vigorous discussion at the 2013 and 2014 AFRM member meetings and via an online member survey.

3. Evaluation of the training program

In response to the consultation, an evaluation of the training program was conducted using the SWOT analysis format, examining the strengths, weaknesses, opportunities and threats related to the training program.

The origin of the SWOT analysis technique²⁷ is credited to Albert Humphrey in the 1960s and 1970s as a tool used in strategically analysing a business, often at a time where structural or procedural changes are being considered. It facilitates an understanding of the positive and negative aspects of an organisation's internal and external environments. The acronym stands for:

- Strengths – internal positive factors be maintained, built on or leveraged
- Weaknesses – internal negative aspects to be remedied, changed or stopped
- Opportunities – external positive factors to be prioritised, captured and built on
- Threats – external negative factors to be countered, minimised or managed.

4. Identify and evaluate options for change

In response to the SWOT analysis, a range of options for change was identified. These relate to the training program as a whole, as well as to specific options to modify or substantially change the training program.

5. Detailed review of the FRACP option

This option was reviewed in greater depth: specifically the practicalities and implications of implementing such a change, contrasting it to the current training program, the specific advantages and disadvantages of such a change and how it addresses the aspects of the SWOT analysis.

6. Competency mapping

Competency mapping analysis between the Adult Internal Medicine Basic Training Curriculum and the Adult Rehabilitation Medicine Advanced Training Curriculum was undertaken by an educationalist (Andrew Dostine), and curriculum specifications for Advanced Training in adult rehabilitation medicine under this model were delineated.

²⁷ Humphrey, A (December 2005). ' . *SRI Alumni Newsletter* (SRI International).

4. Results

4.1. Consultation

AFRM members enthusiastically provided feedback to the Coordinator of Education in a number of different formats, including face-to-face meetings, telephone discussions, email, as well as two general member meetings which were conducted at the annual scientific meetings of the AFRM in 2013 and 2014.

All members also had the opportunity to provide feedback in the AFRM online survey: “Rehabilitation – The Years Ahead”. This survey was prepared to facilitate comment and input from AFRM members (trainees and members) regarding the training program in rehabilitation medicine and potential changes. It received a strong response and demographics of respondents were consistent with overall AFRM member demographics, increasing confidence in applying these results more broadly.

4.2. Online survey on rehabilitation training

The survey was prepared via the Survey Monkey platform, and was open from 10 March 2014 to 2 June 2014. Responses were collected anonymously.

Two hundred and eleven responses were received, representing 29% of the 737 individuals to whom the survey was sent. The demographics of the electronic survey respondents were consistent with known AFRM member demographics, enhancing confidence in the generalisability of the responses.

4.2.1. Demographics of respondents

Demographics of the respondents are presented in the Table 6. Of the respondents, 93.5% currently worked in Australia, 68% were Adult Rehabilitation Medicine Fellows, and 24.3% Adult Rehabilitation Medicine Trainees, with 2.2% and 0.45% being Paediatric Rehabilitation Medicine Fellows and Trainees respectively. In terms of gender, 45.4% of respondents were female and 52.7% male. Of respondents, 81.1% had completed their primary medical degree in Australia.

The demographics of survey respondents closely matched known College AFRM membership parameters, as shown in Table 5 below. As at 21 August 2014, there were 757 AFRM Members of the College. Of these 67.9% were Adult Rehabilitation Medicine Fellows, 25.5% were Adult Rehabilitation Medicine Trainees, with 4.5% being Paediatric Rehabilitation Medicine Fellows and 2.1% Paediatric Rehabilitation Medicine Trainees. In terms of gender, 45.6% of AFRM members were female and 54.4% male. No comparative data is available on the proportion of AFRM members who have completed their primary medical degree in Australia or the proportion who currently work in Australia.

Table 6 – Comparative data – training survey respondents and AFRM members

	Respondents number (survey)	Respondents %	RACP Number ²	RACP %
Adult RM Fellows ¹	129	68%	514	67.9%
Paed RM Fellows ¹	4	2.2%	34	4.5%
Adult RM trainees	45	24.3%	193	25.5%
Paed RM Trainees	1	0.5%	16	2.1%
Other	8	3.8%	-	-
Skipped question	25	11.8%	-	-
Total	212		757	
Male (total)	112	45.4%	412	54.4%
Female (total)	95	52.7%	345	45.6%
No gender specified	5	2.36%	-	
Total	212	100%	757³	100%

1. Number of Fellows surveyed (757) include active and retired Fellows as at 10/3/2014.
2. Total RACP Fellow and trainee figures are from RACP database as at 21/8/2014.
3. Total RACP AFRM figure (757) may be higher than surveyed recipient number (737) due to some Fellows electing not to receive survey emails from the College.

The average period since completion of the primary medical degree was 21.2 years (see Figure 6), and the average time elapsed since entering specialist training was 14.5 years (see Figure 7).

Figure 6 – Results for question ‘In what year did you complete your primary medical degree?’ from training survey

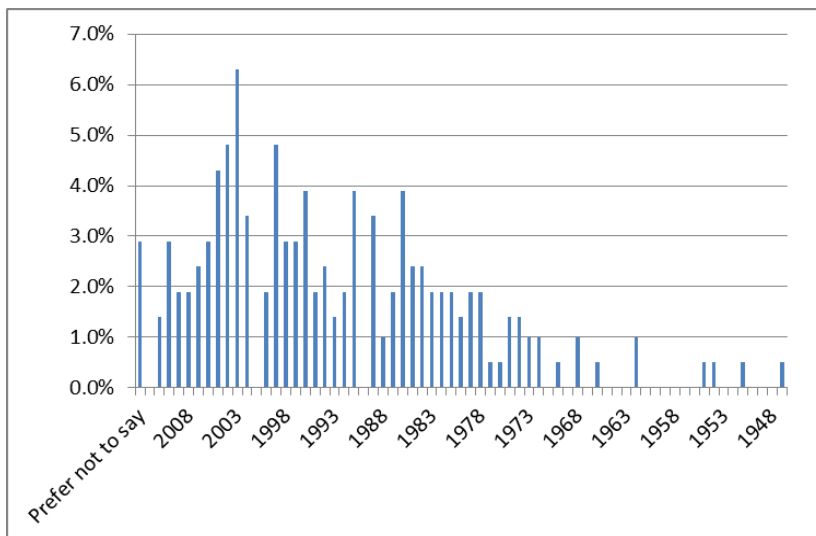
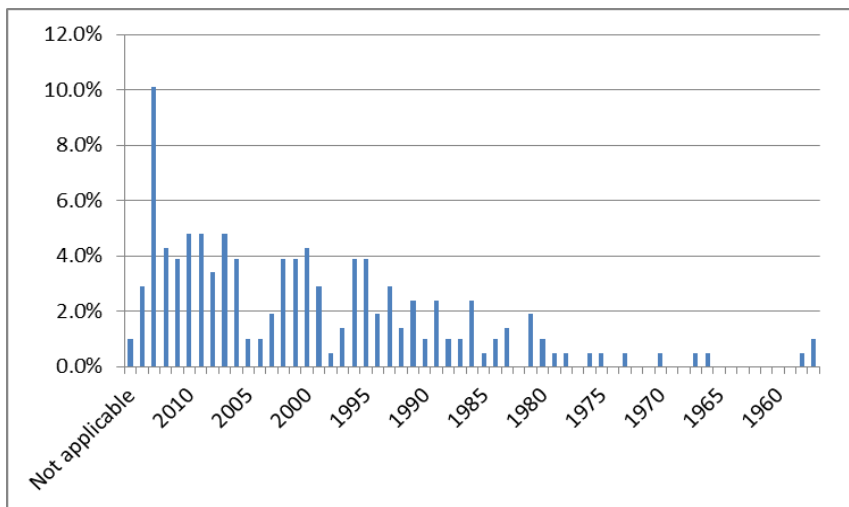


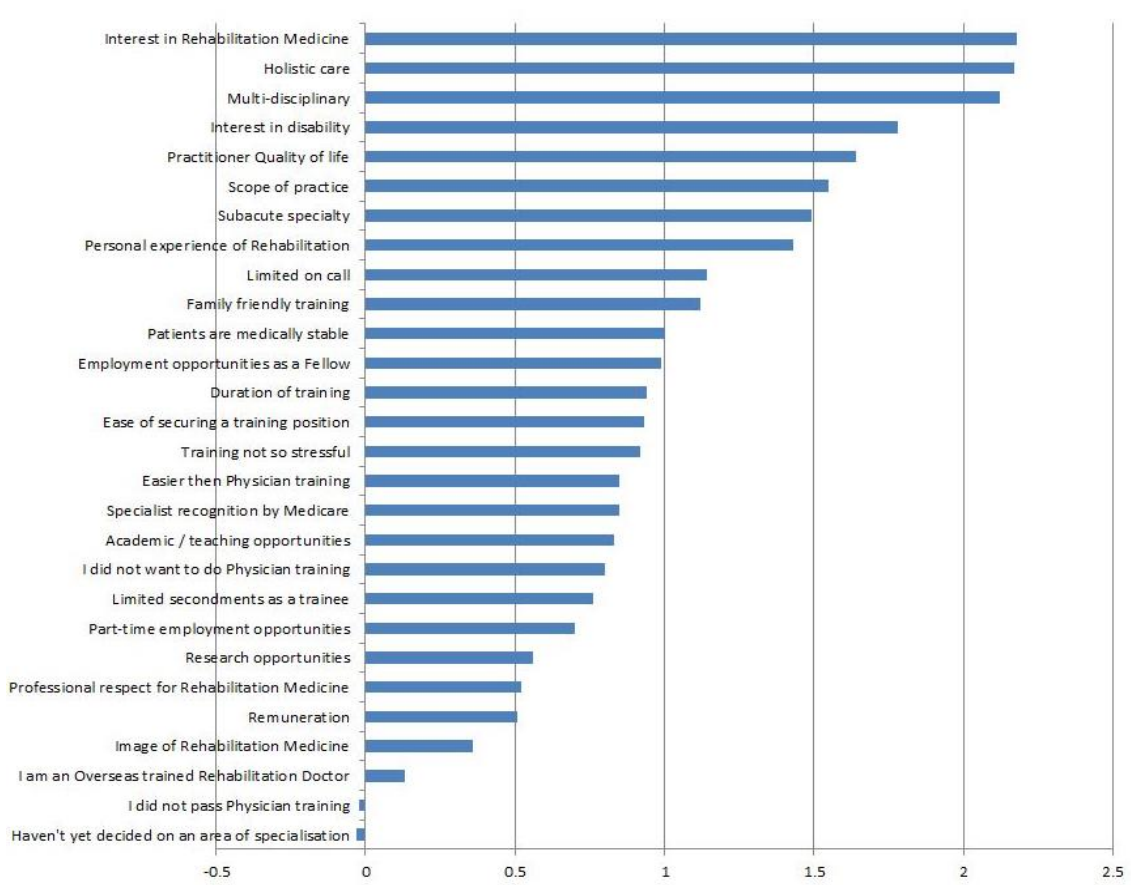
Figure 7 – Results for question ‘In what year did you enter specialist training?’ from training survey



4.2.2. Influences on decision to specialise in rehabilitation medicine

Respondents were asked to rate how influential various factors were on their choice to self-select into the specialty of rehabilitation medicine, ranging from ‘negative influence’ (-1), through to ‘very important influence’ (+2). The results are shown graphically in Figure 8 below.

Figure 8 – Influence of factor on self-selection into rehabilitation medicine



There is a great diversity of reasons for self-selection into rehabilitation training, many of which relate to the training scheme itself. Consequently, changes to the training scheme structure, content and entry requirements may impact on Rehabilitation Medicine Trainee numbers. Consideration of factors which both positively and negatively influence the individual's decision to specialise in rehabilitation medicine must be considered, especially if changes to the training program are on the table.

Factors identified as being important in self-selection into rehabilitation medicine relate predominantly to the specialty itself: an interest in rehabilitation medicine, the multi-disciplinary and holistic nature of the work, rehabilitation medicine is a subacute specialty, as well as a personal experience with rehabilitation.

The least influential factors impacting on self-selection into a career in rehabilitation medicine were: being unsuccessful in physician training, the availability of part-time employment opportunities, remuneration and the availability of research opportunities.

Factors with a negative influence on a decision to specialise in rehabilitation medicine were the image of, and professional respect for rehabilitation medicine. If trainees are to be attracted into the specialty, these factors must be assertively addressed.

Additional factors identified as influencing a decision to specialise in rehabilitation medicine identified by survey respondents are outlined below:

- Interest in neurology
- Interest in musculoskeletal medicine
- Truncated specialisation time with other specialist qualifications (e.g. general practice) reducing training time. (Note that, with the exception of first part physician examinations, other specialist qualifications no longer reduce rehabilitation medicine training duration)
- Relevance of rehabilitation medicine training to the practice of the specialty (compared to BPT)
- Rehabilitation medicine is a developing area of medicine.

Rehabilitation training conditions are identified as being a positive factor in self-selection into rehabilitation medicine training were important for some, probably for those with additional commitments such as family or external study obligations. For most, these factors are likely to represent additional advantages rather than the prime motivator in selecting this career path. The training conditions which had a strongly positive influence on self-section into training included:

- Limited on-call requirements (compared to some specialties) (13% of respondents)
- Availability of part-time employment (9%)
- Limited secondment requirements (6%)
- Family friendly training (11%)
- Training not so stressful (11%)
- Relatively short duration of training compared to other specialties (6%).

'At the time I started training, it was not obvious that part time training was available, nor that rehab medicine was family friendly. If they had been more obvious at the time, I would have rated these 2 highly.'

From training survey

This survey was only sent to members of the AFRM. Because those not specialising in rehabilitation medicine were not surveyed, reasons that dissuaded people from specialising in rehabilitation medicine were not explored. In an effort to increase quality trainee numbers, investigating reasons why people chose not to pursue a career in rehabilitation medicine should be investigated.

4.2.3. Issues facing rehabilitation medicine

Respondents were asked to rate the relative importance of various issues facing rehabilitation medicine in the coming years. Their responses were converted to a number ranging from 0 (not important at all) to 4 (critical importance).

The results were considered in two ways: percentage of respondents who ranked the various issues as being of 'critical importance', and the average rating out of 4 for each issue. These results are presented in the two following Figures.

The most important issues facing rehabilitation medicine in the coming two decades as identified by members relate directly to the training program, particularly the quality and content of the training program and knowledge and skills to manage chronic disability ageing with a disability, and rehabilitation of the older person occupying four of the top 10 concerns. Other key issues of concern relate to leadership within rehabilitation, credibility and image of rehabilitation, and employment opportunities for Fellows.

Additional important issues identified by respondents:

- Need for rehabilitation medicine community to have stronger links with non-government organisations and consumer organisations for people with a disability
- Concern regarding the requirement for Australasian medical registration as a pre-requisite for taking the Fellowship examination
- Restrictive examination requirements and training/professional registration for international medical graduates who have spent time working/training in Australia.

'Should not require trainees from comparable English-speaking countries e.g. Singapore and who have undergone clinical training in Australia to have Australian medical registration as a pre-requisite for taking Fellowship examination.'

From training survey

Figure 9 – % of perceive this issue as being of critical importance

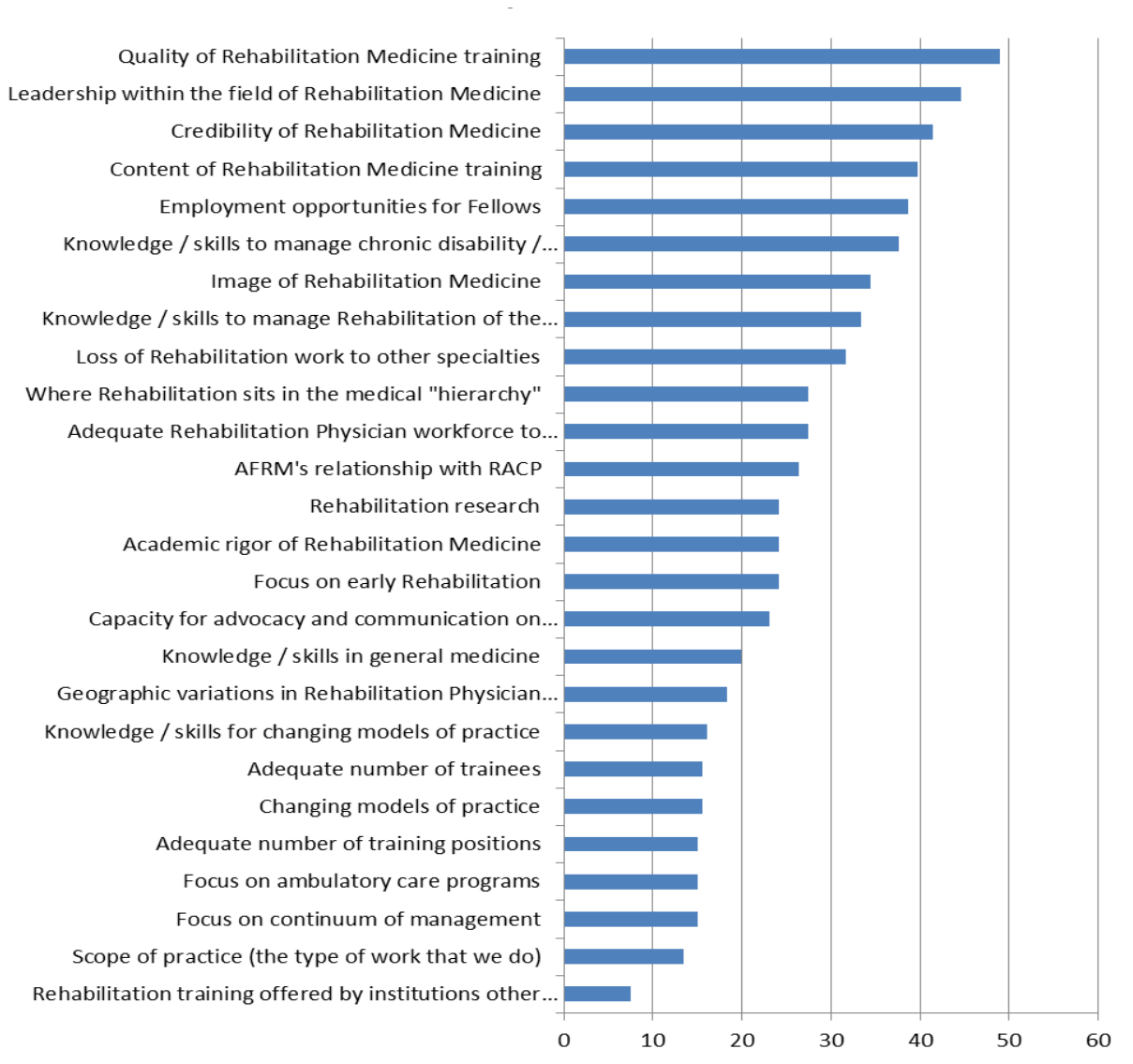
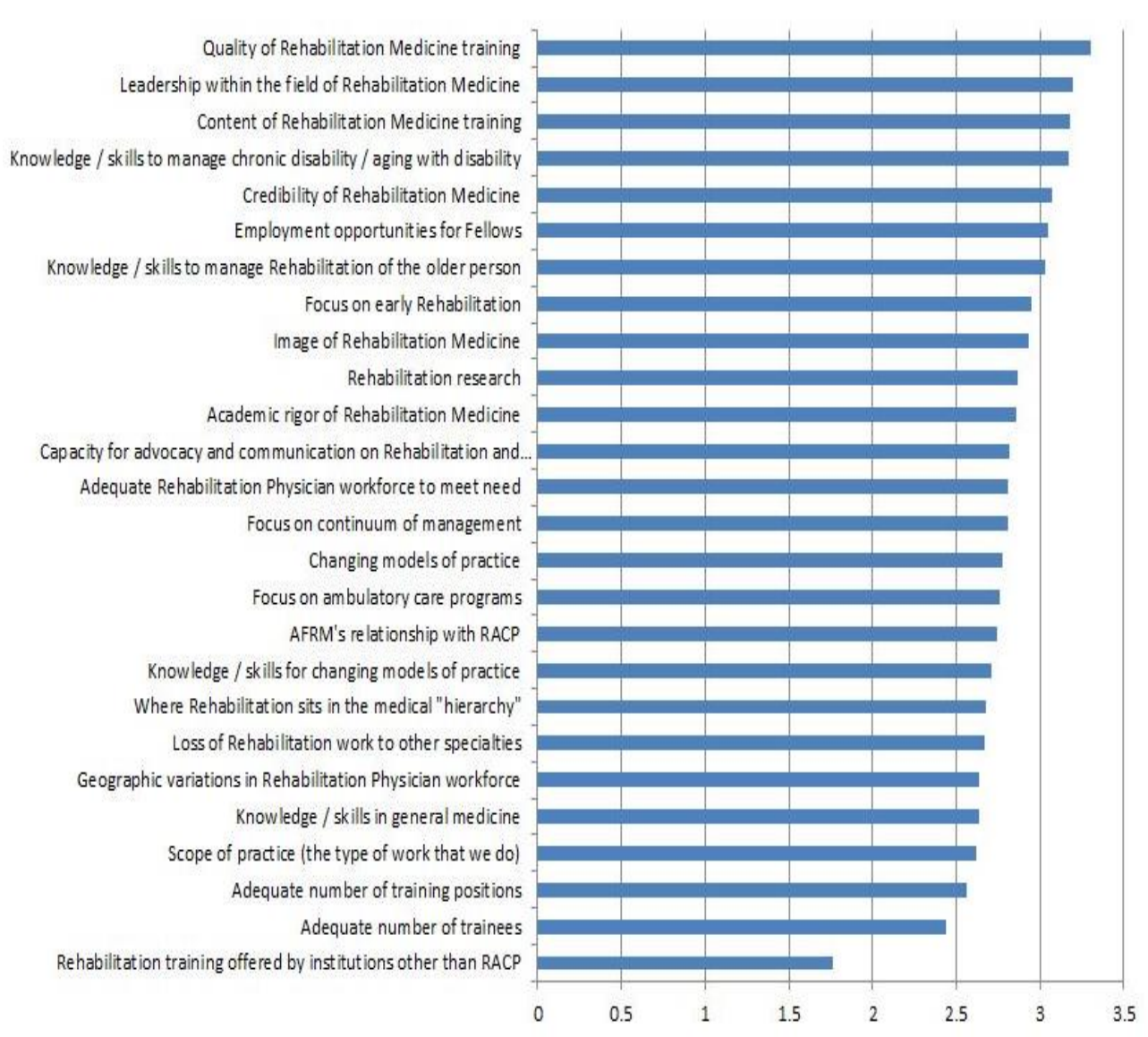


Figure 10 – Importance of issue (score out of 10)



4.2.4. Satisfaction with components of training program

Respondents rated their level of satisfaction with various aspects of the training program on a scale from 0 to 10, where 0 was 'extremely dissatisfied' and 10 was 'fully satisfied'.

Aspects of the rehabilitation medicine training program rated most highly by respondents were:

- Duration
- Prosthetics course
- Timing of Fellowship examinations.

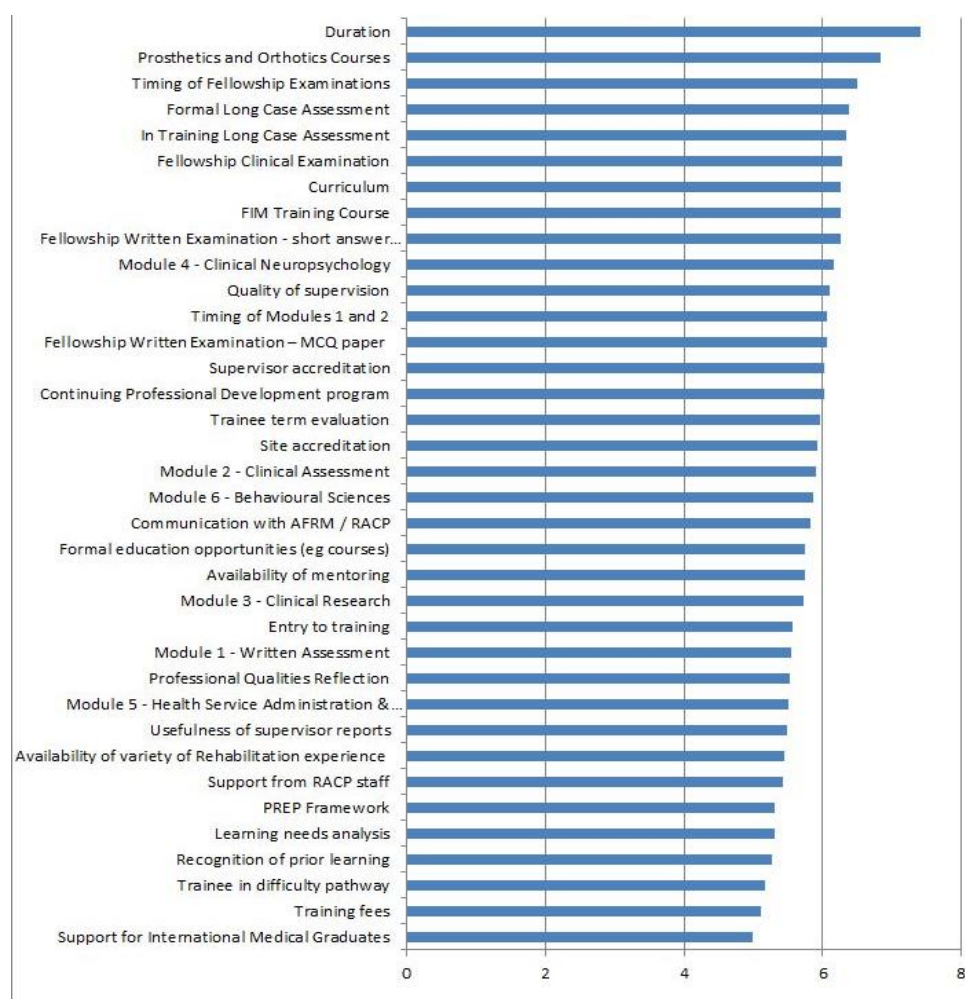
It is relevant to note that the prosthetics course is not a mandatory component of the rehabilitation training program, but is strongly recommended, with implications that the optional aspect of this course should be reviewed.

Aspects of rehabilitation training rated most poorly by respondents were:

- Support for international graduates
- Training fees
- Trainee in difficulty pathway
- Recognition of prior learning
- Learning needs analysis
- PREP framework.

These results are presented graphically in Figure 11 below:

Figure 11 – Satisfaction with aspect of training program (score out of 10)



4.2.5. Options for change to training program

The degree of member support for a range of potential changes to the training program was determined – ranging from ‘strongly disagree’ (ascribed a score of -3) to ‘neither agree, nor disagree’ (given a score of 0) to ‘strongly agree’ (given a score of +3).

Regarding the contentious option of changing the current training program to the FRACP option, 41% were in favour of, and 49% were opposed to the changing adult rehabilitation medicine training to RACP Basic Training with Advanced Training in rehabilitation medicine via the Adult Medicine Division.

Of the options for change included in the survey, the strongest support was for:

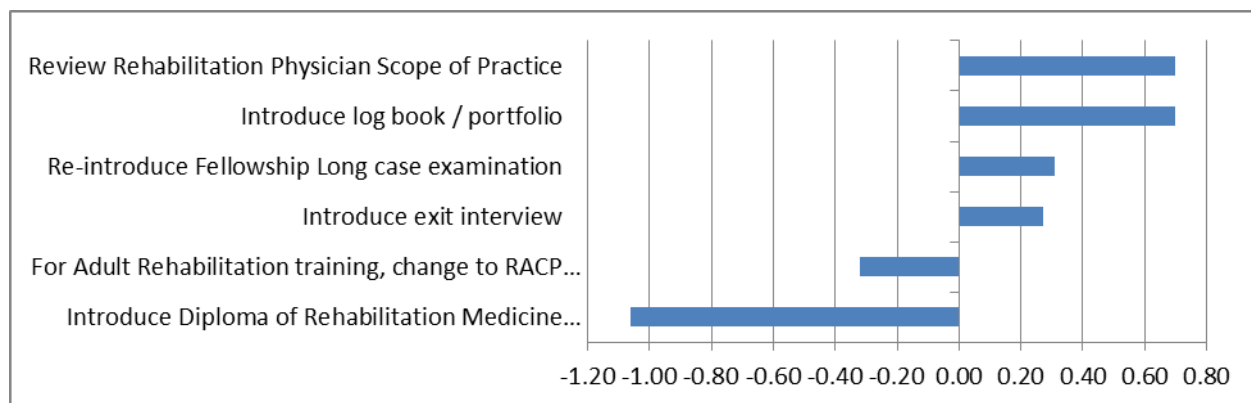
- Introduction of a log book/portfolio
- Review of the Rehabilitation Physician Scope of Practice
- Reintroduction of the Fellowship long case examination.

These results are presented in Table 6 and Figure 12 below.

Table 6 – Support for options for change from training survey

	Disagree	Neutral	Agree
Introduce log book/portfolio	19.3%	23.6%	57.1%
Reintroduce Fellowship long case examination	33.5%	13.7%	52.8%
Introduce exit interview	29.2%	23.0%	47.8%
For adult rehabilitation training, change to RACP Basic Training with Advanced Training in Rehabilitation Medicine via Adult Medicine Division	49.1%	9.9%	41.0%
Introduce Diploma of Rehabilitation Medicine (alternative pathway for fellows of other colleges with an interest in rehabilitation medicine)	60.9%	18.0%	21.1%
Review Rehabilitation Physician Scope of Practice	14.9%	30.4%	54.7%

Figure 12 – Support for options for change from training survey



4.2.6. Satisfaction with aspects of being a Rehabilitation Medicine Trainee

Respondents were asked to rate their level of satisfaction with various aspects of trainee qualities, and also aspects of trainee life.

As shown in Table 7 below, greatest satisfaction was reported with:

- Quality of life
- Work/life/study balance for trainees
- Their attitude to patients, family and colleagues.

As shown in Table 7 below, least satisfaction was reported with:

- Trainees' medical knowledge and skills at entry to training
- Verbal and written communication skills.

Table 7 – Level of satisfaction of Rehabilitation Medicine Trainees

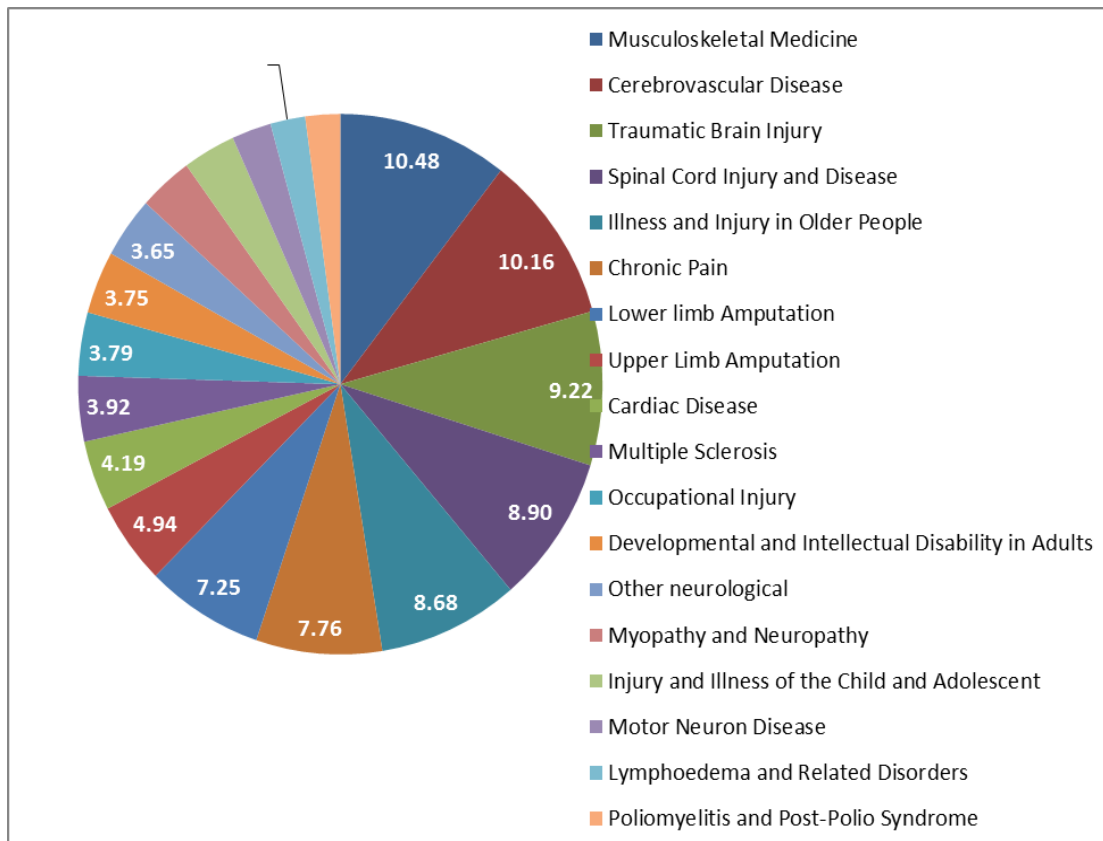
Regarding your recent experience with Rehabilitation Medicine Trainees, or as a trainee, indicate your level of satisfaction with each of the following on a scale from 0 to 10, where 0 is extremely dissatisfied and 10 is fully satisfied													
Answer Options	0	1	2	3	4	5	6	7	8	9	10	Rating Average	Response Count
Medical knowledge and skills at entry to training	2	4	13	12	20	35	21	28	17	4	6	5.40	162
Verbal communication	0	6	4	12	16	26	30	26	26	6	10	5.98	162
Written communication	0	5	4	12	17	24	31	32	26	4	7	5.93	162
Attitude to patients and family	0	1	3	3	7	20	33	36	29	13	17	6.87	162
Attitude to supervisors	0	1	0	9	5	24	27	33	33	15	15	6.85	162
Attitude to other colleagues	0	1	2	6	8	19	29	34	33	17	13	6.85	162
Attitude to receiving feedback	1	2	3	13	11	21	28	31	26	14	12	6.39	162
Attitude to learning	2	5	4	6	15	20	24	30	26	17	13	6.40	162
Attitude to assessments	3	4	4	4	21	18	22	33	29	13	11	6.30	162
Workload	1	3	5	5	13	31	21	34	31	8	10	6.29	162
Junior Medical Officer support	5	2	4	6	13	34	25	30	29	10	4	6.00	162
Stress levels	2	1	3	3	10	41	28	40	22	8	4	6.15	162
Quality of life	0	0	3	0	5	26	24	35	44	17	8	6.98	162
Work/study/life balance	0	0	4	4	2	28	26	37	40	15	6	6.78	162
Other/comments													21
answered question													162
skipped question													45

4.2.6. Recommended Rehabilitation Medicine Clinical Curriculum

Respondents were asked about the weightings which should be assigned to topic areas (themes) from within the existing Advanced Training Clinical Curriculum in Adult Rehabilitation Medicine.

The combined recommended curriculum weightings are shown below. This data should be used to inform any future curriculum development.

Figure 13 – Recommended curriculum weightings



There were additional suggestions for excurriculum topics which could augment the existing curriculum:

- General medicine
- Debility (which could include topics of general medicine such as renal, cardiac and respiratory failure, and obesity rehabilitation)
- Orthotics
- General rehabilitation topics which pertain to multiple categories within the existing curriculum)
- Neurophysiology and diagnostic ultrasound skills
- Pulmonary rehabilitation
- Burns rehabilitation
- Novel methodologies in rehabilitation medicine, such as robotics
 - Medico-legal report writing (add to Professional Qualities Curriculum, or add as an external module).

Some respondents expressed difficulties in assigning a particular percentage rating to the existing curriculum because there are many general rehabilitation topics which cross the boundaries of individual system/imparimrent topic areas. This has important implications in the potential redesign of a future rehabilitation curriculum. This issue should be addressed in future curriculum refinement. Consideration should be given to a change in the structure of the curriculum so that impairments which are relevant to several diagnoses are addressed separately.

4.3. *Evaluation of the training program: SWOT analysis*

In response to the feedback provided through the various avenues available, the Rehabilitation Medicine Training Program was evaluated according to the SWOT analysis, identifying the strengths, weaknesses, opportunities and threats pertaining to the training program.

This model provided a useful starting point from which to evaluate the various aspects of the training program so that the things which are working well can be reinforced, strengthened and protected, and so that the less positive aspects can be remediated in a positive practical manner.

The summary points of the SWOT analysis are presented below (Table 8) and will be discussed in greater detail in the coming chapters.

Table 8 – SWOT analysis summary

	Helpful	Unhelpful
Internal	<p>Strengths</p> <ol style="list-style-type: none"> 1. Quality of the rehabilitation medicine training program 2. Relevance of the rehabilitation medicine training program. 3. Increasing adequacy of trainee numbers 4. Strong engagement of rehabilitation medicine community in the training program 5. Effectiveness and responsiveness of the AFRM 6. Advantages of the AFRM being under the RACP 'umbrella' 	<p>Weaknesses</p> <ol style="list-style-type: none"> 1. Concerns regarding entry to training criteria 2. Rehabilitation Medicine Clinical Curriculum due for review and update 3. Quality of and access to consistent teaching and learning opportunities 4. Breadth and oversight of individual clinical training 5. Density of training program components 6. Timing and content of Modules 1 and 2 7. Fellowship Examinations: timing, content and results fluctuations. 8. Utility of some aspects of other training elements 9. Concerns about some training settings and supervision
External	<p>Opportunities</p> <ol style="list-style-type: none"> 1. Future workforce demands for Rehabilitation Medicine Fellows 2. Expansion of the role of rehabilitation medicine – acute setting, higher patient acuity in subacute setting, greater focus on 're-conditioning' rehabilitation, focus on continuum of management including ambulatory care programs, older person rehabilitation, and managing chronic disability and ageing with disability 	<p>Threats</p> <ol style="list-style-type: none"> 1. Institutions other than RACP offering specialist training in rehabilitation medicine 2. Adequacy of geographic distribution of Rehabilitation Medicine Trainees and Fellows 3. Rehabilitation Medicine Fellows inadequately equipped to meet the evolving trends of the specialty with the potential for: suboptimal patient care, clinicians working on the margins of clinical practice, restricted involvement in certain models of clinical care, negative impact on image and credibility of rehabilitation medicine, rehabilitation medicine roles taken on by other specialties

5. Strengths of Rehabilitation Training in Australasia

5.1. Introduction

The existing training scheme has evolved over decades to meet the needs for the developing specialty of rehabilitation medicine in Australia. The work and foresight of the pioneering Australasian Rehabilitation Physician have been at the core of the development of this specialty and its training program which translates daily into improvement in the lives of people with disability.

The specific strengths of the training program are outlined in the following sections. Preservation of these strengths must be a paramount consideration in the future moulding of the training program.

5.2. Quality of the rehabilitation medicine training program

The rehabilitation medicine training program is well respected both in Australasia and internationally. It is regarded as a program that is well-structured, rigorous and comprehensive for training specialists in rehabilitation medicine. It is acknowledged as having rigorous policies and procedures, supported through a strong relationship with the Royal Australasian College of Physicians.

In its 2008, AMC review of the College, the AFRM was commended for its commitment to high standards of education, training and assessment. It commended the faculty's modular program, and approach to assessment of trainee learning. No changes to the program were recommended.

The FEC continues to oversee the training program and is strongly commended for its commitment to the highest of standards and procedures.

5.3. Relevance of the rehabilitation medicine training program and assessments

It is argued by many that the training program in its current form is 'fit for purpose' as it offers training with a focus from the outset on the biopsychosocial model of medicine, which is quite different from the medical model. Its fundamental emphasis is different, with the central focus on the functional impact of injury and illness and how that function can be optimised, rather than on the management of the injury or illness itself, as in the 'medical model'.

It is also argued that, although there is no dedicated curriculum for the Module 1 and 2 assessments, that these assessments are highly relevant and meet the needs of trainees in the early phase of their training. Module 1 includes evaluation of the trainee's knowledge of the basic sciences, with a strong focus on anatomy and physiology of the musculoskeletal and neurological systems, features which may not necessarily be addressed in the BPT Program. Potential loss of these critical aspects of the existing

rehabilitation training program with change to the FRACP model is of great concern to many. If we were to move to the FRACP model, consideration of incorporating learning of the relevant basic sciences for Rehabilitation Physicians is of key importance.

5.4. Increasing adequacy of trainee numbers

Five to 10 years ago, Registrar position vacancies were frequently encountered, as there were often inadequate numbers of applicants to fill positions.

While there are geographic variations in recruitment of sufficient trainee numbers to the training program in some regions (see later discussion) far fewer rehabilitation training position vacancies have been observed, particularly for the more popular metropolitan terms. Recruitment panels have reported that, not only have the number of applicants increased, but the calibre of applicants has also improved²⁸.

‘Overall, there seems to have been an improvement in the last 2 years with higher quality trainees who seem to actually want to do Rehabilitation.’

From training survey

This increasing adequacy of trainee numbers is in the face of rapid growth in the number of training positions available in rehabilitation medicine. From 2010 to 2014, there has been a 41% increase in the number of advanced training positions in Australia for rehabilitation medicine, making rehabilitation medicine one of the fastest growing medical specialty training programs, with only general practice, addiction medicine, ophthalmology, pathology, and emergency medicine with higher growth²⁹.

The growth in training positions and low vacancy rates has been fuelled by higher medical graduate outflow, with greater competition for training programs, the so-called ‘medical student tsunami’. In 2013 there were 3,441 medical graduates, over double the 1,400 graduates in 1999.³⁰ These higher graduate numbers will continue to filter through to registrar training posts, which will plateau in the next five years.

²⁸ Personal correspondence, John Estell, September 2013

²⁹ Commonwealth of Australia (2015). *Medical Training Review Panel 18th Report*. [http://www.health.gov.au/internet/main/publishing.nsf/Content/06186F3D9088F7CACA257E490009C084/\\$File/Medical%20Training%20Review%20Panel%20eighteenth%20report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/06186F3D9088F7CACA257E490009C084/$File/Medical%20Training%20Review%20Panel%20eighteenth%20report.pdf)

³⁰ Commonwealth of Australia (2015). *Medical Training Review Panel 18th Report*. [http://www.health.gov.au/internet/main/publishing.nsf/Content/06186F3D9088F7CACA257E490009C084/\\$File/Medical%20Training%20Review%20Panel%20eighteenth%20report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/06186F3D9088F7CACA257E490009C084/$File/Medical%20Training%20Review%20Panel%20eighteenth%20report.pdf)

In New Zealand, medical graduate numbers have increased in recent years by 10%, though New Zealand faces unique challenges with significant medical migration, especially to Australia³¹.

Unless there is substantial growth in recruitment to other specialty training programs, and with the rehabilitation medicine training program in its current format, it can be expected that the adequacy of trainee numbers will be maintained in most areas.

Paralleling the rising number of Rehabilitation Medicine Trainees in Australia and New Zealand is the increase in the Rehabilitation Physician workforce, borne out of demographic trends and development of new models of care.

While specific data on the employment rate for Rehabilitation Physicians is not available, anecdotally, most new Fellows are able to find employment. Vacancies for fellows are rare, other than perhaps in some regional settings. Indeed, compared to many other physician specialties, new Fellows in rehabilitation medicine are often able to secure a specialist position in a public hospital setting, without the need for further qualifications, which is the norm in many other specialties.

Comment

Potential training program changes must include modelling of the impact on rehabilitation medicine trainee numbers. This is even more critical for regions where trainee numbers are less secure. The calibre and quality of trainees entering into the training program is of equal, if not more importance than the raw number of trainees entering into the program. Any discussion about ensuring adequate trainee numbers must be coupled with consideration of entry to training criteria, as will be discussed in a later section.

Regardless of the decisions made regarding the structure of rehabilitation medicine training, enhancing awareness of rehabilitation medicine as a career option among potential trainees at both the graduate and undergraduate level, and addressing questions regarding the image of our specialty will potentiate competition for entry to training and facilitate maintenance of adequacy of trainee numbers for the future.

5.5. Engagement of the rehabilitation medicine community in training program

With a combined total of over 700 Rehabilitation Medicine Fellows and trainees in Australasia, Rehabilitation Fellows and Trainees are part of a close knit rehabilitation medicine community via the AFRM. Even though the faculty is part of the much larger RACP which has over 10,000 fellows and trainees, the distinct identity within the

³¹ Gorman DF, Brooks PM (2009). 'On Solutions to the shortage of doctors in Australia and New Zealand'. *Medical Journal of Australia* 2009; 190(3): 152–156.

rehabilitation community remains, and is tangible whenever Rehabilitation Physicians interact. This identity in part relates to the personal identification with and connection to the relatively brief yet progressive history of rehabilitation medicine in Australia, and the pioneers of Australian rehabilitation medicine.

The dedication of the rehabilitation medicine community to training future specialists is further highlighted by the active and enthusiastic engagement of members (Fellows and trainees) in this review process of the training program.

The AFRM training and education program is highly dependent on the significant volume of volunteer work of the AFRM members. AFRM members demonstrate a high rate of engagement within the operation of the AFRM. Thirty-one percent of Fellows are registered supervisors and there is a high rate of involvement on committees, subcommittees and working parties. This reflects the strength of commitment to the faculty's education program and is even more profound given the rapid increase in trainee numbers, increasing by over 40% from 2010 to 2014³².

Comment

The operational success of the faculty's education program is dependent on the ongoing engagement of faculty members in the education process. This will be enhanced by facilitating meaningful input by Fellows and trainees into the future moulding of the training program. It is vital to also ensure that fellows are appropriately supported in their delivery of the education programs, particularly with the rapid growth of trainee numbers recently observed. Factors which have the potential to erode this member engagement with the training program need to be identified and mitigated to secure its ongoing success.

5.6. Effectiveness and responsiveness of AFRM

Over the last 20 years, with relatively small numbers of rehabilitation medicine trainees and fellows, AFRM staff have been able to maintain a personal yet professional connection with members through direct contact in person, by phone and electronically, and through group communication methods. Staff have been highly efficient, intuitive and responsive to the needs and requests of the members.

The core engagement of College staff has been identified as a key component in the efficiency and success of the training program.

³² Commonwealth of Australia (2015). Medical Training Review Panel 18th Report.

[http://www.health.gov.au/internet/main/publishing.nsf/Content/06186F3D9088F7CACA257E490009C084/\\$File/Medical%20Training%20Review%20Panel%20eighteenth%20report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/06186F3D9088F7CACA257E490009C084/$File/Medical%20Training%20Review%20Panel%20eighteenth%20report.pdf)

There have been recent changes within operational staff secondary to operationalisation of the Educational Governance Review, and with resignations of some senior and longstanding AFRM staff. The impact of these changes is not yet known, but members express concerns of the impact of these changes on the future success of the training program, and on the engagement of the rehabilitation membership in the training program.

From the member survey, areas for improvement related to AFRM staff operations included: acknowledging and responding to correspondence in a timely manner and timeliness of education decisions (e.g. recognition of prior learning).

5.7. Advantages of the AFRM being under the RACP 'umbrella'

Several key strategic advantages for the rehabilitation medicine training program are afforded through being a faculty of the RACP, including:

1. Centralisation of education processes through RACP enables them to be provided with efficiency and the requisite expertise (for example, educational resources and expertise, curriculum development, fellow relations, examination development, policy development)
2. Centralisation of administrative processes through RACP offers greater efficiencies and economies of scale (for example, Fellow relations, administration of examinations, membership and training fees)
3. Widespread community and professional respect and credence of the RACP as a professional and training body flow through to the specialty of rehabilitation medicine under the auspices of the RACP
4. Extensive College-wide educational reform is currently underway, with development of College-wide integrated standards framework, an overarching scaffold of defined domains of competence or standards common to all members of the profession. Development and refinement of this framework will add further value to the quality of the rehabilitation training.

6. Weaknesses of Rehabilitation Medicine Training in Australasia

6.1. Concerns regarding entry to training criteria

While the vast majority of trainees progress through the training program, completing their training as competent productive Rehabilitation Physicians, variations in the quality of trainees entering in and progressing through the training program have been identified.

'Some trainees I have worked with had had very limited knowledge and communication skills, and the wrong attitude and personality to work in rehab. They then risk wasting years before realising they can't get through training.'

From training survey

Issues

1. Entry to training too early

Entry to rehabilitation medicine training can commence in the third year after graduation. This is one year later than entry to BPT, general practice training and psychiatry training, and the same earliest entry point as with Australasian surgical training.

Despite the already delayed entry point to training, Rehabilitation Physicians express concerns that it is still too early, and that trainees do not have sufficient experience, knowledge and skills to function as a Rehabilitation Trainee.

'Entry at Post Graduate Year (PGY) 3 does not allow for enough general skills to be attained before embarking on Rehabilitation training.'

'Trainees are not medically skilled enough - have not spent enough time as a general registrar and do not take up the role of being a registrar but act like a slightly more senior JMO.'

From training survey

2. Lack of clear standards for entry to training in rehabilitation medicine

Recruitment into training positions varies widely across Australia. Rehabilitation Medicine Fellows on centralised or institution-based interview panel act as arbitrary gate keepers for entry and to some degree progression through the training program for trainees who may already be accredited with the AFRM.

A key issue adversely impacting on trainee selection and entry to training is the lack of consistent standards on which to assess suitability of trainees to enter the training program. There is significant variation in which variable standards are applied across Australasia.

Centralised interview panels in some states and regions have developed robust assessment criteria, and the processes applied in such procedures certainly facilitates standardisation at the regional or state-based level. Without standardisation between settings across Australasia, however, there is an inconsistent and heterogeneous set of standards applied. Without the guidance of clear standardised entry criteria, the ‘gate keepers’ for entry and progression to training (whether at the individual institution level or in the centralised panel) are hampered in this vital role with a resulting variability in trainee quality.

‘It is too easy to become an accredited trainee and this process is completely dis-associated from the state branches that run the "recruitment processes" and actually have some capacity to determine whether an individual is suitable to commence training.’

From training survey

3. Limited competition for rehabilitation medicine Registrar positions in some settings

As previously noted, competition for rehabilitation training positions has improved in many areas due to increased medical school output. Some areas have persistent recruitment issues due to supply geography, popularity of the term or because of a mid-term resignation.

In these situations, the institution’s need to fill a position and to provide care for patients usurps the needs for consistency in trainee selection. These trainees (who may have been unsuccessful in securing a position in a centralised interview process) may then have an automatic advantage over a new trainee in the following year’s centralised interview processes because they are already ‘in the system’.

‘Should be more competitive, not based on applying for a job and getting through the central interviews. Some people should not be accepted as trainees i.e. if they don’t actively want to do rehab, or are performing poorly, or perhaps even averagely as a JMO.’

‘Poor calibre candidates are being selected. It is better to leave a vacancy than select poor candidates.’

From training survey

4. Experience and knowledge of some international medical graduates entering into rehabilitation medicine training

Some AFRM members express concerns regarding variations in quality of trainees related to limited recent experience in the Australasian health care setting.

‘Medical knowledge has been sparse in International Medical Graduates. This is not the case with Australian or New Zealand trained rehab registrars.’

'Some trainees have limited English and/interest in rehab on admission (to training).'

From training survey

5. Non-recognition of prior learning for training and qualifications from other colleges

The only accepted examination which provides an exemption from Modules 1 and 2 is successful completion of the RACP Basic Training written and clinical examinations respectively. In the past, successful completion of other College program (such as general practice) permitted exemption from entry examinations, and resulted in significant truncation of training duration.

'Reconsider flexibility in acceptance to advanced training – FRACGP.'

From training survey

Comment

There is a strong need to develop robust and evidence-based entry to training criteria and pre-requisites for entry to training in rehabilitation medicine. This process will include developing consensus regarding the characteristics of the ideal rehabilitation medicine trainee, and requirements regarding previous experience, skills and other qualities.

Preliminary discussion with AFRM members suggests the following characteristics are of particular relevance:

- Personal maturity
- High standard of communication skills – verbal, non-verbal and written
- Baseline knowledge about rehabilitation medicine
- Commitment to the training program
- Entry level knowledge and skills in the management of commonly encountered medical and surgical issues
- Relevant experience to allow the trainee to have developed entry level knowledge and skills in the management of commonly encountered medical and surgical issues
- Entry level knowledge of anatomy and physiology relevant to training in rehabilitation medicine
- Demonstrated professionalism
- Potential to develop leadership skills
- Commitment to collaboration and team work.

There is a strongly expressed view that trainees need to have recent and relevant clinical experience within the local healthcare setting, and also have the relevant acute skills to manage acute issues as they arise in rehabilitation patients, particularly in the context of the greater acuity of rehabilitation patients as previously discussed.

A review of entry to training criteria also encompasses a consideration of the role and timing of Modules 1 and 2, which may be better placed as pre-requisites to training.

Other options for modifying the entry to training criteria include the following:

- a. Pre-requisite acute skills at entry, e.g. having completed the Advanced Trauma Life Support (ATLS) or Advanced Cardiovascular Life Support (ACLS) prior to entry – though it is noted that these courses are in high demand and there may be access block to them.
- b. Pre-requisite recent acute care experience, e.g. intensive care unit term or emergency department term during the year prior to entry.
- c. Pre-requisite relevant clinical experience e.g.:
 - i. Completion of one year of Basic Training or
 - ii. Within the last two years, trainee has completed at least one surgical and medical term from a list of relevant terms within an Australasian health care setting e.g.:
 - Medicine, e.g. neurology, geriatrics, rheumatology, general medicine, cardiology, respiratory
 - Surgery e.g. orthopaedics, neurosurgery, vascular surgery, general surgery.
- d. Increase time from completion of medical school to entry to training to three years (though this would bring rehabilitation medicine further out of alignment from other training programs).
- e. Develop standardised methodologies for the implementation of entry to training criteria.
 - i. Interviews – either independent from employment interviews (conducted by AFRM/RACP) or combined with employment interviews (with RACP/ARFM representative on interview panel for positions at onset of training)
 - ii. Reference checks by AFRM prior to entry to training to review specific qualities of suitable trainee
 - iii. Other options such as multiple mini interviews (a variant of objective structured clinical examinations), situational judgement tests, personal statements, portfolios.
- f. Other options for entry to training e.g.:
 - i. Successful completion of Module 1 and 2 prior to entering training
 - ii. Basic Training (adult) – see later
 - iii. Reintroduce training exemptions for individuals who have completed relevant qualifications within a recent time period (e.g. general practice).

The final set of criteria must be supported by evidence-based and practical methodologies for implementation of entry to training processes.

It is noted that the RACP is currently undertaking extensive work regarding college-wide entry to training criteria. Any work in this area should integrate with this larger body of work.

Recognition of relevant and recent qualifications which trainees may bring from training through other colleges may enable enrichment of the profession by including mature and experienced clinicians into the profession. This could only be considered within the context of the College's Recognition of Prior Learning Policy.

6.2. *Rehabilitation medicine clinical curriculum due for review and update*

The clinical curriculum was developed with significant input from AFRM's Special Interest Groups, giving it direct connection to the subspecialists within the faculty. It is both wide ranging and detailed in the depth of knowledge and clinical skills detailed, and does not contain subject matter which could be considered to be superfluous to the needs of a Rehabilitation Physician.

'I did not wish to learn about things that I would never use again such as chemotherapy and glomerulonephritis.'

From training survey

Rehabilitation Physicians appreciate that the training and curriculum emphasise a biopsychosocial approach from the outset of training, without a preliminary Basic Training curriculum which is perceived to have more of a 'medical model' focus.

Evolving trends within our specialty demand that the clinical curriculum be urgently reviewed and updated with substantive input from the rehabilitation community.

The current curriculum does not include an indication of the weighting of topic areas within the clinical curriculum. Without this, trainees may face difficulties in balancing their approach to study.

Comment

So that the clinical curriculum can be maintained as a strength of the training program and reflect contemporary practice, it should be regularly mapped to the evolving requirements of the profession, with substantial input from clinicians and educational professionals and modified as appropriate.

The coverage of some areas of content could be augmented in the current curriculum, including: de-conditioning, pulmonary rehabilitation, burns and cancer rehabilitation, along with skills in some current and emerging techniques e.g.: musculoskeletal sonography, and anti-spasticity injections and orthotics prescription.

The structure of the curriculum could be changed with separate coverage of rehabilitation specific content which is relevant to multiple clinical areas, and inclusion of topic weightings. AFRM members have provided an initial indication of relevant weightings, as outlined in the 'Results' chapter.

The breadth of content needs to be balanced with the detail of knowledge required within an already crowded curriculum so that training requirements do not become increasingly burdensome. It may be that some detailed subspecialty content which is encountered only rarely in the working life of the general Rehabilitation Physician could be shifted from the core curriculum. Some of the current core content could be moved to non-core or elective content. Self-selected components of this non-core content could be addressed through additional external training modules, during a compulsory Fellowship year or advanced graduate diploma course.

'I think an additional year rotating through the sub-disciplines (of Rehabilitation) would assist the candidate.'

'There are so many relatively "rare" disorders that are included in the curriculum. Perhaps "zebras" are taken out of the current general curriculum and post-AFRM qualifications/subspecialisations in these areas are created... Bread and butter Rehab needs to be emphasised.'

From training survey

6.3. Quality of and access to consistent teaching and learning opportunities

While learning opportunities in most settings are excellent, there is heterogeneity observed.

'The quality of the terms determines the quality of the physician. There are too many poorly run terms, and there are unfortunately physicians that spend their four years of training in terms with poor educational or experience outcomes.'

From training survey

Issues

1. Variation in access to teaching and learning

Geographical, academic and financial factors impact the trainee's access to training resources, websites, courses, and mock examinations. There is no Australasian-wide consistency for access to resources and teaching, other than the Bi-National Training Program which is a monthly two-hour session. Some states offer highly developed training resources and programs to support their local trainees, but there is great variability.

2. Access to protected teaching time

Trainees often describe difficulties with accessing protected teaching time related to workload, support from supervisors and availability of cover for study leave/training commitments.

3. Lack of appropriately skilled clinicians and educators to develop and deliver the teaching and learning program

The bi-national and state-based teaching programs depend largely on volunteer time, and the educational expertise of the Fellows involved in the face of rapidly increasing trainee positions. While the extensive input of a minority of Fellows is applauded, those involved are clinicians who often do not have the backing of formal education training. This may impact the quality, or development of teaching programs. It is essential that volunteer educators continue to receive accessible and relevant support in their responsibilities.

4. Variability of individual teaching quality

Significant variation in the quality of individual supervision and teaching is also described. This may relate to opportunities at the particular institution, interest of the supervisor in teaching, and the supervisor's skills in and attitude towards teaching.

'(The) trainee (is) left to the mercy of accidental circumstances, such as the keenness or interest of their supervisors to teach them or guide them, and the widely varying qualities of their supervisors.'

From training survey

Furthermore, some trainees note a negative approach by supervisors to teaching.

'I have become completely disillusioned with the training programme. Certain supervisors have been harsh in their criticism and not supportive in ensuring completion of the training and consequently I have felt demoralised and not at all like continuing the programme.'

From training survey

5. Availability of relevant teaching courses

It is acknowledged that there are specific challenges in providing courses to augment the training program within the context of a relatively small faculty.

Specific concerns identified regarding courses:

- Trainees may not be granted study leave days to attend training courses (for example, FIM training course)
- Practical and financial challenges for rural trainees, and trainees from smaller states in accessing courses
- Fees are too high, particularly for elements which are either required or highly recommended as part of the training program (for example, FIM course and prosthetics courses)
- Trainees report difficulty in accessing education for some aspects of the training course as such courses do not exist e.g. orthotics

- Difficulties with access to specific Fellowship preparation course (inaugural one was held in 2014 in Sydney) related to cost, geography and academic entry criteria. It is noted that the pass rate for those attending this course was 100%³³.

6. Variable enthusiasm and skills in teaching and learning

Some Rehabilitation Medicine Fellows report trainees have poor attitudes to receiving teaching and supervision.

‘Trainees have it too easy these days. They are demanding, won't put in extra effort without complaining. They often don't respect the consultants and are hardly grateful.’

From training survey

Comment

A review of the existing clinical curriculum must naturally be coupled with review of the teaching and learning program so that they complement each other.

The current bi-national teaching and learning strategy should be reviewed and updated so that it maps accurately to the curriculum and meets the needs of the trainees as part of a the contemporary adult rehabilitation medicine training program. Session frequency could be increased, as is seen in other specialties, and delivery in different formats may enhance equity of access, utilising options such as learning online modules, webinars.

A contemporary teaching and learning program will also be facilitated if learning networks are strengthened at the state, regional, national and international level.

Successful development of teaching and learning programs is contingent on appropriate resourcing. Outcomes stemming from recent Fellowship examination course and the development of a state based rehabilitation hub in Victoria should be evaluated. These recent developments may serve as useful templates to develop teaching and learning programs across Australasia.

6.4. Breadth and oversight of the individual's training

Centralised coordination of the range of clinical terms undertaken or the clinical skills developed throughout training is underdeveloped. Trainees face difficulty accessing clinical experience in some subspecialty areas, especially in some subspecialty terms such as spinal and brain injury. Trainees may also be hampered in their selection of suitable terms with casemix data for prospective terms not readily available.

³³ Personal correspondence, Associate Professor Steven Faux, 18 August 2014.

Limited use is made of mentors, who could be a valuable resource in assisting the trainee to plan and access the breadth of clinical exposure necessary to successfully advance through training.

Issues:

1. Lack of oversight of the breadth of clinical exposure throughout training.

'Many trainees end up repeating similar rotations without getting adequate exposure to the diverse practice areas in rehab medicine.'

From training survey

While trainees are encouraged to undertake terms in a range of clinical settings, there are no clearly defined specific requirements to ensure a breadth of clinical exposure. The Teaching and Learning Committee does not make specific recommendations regarding term allocations, nor is accreditation declined on the basis of inadequate breadth of training experience, other than for trainees in difficulty. Inadequate breadth of clinical exposure may have a flow-on impact on the likely success in Fellowship examinations, though this correlation has not been specifically examined.

2. Limited number of available positions in high demand rotations

'Many trainees have not done jobs in Brain, Spine or Amputee units and it shows when they come to be examined.'

From training survey

While the number of training positions has increased substantially over the last five years, this has mainly been in general rehabilitation units, while the number of subspecialty units (such as spinal and traumatic brain injury) has remained largely static. Market forces mean that higher quality trainees have a better chance of securing these highly sought after rotations, regardless of their state of training, leaving other trainees less able to access subspecialty terms, with flow-on implications for likely examination success.

Regional rehabilitation units offer an important exception to the observed difficulties in accessing specialty terms in metropolitan centres. Regional units frequently offer an excellent opportunity for trainees to experience a broad coverage of the clinical curriculum. Utilisation of these regional training terms, which are traditionally less popular, is a logical and simple solution to the issue of access to the entire scope of clinical experience

Exposure to other clinical subspecialty areas may also be limited due to changes in practice and the settings in which training typically occurs. Difficulties acquiring experience in the following areas have been reported:

- Cancer rehabilitation
- Occupational rehabilitation

- Burns rehabilitation
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Rehabilitation of lymphoedema
- Specialised musculoskeletal training
- Developmental and adult intellectual disability rehabilitation
- Outpatient clinics
- Private consulting suites.

3. Limited use of mentors/Professional Development Advisors (PDAs)

The use of mentors among Rehabilitation Medicine Trainees is very low. On average, only three requests to the Faculty for PDAs are made each year, and the majority of these are for trainees who have undergone an independent review of training³⁴. There appears to be limited knowledge among AFRM fellows and trainees about the mentor/PDA program.

Having a mentor may assist trainees with ensuring that they acquire an adequate breadth of clinical exposure throughout their training generally, and more broadly with future career planning. This may be particularly relevant for trainees in difficulty (self-identified or supervisor-identified), and for some international medical graduates.

Comments

Approaches to improve coordination of the individual's training program will assist in successful progression through the training program.

This may include greater coordination of the individual's program at the faculty level, or at the state level, including the possibilities of centralised term allocation and compulsory non-metropolitan rotations.

The possibility of shortening training terms, particularly for high-demand terms, should be considered, in addition to offering modular short-term clinical placements. This could be allocated through a centralised online booking system e.g. week-long placements in spinal units, specialist ambulatory clinics or private settings. Encouraging the uptake of rural and regional placements will also go a long way to enhancing the scope of clinical exposure among trainees.

Additionally, serious consideration of the introduction of logbooks/portfolio tools should be pursued to ensure trainees have a minimum level of clinical exposure and designated skillset. In the training survey, this option had strong support, with 57% of respondents being in favour of the introduction of log books.

³⁴ Personal correspondence, Paul Washington, AFRM, 13 May 2014.

Furthermore the role of the mentor should be developed to assist trainees in acquiring the requisite breadth of clinical training.

6.5. Density of training program components

The training program requirements for adult rehabilitation medicine are great when compared with many other specialties, with both entry and exit examinations, several external training modules, in addition to the clinical responsibilities and other program requirements. These factors make it extremely challenging for the trainee to meet the training requirements within the available time frame, while mindfully learning and developing the 'trade' of the specialty.

'(The trainee) has a seriously uphill task ahead of him to cover the elements of a curriculum which is really vast (compared with most other disciplines), to get to actually 'see' equipment and see therapists at work, to do the External modules (which trainees in other fields don't have) and on top of this to attend to their ordinary Service duties - which themselves may be quite onerous. For the Rehab trainee in Australasia there is therefore this double-burden...'

From training survey

Comments

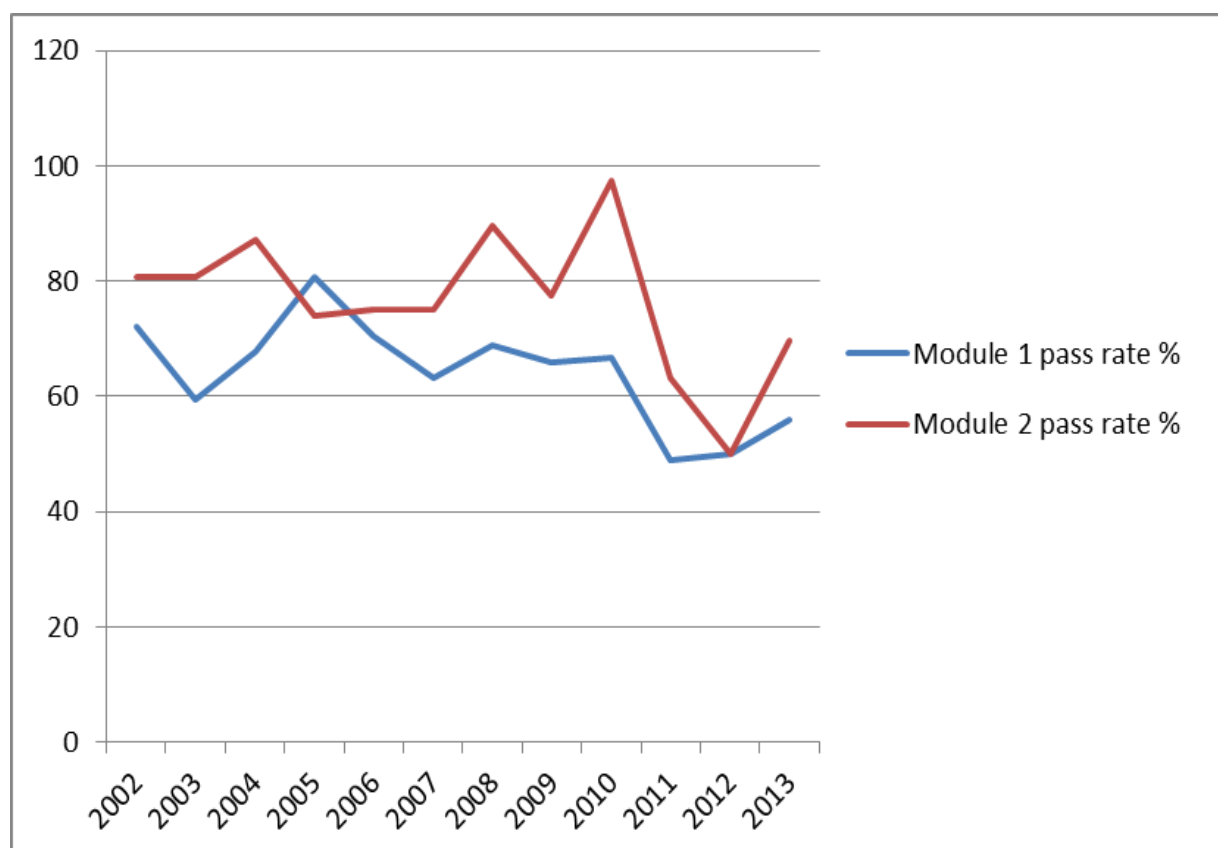
There are several broad approaches which could be utilised to address the challenges associated with the density of training program requirements:

- Improve efficiency of teaching and learning (through improved coordination of the individual's teaching and learning, and enhancement of teaching and learning processes)
- Increase duration of training
- Review timing of assessments
- Reduce components of curriculum (change from core to non-core).

6.6. Timing and content of Modules 1 and 2

Recent pass rate for Modules 1 and 2 are shown in Figure 14 below. A gradual downward trend is noted for both examinations, flagging potential concern regarding the quality of trainees coming through the rehabilitation medicine training program in the coming years.

Figure 14 – Pass rate in Modules 1 and 2, 2002–2013



Issues

1. No curriculum for either assessment

There are no specific competencies or curricula set out for Modules 1 and 2. Trainees are expected to be familiar with the material in current text books of internal medicine, and with the relevant aspects of basic sciences that are applicable to internal medicine and therapeutics.

Trainees report they feel at times overwhelmed at the breadth of basic science and clinical material which they are expected to address in preparing for these examinations. Much of the trainee's training time in the lead-up to these assessments, which is often up to 18 months of 48 months, or a third of their training, is spent preparing for assessments with no clearly stated competencies.

These assessments are viewed by Rehabilitation Physicians as being an important component of the training program and serve several key purposes:

- i) Ensuring that trainees have foundational knowledge for the remainder of the training program, especially in anatomy and physiology (but this is difficult without specific learning guidelines)

- ii) Ensuring that trainees have the requisite basic medical and communication skills to be 'safe' junior registrars, in part acting as a screening tool for suitable trainees (though the timing is difficult as trainees are already accepted and personally invested in the rehabilitation training program, raising the questions about whether this assessment should be a pre-requisite for entry to the training program).

2. Timing of Modules 1 and 2

If trainees do not attempt Modules 1 and 2 until their second year of training, or do not pass until their second year of training, more than a third of the trainee's training time may be spent preparing for examinations, leaving less time to focus on the remainder of the rehabilitation curriculum. Consideration should be given to making them pre-requisites for entry to training, or as barriers for progression to the second year of training.

3. Limited support in preparation for Modules 1 and 2

Other than written guidelines in the Trainee Handbook, there is little formal support in preparation for Modules 1 and 2. The trainee's success in passing may be significantly influenced by their capacity to connect with previous candidates who can give access to previous papers. This is in contrast to the part 1 FRACP examination preparation, where there is strong collegiate atmosphere with the availability of regular lectures, examination preparation courses and structured hospital-based teaching.

'If it is part of the training program...then it should be treated that way e.g. have a more detailed curriculum and specific assistance for trainees to prepare and gain necessary knowledge and skills.'

From training survey

'It is, essentially an examination in which we are not given specific study preparation for and only proves a lesson in being able to 'learn' past paper answers. The past paper questions are taken from Physician training papers - and these exams are such that they are given a years' worth of LECTURES, TUTORIALS, and WORKSHOPS for. Instead of teaching or instructing us in a similar way such that we can function as physicians, we are given 3 months at the start of our training program to 'self-direct some learning' toward the same. If the college expects trainees to have that baseline 'physician' knowledge - we should at least get a series of lectures or workshops as per the physicians program.'

Module 1 Feedback

It is noted that due to the relatively small number of Rehabilitation Medicine Trainees that such structured support is not feasible, but stronger alliances with physician training networks would be quite achievable.

4. Rate of repeat questions in Module 1

Because of the rate of repeat questions in Module 1, trainees spend a considerable amount of time learning the response to recall questions, the educational value of which is questionable. Those trainees who are better connected or who work in large teaching hospitals with access to other Rehabilitation Medicine Trainees may be advantaged as they have access to past papers.

'I have only done module 1, which was 80% past paper so I was able to pass by going through the past papers and memorising the answers.'

'Whether or not a trainee passes or not depends almost entirely on the quality and quantity of past remembered questions they've been given.'

From training survey

'Feeling as though I had to memorise answers to thousands of RACP questions was ridiculous and a waste of time as I did not learn the material as I was not sure what was relevant or expected. Module 1 appears to be a meaningless hurdle in rehab training. I am not impressed. This needs serious revision.'

Module 1 feedback

AFRM has not been granted access to more recent questions from the RACP bank due to the confidentiality of this question bank. It is noted that there has been much work done to encourage Fellows to prepare new MCQs for the bank. Workshops and held to inform Fellows on the methodology for this and MCQ preparation gives the Fellow CPD points.

5. Module 2 pass standard 'too low'

Rehabilitation Physicians express strong views that the standard required to pass Module 2 should be higher because this assessment in essence acts as a quasi-mechanism for entry to training. However, if this is to be the purpose of Module 2, then its timing is wrong. Trainees attempting Module 2 are already accepted onto the training program and are either 6 or 18 months into their training program. If a trainee is not successful in passing Module 2, it is likely that they will continue to attempt the examination until it is passed.

Because of the important role that Module 2 has, some express concern that that the standards required to pass Module 2 are too low and should be more rigorous, particularly with regards to communication skills and knowledge and skills regarding acute medical issues that rehabilitation medicine clinicians increasingly need to address. It is noted that the pass mark required to pass this examination has been raised in the last two years' examinations

'The bar is set too low, trainees passed the exam still not good at reliably and confidently determine clinical signs.'

From training survey

Comment

The concerns raised about Modules 1 and 2 prompt questions regarding their timing. Options for change include:

1. Make Modules 1 and 2 pre-requisites for entry to rehabilitation training. The impact of such a move on trainee self-selection into training, and capacity to prepare adequately given the relatively low volume of trainees deserve serious consideration and modelling.
2. Make Modules 1 and 2 obstacles to progression to the second year of training.

‘Should be done in first year of training only. It wastes rehab learning time if done in second year.’

From training survey

The content and purpose of Modules 1 and 2 require greater clarity, including development of specific rehabilitation standards, curriculum and an assessment rubric. One option would be to develop Module 1 as a pre-requisite run course (in person or online) which is a pre-requisite for entry to training.

Content of Modules 1 and 2 could be made more rigorous and further enhanced by opening the development of these assessments to our acute care clinicians and expanding the sources from which questions in Module 1 are sourced.

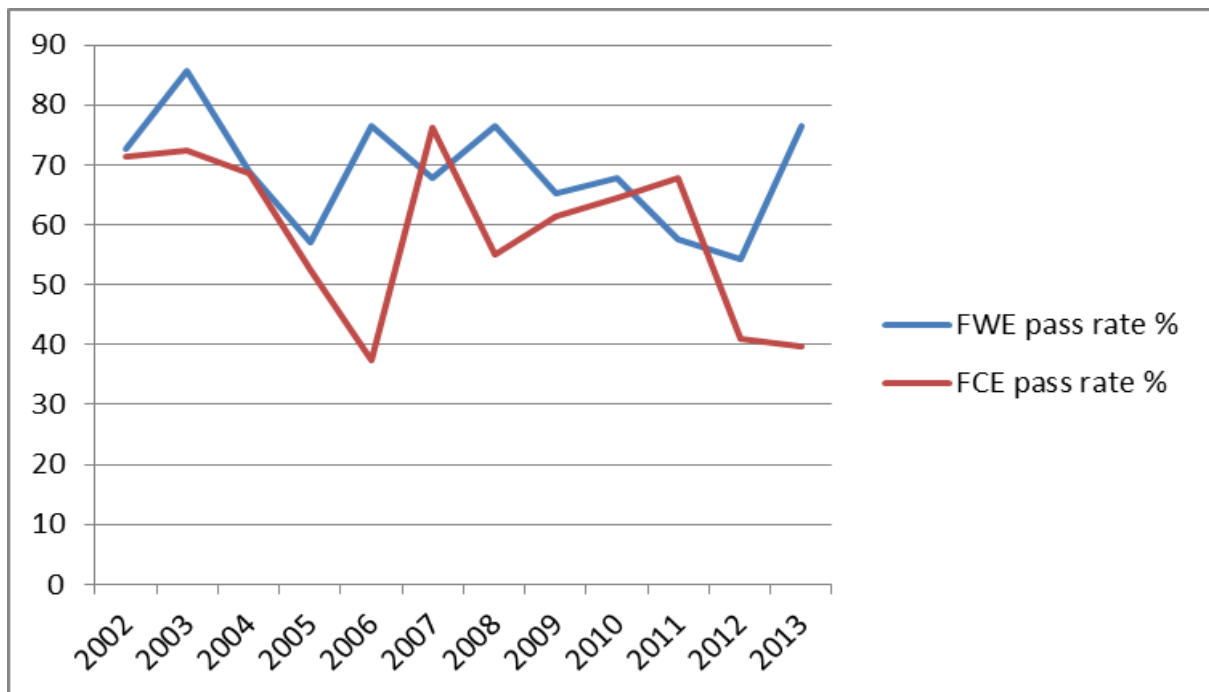
The other key question relates to the overall role of Modules 1 and 2 and whether they should remain as a component of training. If the faculty decides to change training to the FRACP model, the need for Modules 1 and 2 will no longer exist as this entry to training aspect would be outsourced to BPT.

6.7. Fellowship examinations: timing, content and result fluctuations

The results of the Fellowship Clinical Examination (FCE) and Fellowship Written Examination (FWE) over the last 10 years are shown graphically below. Key issues to note are:

1. Volatility in pass rates
2. General downward trend
3. Low pass rates in individual years, especially for the clinical examination.

Figure 15 – FCE and FWE pass rates 2002–2013



If the training program is performing as it should, and, assuming that the Fellowship examinations are fair, a high pass rate should be observed for these exit summative assessments.

The results of the Fellowship examinations (clinical and written) can be considered as a surrogate marker of the net effectiveness of the training program in meeting its stated objectives, including its entry to training/self-selection into training. Variations in recent Fellowship examination outcome trends require these examinations to be reviewed, along with other components of the training program which may be contributing.

In Australia, all providers of specialist medical education must be accredited by the AMC. In New Zealand, the process of accreditation is managed by the Medical Council of New Zealand (MCNZ). The primary objective of these accreditation processes is to provide external assurance of the quality of medical education, based on explicit standards. During the last review, the RACP, including the Specialist Medical Education and Training Program in rehabilitation medicine was granted accreditation by the AMC and the MCNZ. Between accreditation visits, the AMC and MCNZ monitor developments through annual reports. The observed fluctuations in the Fellowship examination results have prompted a request for explanation by the AMC.

It is noted low pass rate in the 2013 FCE prompted an internal review of the examination's conduct and content, and no significant issues were identified.

Issues

1. Timing of Fellowship examinations

Variability in the examination pass rate may reflect inadequate time in the training program for trainees to address the existing curriculum.

Trainees report significant challenges in having sufficient opportunities to learn and assimilate the knowledge and skills relevant to the daily practice as a rounded Rehabilitation Physician in the allocated training time between compulsory assessments.

Trainees can present for the Fellowship examinations in their third year of training. Other than the Health Services Evaluation and Administration Module, all other external training modules need to be completed prior to presenting for the examination. The time between presenting for the assessments at the start and end of training, during which rehabilitation knowledge is developed and assimilated, is potentially very short. The challenges of addressing a busy curriculum in a limited time may be reflected in low pass rates in the Fellowship clinical and written examinations.

'Exit exam should be just that not people just trying their hand and wasting the examiners time.'

'Fellowship Exams should be open to 4th year trainees and beyond. Third year trainees are often still too junior.'

From training survey

Holding the FCE during the same week as the term change-over may result in competing priorities, with the potential for disadvantage both to the trainee and their employers. Similarly, the FCE often coincides with employment interviews for the subsequent year and competing priorities may disadvantage the trainee for both. Additionally because the FCE results often determine the trainee's need for employment for the following year, those who are successful in passing the FCE may subsequently withdraw from accepted positions, leaving a position vacancy.

2. Mismatch between Fellowship examination content and clinical experience

There are concerns expressed that there is a mismatch between the content of the Fellowship examinations and the nature of daily clinical practice and examination preparation undertaken by supervisors/trainees. This may reflect an issue either with the routine clinical teaching, supervision and the nature of mock examinations, or an issue with the casemix within examinations.

Some argue that there is an excessive focus in the examination on subspecialty, rather than bread and butter areas of rehabilitation medicine. Others argue that there are not enough hands-on clinical stations, instead, with an unbalanced focus on communication/education stations.

'(The Clinical examination) does not really match up with the actual patients that (Rehabilitation) doctors see.'

'Exam questions should be clear and unambiguous and test knowledge that is readily applicable to day to day Rehab physician work.'

From training survey

It is noted that there has been a move away from using live patients in the FCE because of challenges in ensuring clinical consistency across examination sessions and sites, especially with greater trainee numbers. It is unlikely that this trend relates to the requirement for international applicants (other than those from New Zealand) to have temporary Australian Health Practitioners Regulation Agency (AHPRA) registration in order to examine a live patient even in an examination setting.

It is felt by some that the range of examiners involved in the examinations may be too restricted, and that this has the potential to adversely impact of the equity of the examination for candidates.

'Exam writers/examiners need be rotated. All AFRM Fellows should be involved periodically to ensure moderation of expectations and results.'

'Even distribution of examiners from different states paired together to avoid bias, instilling formality of the exam at the hospital the exam is being held.'

From training survey

Despite these expressed concerns, it is noted that the examinations are mapped against the curriculum, that they are trialled extensively on new Fellows, and that there is significant effort put into ensuring that input and feedback is received from both senior and more recent Fellows who work across a diversity of clinical settings across Australasia. Additionally, the process for appointment of members to the Register of Examiners has recently undergone significant review to standardise their selection. Additionally, there is now a rigorous standard setting process in place for all AFRM examinations.

3. Removal of essay questions from the Fellowship Written Examination (FWE)

Commencing in 2007, the written examination has moved from eight standard essays to eight 'evolving scenario' short answer questions. While the latter style of question is much simpler for marking and may have offered greater objectivity in marking, there is limited scope for this style of question to assess the detailed written communication skills of the trainee, and their capacity to assimilate and distil a complex clinical scenario and to communicate an holistic management plan taking into account complex clinical considerations.

'Need to reintroduce Essay questions to assess trainees' thought processes.'

'Too much spoon-feeding without essay questions.'

From training survey

4. Fellowship written examination MCQ paper database

As with Module 1, there appears to be a widely held view that the FWE MCQ examination contains too many repeat questions, that trainees' capacity to pass this examination depends to some degree on their access to past 'recall' papers, and that there is a need to expand the question bank with contemporary and challenging questions.

'Whether or not a trainee passes or not depends almost entirely on the quality and quantity of past remembered questions they've been given.'

'An extensive up to date examination question bank is very much needed. Other training programs have them.'

From training survey

It is noted that there has been much work done to encourage Fellows to prepare new MCQs for the bank. Workshops and held to inform Fellows on the methodology for this and MCQ preparation gives the Fellow CPD points.

5. Other aspects of the Fellowship Clinical Examination (FCE)

Other identified areas of concern relating to the FCE:

- Recent reduction in number of stations from 15 to 12 – while this move has occurred because this number of stations allows for good discrimination between successful and unsuccessful candidates, it is argued that not only does this reduce the candidate's capacity to demonstrate competence in the breadth of the curriculum, it is also felt that the reduction in station number concentrates the impact of exam nerves, which may impact a greater proportion of stations with a reduction in the number of stations.
- Examination conduct – there was a broadly held view that not allowing the examiners to repeat the questions is unfair to trainees, as this examination is not a test of memory.

Comment

There are a number of relatively simple approaches that could be implemented to address the identified areas of concern pertaining to the Fellowship clinical and written examinations, specifically relating to the timing of the examinations within the training program, addressing scheduling issues, and increasing the relevance of clinical content.

1. Fellowship examinations can be only attempted in the final year of training to increase the amount of clinical exposure prior to examinations. This could be coupled with a compulsory Fellowship year to allow for consolidation of clinical skills and practice
2. Change calendar timing of FCE so there is less overlap with the change of terms
3. Increase variety of Fellows involved with Fellowship examinations to enhance consistency between examinations and routine clinical experience
4. Consider reintroduction of essays into the FWE
5. Broaden Fellowship written examination MCQ database – continue to encourage Fellows to write questions, explore other options for accessing other College’s MCQ databases.
6. Increase number of stations in FCE
7. Introduce examination of live patients with clinical signs in the FCE
8. Permit FCE examiners to repeat the question
9. Review evidence supporting exit Fellowship examinations to ensure that they continue to be best practice in ensuring that the required standards are met prior to Fellowship.
10. Review of components of rehabilitation medicine training which together impact the trainee’s likelihood of success in the Fellowship examinations.

6.8. Utility of some aspects of other training elements

6.8.1. External training modules

The content and nature of the external training modules is held to be of significant importance to the training program.

Other than the importance of the content of the external training modules, they hold particular value in that they are one area of the training program which requires the candidate to demonstrate high-level written communication skills, incorporating information from multiple sources, and formulating and expressing opinions. The value of this cannot be understated as it is not well assessed in other areas of the training program.

Despite these factors, there are some issues that have been identified regarding the modules in general, and specifically pertaining to individual modules.

General issues with external training modules

1. Timing – because completion of external modules (other than administration) is a pre-requisite for sitting for the Fellowship examinations, trainees struggle with the competing demands of the examinations and modules (though the modules’ content is relevant to the Fellowship examinations). This is particularly problematic for the research module which may be difficult to complete within a six-month term, especially if ethics approval is required.
2. The educational value of these modules is diminished by inadequate supporting course material and teaching.

3. The educational value of the modules is diminished without provision of detailed individual feedback.

‘Formal detailed and specific feedback is required. Development of an online learning module that is standardised and mapped to the curriculum would ensure that all trainees are provided with appropriate teaching. Currently the topics are too vague, unstructured and important concepts can easily be neglected.’

From training survey

4. Delayed feedback with some training modules

“14 months after submitting my module, I received an email stating that I had passed with my marks and without any individualised feedback.”

Personal communication with a trainee

Specific issues with individual external training modules

Research Module

Due to the time constraints in completing a project during a six-month rotation, topics may be quite ‘soft’. Supervisors who are not actively engaged in research may not be adequately equipped to supervise this module.

Neuropsychology Module

There is concern that this module is not clinically focused enough. This is of particular significance for trainees who have not previously undertaken a brain injury term. For them, this module poorly augments previous clinical experience.

‘For such an important area of rehab, a more innovative and comprehensive teaching style should be employed.’

From training survey

Health Services Administration and Evaluation Module

There is a consensus view of the importance of trainees acquiring knowledge about health services administration and evaluation as part of their training. Recent changes in this module with the introduction of the option of completing a course to satisfy the requirements of this module have been welcomed, particularly by the trainees. Few trainees now undertake the written option for this module.

'I felt there was not enough support (before), but fortunately the model has been changed.'

From training survey

Concern is expressed by some regarding the optional attendance of a course to meet the criteria of this module. It is felt that courses are a 'soft option' and are not taken seriously, particularly if training is not augmented by personal reflection. Some courses attended by trainees are too generic.

Behavioural Sciences Module

Feedback received suggests that educational value of this module is adversely affected by being marked by individuals who possibly have limited rehabilitation experience.

'Feedback from markers is odd and seems to demonstrate misunderstanding about rehab medicine. The learning objectives of the module are not met by the essay questions set.'

From training survey

Comment

As part of a more global review of the rehabilitation medicine clinical curriculum, the external modules need to be mapped against the curriculum to ensure that they are providing relevant educational value for trainees. To increase their educational worth, they should be supported by relevant course material, teaching and feedback, which must take place in a timely manner. Innovative contemporary approaches for augmenting these courses should be explored, including workshops, online modules and webinars.

In order to offer the best educational value for trainees, the timing of the modules should be reviewed within the context of the entire structure of the training program. Earlier completion of external training modules (other than Research), in combination with delayed Fellowship examinations would offer trainees more time for Fellowship preparation.

There would be value in delaying the requirement for completion of the Research Module until after the Fellowship examinations as this may promote undertaking focused research among trainees/new Fellows, particularly if a Fellowship year was taken up. Introducing the requirement for presentation of the research at a scientific meeting would also augment and expand the value of this module, contributing also to the academic strength of our specialty. Furthermore, expansion of national and international research networks will enhance trainees' participation in this module, not to mention the wider advantages for our specialty.

For the Health Service Evaluation and Administration Module, the option of developing a rehabilitation-specific course should be pursued, along with incorporation of an element of self-reflection to this course.

'A standardised (Rehabilitation) course would be more useful to all trainees instead of being able to go to any approved courses.'

'Should have some written assessment component in addition to doing the course (people can sleep through a course)!'

From training survey

The Behavioural Sciences Module could be enhanced by enhancing trainees' high-level communication skills and behavioural management techniques.

'Surprisingly little formal study required of how to work/communicate in teams, issues related to goal setting, working in healthcare teams, conflict resolution.'

From training survey

If some elements of the curriculum are moved from core to non-core, this would provide the opportunity for the development of additional external training modules, which would offer trainees additional individualised training programs.

6.8.2. Long case assessments

In-training long cases

The importance of in-training long cases cannot be over-emphasised as they closely approximate the nature of the work of the Rehabilitation Physician more than other training components. These encompass holistic patient evaluation, and assessment of the trainee's capacity to assimilate and communicate in written and verbal form a complex rehabilitation patient case scenario.

'Long cases are our job for life.'

From training survey

Despite the significant work which has gone into standardising assessment processes, lingering concerns remain about variability in process and assessment of in-training long cases, and that a greater proportion of the long cases should be directly observed (where the supervisor physically observes the trainee's patient assessment).

'Despite much work and effort over many years, there is far too much variability in the way Long Cases are performed and assessed for them to be useful from an assessment perspective. However, the skills that they are trying to assess are vital.'

From training survey

Formal long case assessment

Regarding the specific format of the formal long case assessment, there are a number of areas of concern identified.

Formal long case assessments can be undertaken in the trainee's existing training setting and with their current supervisor, reducing the independence of the assessment. Trainees are allowed unlimited attempts at passing the formal long cases. Some trainees report difficulties in accessing accredited assessors to carry out these assessments.

Given the importance of the long case, there is a view among some AFRM members that the long case assessment should remain part of the Fellowship examination, and that their removal from the Fellowship examinations may be an important contributor to the declining pass rates in the Fellowship examinations.

Comment

Centralised conduct of the formal long case during a specified time period may improve access and standardisation of this important assessment process, though the administrative burden would need to be considered. Introducing a maximum number of attempts would emphasise the importance of this assessment.

Alternatively, consideration could be given to returning to the past process of including long cases as part of the clinical examinations. This option had strong support in the training survey, with 52% of respondents being in favour of this option.

6.8.3. Learning Needs Analysis (LNA)

While the value in establishing a plan of learning is acknowledged by many, and has a strong educational basis, many express concerns regarding the current format of the LNA.

While senior trainees may have the experience and knowledge of the training needs and be able to adequately perform a gap analysis of their learning needs, this may be much more challenging for junior trainee who does not necessarily know what they do not know.

Specific standardised knowledge about the teaching and learning opportunities available from a specific training term, and supervisors, is generally not available to the trainee at the commencement of term, when the LNA is completed, reducing the pragmatic usefulness of this learning tool.

Some report having an inadequate knowledge of the LNA process and describe it as being too lengthy, complicated and theoretical.

'Agree with concept but the format is ridiculous. Keep it basic that trainees/supervisors agree as to what should be accomplished by end of term.'

From training survey

Comment

Processes around the LNA should be reviewed to ensure that trainees/supervisors have the relevant background knowledge and skills in their completion to enhance the effectiveness of this tool. Developing LNA templates for specific training terms / stages of training may improve the utility of this tool.

6.8.4. Trainee Term Evaluation Form

Trainee Term Evaluation Forms can provide real-world, meaningful and constructive feedback about the trainee's experience during a term, and supervision. If identified issues are addressed, these have the real potential to improve the term, supervision and clinical experience for future trainees. If collected information is not translated into feedback for the training site/supervisor, then the purpose of this tool is questionable.

'All well and good that these are completed, but feedback is not acted upon. I have put my feedback in writing, hence I do not want to talk to the New Fellow Rep, but I do want feedback from the Faculty as to how my feedback is acted up so that future trainees and training sites benefit.'

'I understand these are anonymous, but do not feel safe enough in a relatively tight job market to adequately communicate any concerns.'

From training survey

Comment

Feedback and recommendations stemming from trainee term evaluations can enhance information collected during virtual and physical site visits and supervisor accreditation to holistically improve the experience and learning of future trainees and means of incorporating feedback into accreditation of sites and supervisors deserves attention.

Trainee feedback has the potential to enhance the supervisor's future performance. Options for periodically providing de-identified feedback to supervisors should be considered to assist the supervisor with self-reflection for performance appraisal and supervisor accreditation.

6.9. **Concerns about some training settings and supervision**

As previously described, there has been a rapid increase in the number of accredited training positions and settings in the last decade, which represents exciting growth of the specialty.

The Specialist Training Program (STP) has provided some of this growth. The STP is an Australian Government initiative, funding training places in settings outside public teaching hospitals. Of the 374 accredited training positions, 27 are listed as STP-funded, representing 7% of all training posts, the greatest proportion of which is in Queensland,

where there are 11 STP funded positions³⁵. The current STP contracts are for three academic years, from February 2013 to February 2016.

Despite rigorous site accreditation processes for all training sites, some express concerns regarding aspects of some training positions.

Issues

1. Accreditation process

The virtual site visit is felt by some to be insufficient to identify issues. There may be a need for more in-person visits, particularly for recently established positions, and for positions about which specific concerns have been raised.

'Currently it is clear that many sites that are accredited do not meet the basic tasks that are required of accreditation, particularly with regard to teaching. The AFRM clearly states that centres should provide at least 1 hour of face to face teaching per week to trainees, especially large metropolitan sites which should have the resources (staff, time) to do so. There is no doubt that many and perhaps most sites do not provide this, and a simple audit of trainees would confirm this. This inevitably breeds cynicism among trainees.'

'Private Hospital rotations need to have very strict on-site review and accreditation. Too often these service positions are masquerading as training sites when they are not even fit for an intern/RMO position as they are so unsafe. Patient safety should never be compromised, especially when accreditation is supposed linked to it.'

From training survey

2. Suitability of some training positions

While the creation of new rehabilitation positions (including STP positions) has facilitated expansion of the number of trainees, questions remain regarding the educational value of some of some positions. There is a concern that while positions may be providing a necessary service to rehabilitation patients, some may be better suited for a junior medical officer as they do not offer sufficient educational value.

'Funding and acknowledgment of the role of rehabilitation medicine are critical issues, however we need to make sure we provide a service that is actually valuable to the health service.'

From training survey

³⁵ Personal correspondence, Helen Gane, 27 May 2014.

Comment

More onsite accreditation visits may be needed to ensure the suitability of training positions, particularly for new training sites, or for sites where specific concerns have been raised. Adequate resourcing for this process must be ensured. Accreditation should include specific consideration of trainee term evaluation feedback as previously described.

Some positions may need downgrading to resident/junior medical officer where their educational value is limited. This would increase exposure to rehabilitation medicine for potential trainees, though may jeopardise funding in some situations.

6.9.1. Supervision challenges

1. Difficulties with giving negative feedback and managing trainees in difficulty

The supervisor report, which is completed for each six-month training term, has the potential for significant value in giving feedback to the trainee and improving their future performance.

There can be reluctance in giving negative feedback to trainees, often due to underdeveloped skills or interest in this area. Feedback to the poorly performing trainee should be provided informally early in the term so deficiencies can be addressed and remedied.

If issues continue in a particular rotation, they should be identified in the supervisor term report; however, many report a reluctance to mark a trainee poorly on the biannual supervisor report. This may lead to an independent review of training (IRT) in which they need to participate. There are perceptions that an IRT is time-consuming, personally confronting for the supervisor, whose judgement is seemingly questioned, and that the usual outcome is that the trainee is ultimately passed for the term. There may be a resulting disinclination to giving accurate (negative) feedback where indicated.

'I have worked with very inadequate trainees who managed to pass several rotations but should not have (sometimes each rotation is hoping the next will fail these trainees).'

'Supervisors are not prepared to fail a candidate – partly due to faculty actions when they do, also often say "they will be ok in the end or if they do not do this area of practice" – not realising competency should be in all areas, faculty fails to hand on issues to next supervisors – all supervisors reports should be handed on to the next supervisor in a timely manner so areas of weakness can be addressed early.'

'Supervisors need to be strict and fail candidates who don't make the grade instead of passing the buck.'

From training survey

Unless the trainee fails a term, there is no requirement for previous supervisor reports (good or bad) to be forwarded to future supervisors. This is a lost opportunity to both reinforce positives and address deficiencies and issues.

Struggling trainees who continue to be unidentified and unassisted may then progress through the training program and present for Fellowship examinations. This is sometimes the first point at which the struggling trainee is officially identified.

'(The FCE is) currently our most reliable method for identifying trainees in difficulty which is not good for them or for the specialty.'

From training survey

Challenges associated with identifying trainees who are experiencing difficulties in the training program, and implementing relevant remediation may be contributing to the recently observed trends in the Fellowship examinations.

It is noted that there has been extensive work recently undertaken by the College with the development of the SPDP, which consist of three 3-hour workshops³⁶ which will go a long way to addressing this concern.

2. Training program specific knowledge

It has been reported that there is much variability regarding supervisors' knowledge about the training program and its requirements. While changes to the training program are noted in the online training manual, and referred to in the e-bulletin, other than through the self-evaluation undertaken during supervisor reaccreditation, there is no structure in place to ensure up to date knowledge regarding timing and requirements of assessments.

If the supervisors have inaccurate or out-dated knowledge of the training program requirements and standards, the supervision and support provided for trainees may be less helpful at best and potentially disadvantage the trainee at worst. For example, there have been instances where supervisors set the superseded essay style questions for trainees preparing for examinations.

3. Lack of feedback for supervisors

Improvement of the supervisor's skills is in part contingent on the supervisor receiving accurate feedback regarding their own performance. There is no current mechanism whereby feedback from the trainee is routinely provided to the supervisor and/or to the supervisor's manager. Access to feedback regarding supervision may assist the supervisor to improve in their role.

³⁶ SPDP programs <https://www.racp.edu.au/fellows/supervision/supervisor-workshops>

4. Inadequate supervision in some settings

Access to adequate supervision may be problematic for some in the private setting, where the supervisor is often a Visiting Medical Officer for whom supervision time may not be included in their working hours, and therefore may take a lower priority than direct patient contact.

'My experience of Private Hospital Rehabilitation rotations has been extremely poor. Despite supposed accreditation of terms, there is minimal teaching and unsafe work expectations and practices. Consultants have held trainees to ransom by threatening to not satisfactorily complete supervisor reports if they do not participate in unsafe working practices e.g. a sole registrar looking after a large unit with no other JMO support. It is jeopardising training and patient care. Something needs to be done.'

From training survey

Comments

Supervisors need to be equipped with the skills to give constructive feedback, to identify trainees in difficulty and to provide them with the assistance they need.

Engagement with the SPDP program will go far to achieving these aims, especially if SPDP training is tailored to the specific needs of rehabilitation supervisors, and it is available in alternative formats for those who may struggle to attend training in person. Development of online networks for rehabilitation supervisors may further support them in their roles.

Supervisors also need accurate information regarding elements and standards in the current training program in addition to the long case. This will enable supervisors to provide accurate guidance for their trainees progressing through the training program. This could be delivered as part of the already existent long case calibration sessions that supervisors regularly attend.

Providing supervisors with past supervisor reports will assist supervisors in their role. As previously discussed, de-identified trainee feedback will help improve the quality of supervision.

7. Opportunities

7.1. *Future workforce demands for Rehabilitation Medicine Fellows*

It is likely that there will be a growing demand for Rehabilitation Physicians in the coming decades with the ageing of the population, and ageing with disability as previously discussed. There is also likely to be substantial growth within certain subspecialty areas of rehabilitation medicine. These predictions represent exciting opportunities for rehabilitation medicine specialists in the coming decades in Australasia.

As a specialty, we need to continue to promote strategies to enhance awareness of rehabilitation medicine as a career option among potential trainees so that there continues to be strong competition among high quality trainees for entry into training.

The training survey revealed that 'image' and 'professional respect' for rehabilitation medicine are factors which would make it less likely for self-selecting rehabilitation medicine as a specialty. These factors must be addressed to ensure maintenance and growth in trainee numbers

To preserve the strength of employment opportunities, specialists in rehabilitation must be suitably credentialed and equipped to fulfil the requirements of emerging directions in the specialty, as previously detailed. If not, there is a risk that these roles may be usurped by specialists in other fields, and/or that the reputation of the specialty may be adversely affected (see following section).

7.2. *Expansion of the role of rehabilitation medicine*

Chapter 2 described the trends and change which has been observed in the nature of rehabilitation medicine work: settings, acuity and casemix and development of new models of care. These trends have seen the rapid and organic needs-based expansion of existing and development of new services and models of care, including acute rehabilitation teams, and roles within orthogeriatrics services, stroke units and in telemedicine.

Rehabilitation Physicians and trainees describe concerns about deficiencies in knowledge or skills to manage issues in their patients who are undergoing rehabilitation earlier.

'There is an increasing need of good general medical skills for rehabilitation doctors to meet future demands which are not adequately addressed by the current training system.'

'Need to ensure (trainees have) adequate training and experience in general medicine to deal the acute medical and surgical conditions that occur in inpatient rehab population.'

From training survey

If the trends identified in the specialty of rehabilitation medicine are accepted as being a true reflection of the future of rehabilitation, there are exciting opportunities awaiting future Rehabilitation Physicians, who will need suitably training to meet the evolving needs of the specialty.

These changing training needs would largely be met by providing a more solid grounding in internal medicine than is currently facilitated by the existing training program.

Acceptance of the changing role not globally accepted

The view that there is a need for knowledge and skills to address changes in rehabilitation medicine is not globally held among Rehabilitation Physicians.

Interestingly, only 16% of training survey respondents rated the changes in rehabilitation medicine practice as an issue of critical importance, 24% rated 'focus on early rehabilitation' as an issue of critical importance and 20% rated 'knowledge/skills in general medicine' as an issue of critical importance.

The alternative view is there is no need for Rehabilitation Physicians to have specialist skills and knowledge in internal medicine as the role of the Rehabilitation Physician is predominantly in disability management, and that complex medical issues are best left to the relevant internal medicine specialist. The parallel is made with psychiatrists working in liaison psychiatry in an acute medical setting who are not required to have a detailed knowledge of the acute medical/surgical issues that their patients have, but rather to focus on the psychiatric management of patients with acute medical/surgical issues. Like psychiatrists, Rehabilitation Physicians are credentialed to manage general medical issues as demonstrated by general medical registration, and there is an argument that the medical issues are best managed by those suitably qualified.

'It is imperative that medical principles do not become more "worthy" than rehabilitation principles - our most important practice "intervention" is the models of care and way we view disability and it is for us to train others to understand as part of grand rounds, everyday profile of the service and returning patients to their referring physicians in a much better shape and very happy with their care under the rehab team.'

From training survey

It may be that, after rigorous internal debate that the profession decides to focus on the management of disability, without the need for a wider skillset, to focus on our core work without trying to be everything to everyone. Perhaps there are opportunities for greater development of shared care models in the acute, subacute and ambulatory care settings where there is integrated inter-specialty management.

Comment

Roll-out, acceptance and understanding of the full implications of the observed trends in rehabilitation medicine are patchy at best, even among those working in rehabilitation medicine. The wider health environment struggles at times even to grasp the general role of rehabilitation medicine, let alone the rapidly expanding role of rehabilitation medicine.

The rehabilitation medicine community needs to find greater clarity regarding the future direction and expansion of the specialty and what role we want to play in that environment. Only once that discussion has taken place can we be in a position to recommend a fundamental change to our training program.

If, after open and transparent discussion, it is projected that the current training program is not fit for purpose, and that there is a need for a more solid foundation in internal medicine, the training program should be modified accordingly so that the Rehabilitation Physician is appropriately skilled. .

Recommendations:

1. Develop a coherent vision of the future of rehabilitation medicine in Australasia through facilitated internal discussion and debate.
2. If the current training program is found to be unfit for purpose for the future of rehabilitation medicine in Australasia, consideration of one or more of the following options are recommended:
 - a) Curriculum review and update
 - b) Change entry to training pre-requisites so trainees entering the program have a more solid foundation in internal (see previous chapter)
 - c) Promote the currently available option of joint training (explored in a later section)
 - d) Promote the currently available option of dual training (explored in a later section)
 - e) Change training program structure to the FRACP option (explored in a later section).

8. Threats

8.1. *Institutions other than RACP offering specialist training in rehabilitation medicine*

There has been recent change in legislation for the criteria which AHPRA uses for the recognition of a specialist. The implications of this change are that the RACP is no longer the sole provider of physician education in Australia. It is anticipated that its preferred provider status in education for physicians will be increasingly challenged. There are emerging opportunities, especially for universities as alternative providers of specialist training, including rehabilitation medicine, but as yet no alternative providers have come to light.

Additionally, the legislation establishing the agency specifically states that, once training is successfully completed, continued recognition on the register as a specialist is not contingent on Fellowship of a college. If alternative education providers come forward, the AFRM, like the rest of the RACP, may be faced with significant issues in not only attracting, but also maintaining its Fellowship. The RACP and the AFRM are dependent upon the Fellowship for the delivery of the education and training program.

Risk of competition for provision of rehabilitation medicine training by alternative providers will be mitigated if the community remains in meaningful and regular dialogue regarding the ongoing provision of specialist training and if the model of education provided remains contemporary and responsive to shifts in practice.

Comment

In order to provide strength and consistency in the future provision of rehabilitation education in Australasia, the training program must continue to be of the highest standards, and engagement of the rehabilitation medicine community in the education and training in rehabilitation must be maintained and enhanced.

8.2. *Adequacy of geographic distribution of Rehabilitation Medicine Trainees and Fellows*

There are well-recognised deficiencies and imbalances in the availability of specialist rehabilitation medicine services between states, and regions in Australia and across New Zealand^{37 38 39 40 41}.

³⁷ Graham SK, Cameron ID. 'A survey of rehabilitation services in Australia'. *Australian Health Review* 2008; 32: 392-399.

³⁸ South Australia, Department of Health, Statewide Service Strategy Division (2009). *Statewide Rehabilitation Service Plan 2009-2017*. South Australia. Available from:

While rehabilitation is strong in urban New South Wales, Victoria and Queensland, there is relatively less widespread acceptance of its role in rural/regional settings, in some states, and possibly in New Zealand. This inequity in supply, coupled with regional deficiencies in training numbers, challenges future rehabilitation services in some areas.

Reasons trainees may be dissuaded from non-metropolitan training may include: family commitments, financial issues (paying for local accommodation while continuing mortgage repayments), access to teaching, support from fellow-trainees/Fellows, and workload demands. This is despite the many recognised positive aspects of training/working in a non-metropolitan setting (such as quality of life, travel time, living costs and variety of clinical work encountered)^{42 43}. Having a positive training experience in a non-metropolitan setting increases the likelihood of opting for future training in these settings. Previous attempts have been made in some settings to marry high-demand metropolitan terms with regional terms, though they have been very unpopular with trainees and have not continued.

Comments

While a whole of College review of workforce adequacy is underway⁴⁴, the AFRM also needs to consider these issues, specifically as part of a wider workforce strategic review as previously discussed.

Options for development of training should be explored, including: development of STP training positions (being mindful of potential weaknesses of this model), introduction of compulsory non-metropolitan training period into training requirements, linking more popular metropolitan terms to regional terms, developing short-term modular training options in non-metropolitan settings, enhancing access to subsidised accommodation and consideration of training salary supplements in certain areas.

<http://www.sahealth.sa.gov.au/wps/wcm/connect/97db9d0042632bfebce5beb44d317729/serviceplan09-17-clinicalnetworks-sahealth-0911.pdf?MOD=AJPERES&CACHEID=97db9d0042632bfebce5beb44d317729>

³⁹ Health Workforce New Zealand (2011). *Rehabilitation Workforce Service Review Final Report*. Available from: <http://www.health.govt.nz/system/files/documents/pages/rehabilitation-workforce-service-forecast.docx>

⁴⁰ Australian Rehabilitation Alliance (2011). *The Need for a National Rehabilitation Strategy: working towards a clear and united Rehabilitation strategy for Australia*. Available from:

file:///C:/Users/sparker1/Downloads/The_Need_for_a_National_Rehabilitation_Strategy_110810.pdf

⁴¹
⁴² RACP (2011). *Senate Standing Committees on Community Affairs: Inquiry into the factors affecting the supply of health services and medical professionals in rural areas*. Available from:

<file:///C:/Users/sparker1/Downloads/RACPSubmissionSenateinquiryintoruralhealthprofessionals1.pdf>

⁴³ Rural Doctors Association of Australia (2012). *Regional, Rural and Remote Medical Specialists Survey*. Available from

[http://www.rdaa.com.au/Uploads/Documents/Final%20\(with%20Updated%20Logo\)%20RDAA%20rural%20medical%20specialist%20survey_20121011030002.pdf](http://www.rdaa.com.au/Uploads/Documents/Final%20(with%20Updated%20Logo)%20RDAA%20rural%20medical%20specialist%20survey_20121011030002.pdf)

⁴⁴ RACP (2011). *Senate Standing Committees on Community Affairs: Inquiry into the factors affecting the supply of health services and medical professionals in rural areas*. Available from:

<file:///C:/Users/sparker1/Downloads/RACPSubmissionSenateinquiryintoruralhealthprofessionals1.pdf>

8.3. *Rehabilitation Medicine Fellows not equipped to meet the evolving trends of the specialty*

If there is mismatch between the knowledge and skills provided by the training program and the skills and knowledge required to address the future trends of the specialty (see previous section), there is a risk for a series of negative outcomes occurring.

The key importance of appropriate content in rehabilitation training was identified in the training survey, with 40% of respondents rating this as an issue of critical importance.

Issues

1. Suboptimal patient care

Outcomes for patients may be poorer if Rehabilitation Physicians are not adequately equipped to meet their needs. Length of stay may increase, with a greater reliance on consultations by other clinicians and with flow on cost implications for the health industry.

2. Clinicians working on the margins of the scope of practice

Rehabilitation Fellows working on the evolving margins of the defined scope of practice whose patients experience a poor outcome will be at risk of complaints, disciplinary action, litigation and possibly registration.

3. Limitations to involvement in models of care

If graduating Rehabilitation Medicine Fellows are inadequately equipped with the requisite knowledge and skills, their roles in existing and emerging models of care may be restricted e.g. acute rehabilitation, geriatric flying squads, chronic care and participation in medical on-call roster (particularly an issue in rural/regional centres).

4. Detrimental impact on the image and credibility of rehabilitation medicine

Forty-one percent of member training survey respondents identified 'credibility of rehabilitation medicine' as being an issue of critical importance in the future of rehabilitation medicine. Similarly, this factor was identified as being a strongly negative influential factor on self-selection into rehabilitation medicine as a specialty.

It is noted that the image of rehabilitation varies widely between centres and is by no means globally negative. Some even perceive that the 'image issue' of rehabilitation is perpetuated by members of the rehabilitation community more than by our colleagues. In centres where there has been a rehabilitation presence for some time e.g. where rehabilitation is well integrated into models of care, Rehabilitation Physicians are often held in high regard, have a positive image and are respected within the medical hierarchy.

In other centres where rehabilitation is less well established and integrated, and less well understood, acceptance of its importance and value may be less strong. This negative image of rehabilitation may be exaggerated if trainee quality is substandard.

5. Rehabilitation specialist roles taken on by other specialties

A specialist rehabilitation service is defined as being under the management of a Rehabilitation Physician: 'A specialist Rehabilitation service under the direction of a rehabilitation physician (Fellow of the AFRM or equivalent) provides comprehensive, patient-centred multi-disciplinary care'⁴⁵.

Despite this clear definition, there is increasing debate and concern expressed by Rehabilitation Physicians regarding trends for rehabilitation care to be undertaken by other clinicians. The trends have been observed in:

1. Hospital setting:

- Geriatricians (rehabilitation of the older person)
- General physicians (re-conditioning rehabilitation)
- Neurologists (stroke rehabilitation and other neurological rehabilitation)
- Orthopaedic surgeons (musculoskeletal rehabilitation, amputee rehabilitation)
- Vascular surgeons (amputee rehabilitation)
- Cardiologists and respiratory physicians (cardiac and pulmonary rehabilitation respectively)
- Palliative care physicians (palliative rehabilitation).

2. Community setting:

- General practitioners
- Allied health clinicians and case managers (for people with disabilities receiving support via the National Disability Insurance Scheme).

Possible explanations for loss of Rehabilitation Physician roles to other specialties:

⁴⁵ Inpatient adult rehabilitation services are conducted under the leadership of a Rehabilitation Physician:

'A specialist RM service under the direction of a rehabilitation physician (Fellow of the AFRM or equivalent) provides comprehensive, patient-centred multidisciplinary care.'

The Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals (2011). Available from: <https://www.racp.edu.au/fellows/resources/rehabilitation-medicine-resources/standards-for-rehabilitation-services>

Similarly, according to the *Guidelines for the Recognition of Private Hospital-Based Rehabilitation Services* (2012) prepared by the consultative Committee on Private Rehabilitation, Rehabilitation Physicians are critical in the governance structure of Private Rehabilitation settings:

'The multidisciplinary rehabilitation team will be under the clinical management of a Consultant in RM or equivalent' *Guidelines for the Recognition of Private Hospital-Based Rehabilitation Services* (August 2012). Developed by the Consultative Committee on Private Rehabilitation. Available from:

[http://www.health.gov.au/internet/main/publishing.nsf/Content/D05D7DCE1FFD3D93CA257BF0001A8E0E/\\$File/32-13%20A.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/D05D7DCE1FFD3D93CA257BF0001A8E0E/$File/32-13%20A.pdf)

The new national definition of rehabilitation care via the independent Hospital Pricing Authority is, however, less prescriptive, though still indicates the rehabilitation skills/qualifications for medical practitioners delivering rehabilitation⁴⁵:

'Rehabilitation care is always delivered under the management of or informed by a clinician with specialised expertise in rehabilitation...'

Independent Hospital Pricing Authority (2013). *Classification: Subacute and non-acute care: Rehabilitation*. Available from:

<http://www.ihoa.gov.au/internet/ihoa/publishing.nsf/Content/rehabilitation-care-lp>

1. Greater overlap between previously well defined 'phases' of care with blurring of lines of responsibility between physicians traditionally working in 'acute', 'subacute' and ambulatory settings.
2. Specialists want to provide continuity of care for their patients, as they shift from these less well defined 'phases' of care.
3. Patients with significant medical/surgical issues which cannot be suitably addressed by the Rehabilitation Physician's existing skills and knowledge.
4. No suitably qualified Rehabilitation Physicians available to provide rehabilitation care (particularly problematic in some regions).
5. Poor understanding and respect for the role of rehabilitation medicine by some other health professionals, external bodies, potential trainees and patients.

'One of the reasons I have debated rehab medicine as a career path is it appears that a lot of...Geriatricians and many other specialties do not recognise rehab as an important specialty and unfortunately NOR do a lot of our patients.'

From training survey

Notwithstanding these reasons, there are real concerns that outcomes will be poorer for people with disability if rehabilitation care is undertaken by clinicians who have not had specialised training in rehabilitation medicine. While other clinicians have specialty specific knowledge regarding specific impairments, they lack the expertise and training of Rehabilitation Physicians in the management of disability and the optimisation of function

Comment

Ensuring that rehabilitation training meets the future needs for specialists is essential to ensure that Fellows are fully equipped to meet the emerging demands of the specialty and to ensure the best outcomes for patients. This may also help to sure up the role of the specialty in the future health landscape.

Collaborative management of patients between specialist fields will also improve the best possible outcomes for patients, but there needs to be an adequate element of overlapping knowledge between the specialties for this to successfully occur. There are opportunities for this to occur not only in the hospital setting (e.g. as has occurred with stroke units), but also in the community setting, with the opportunity for partnership with allied health practitioners and other providers through the National Disability Insurance Scheme in Australia.

Improving knowledge of rehabilitation medicine's role by other clinicians will go far to facilitating cross-specialty respect and understanding. This is a process that will occur over time, as the role of rehabilitation in the healthcare landscape is refined, and when patients achieve the best outcomes. Ensuring that the training program is of the highest

quality and purpose built for the future of the specialty as outlined in other areas of this report will go far to achieving these aims.

9. Alternative models for rehabilitation medicine training

9.1. Introduction

This section delineates alternative options for structuring rehabilitation medicine training in Australasia. Firstly, the options of dual and joint training are explored. These are already available to trainees and would address several of the issues identified in the SWOT analysis. Secondly, the FRACP option will be explored in greater detail – the specific details pertaining to this option for training, the advantages and disadvantages of this means of training, along with an evaluation of how this training structure addresses or otherwise the factors identified in the SWOT analysis.

9.2. Joint training

There is an existing options for securing a double fellowship including adult rehabilitation medicine and FRACP. This is underutilised, with less only a handful of such double qualifications are being completed.

Reasons for the underutilisation of this pathways relates to the greater time and expense involved in completing two fellowships, and limited awareness of this option.

9.2.1. Joint training

There is a defined pathway of joint training for trainees wishing to obtain dual fellowships, FAFRM and FRACP, via the Adult Division.

Joint training is the model currently utilised by paediatric Rehabilitation Medicine Trainees. In this model, Basic Training precedes Advanced Training in two specialties, rehabilitation medicine, plus another. In paediatric rehabilitation training, general paediatrics is the second Advanced Training specialty which is most frequently undertaken. In this model, the duration of advanced training is discounted as some of the training in each of the advanced training programs is jointly recognised by the other, providing the training requirements of both programs are completed.

An example of a joint Advanced Training program incorporating adult rehabilitation medicine could be structured as follows:

1. Completion of Basic Training in Adult Internal Medicine
2. A minimum of two years of training in rehabilitation medicine
3. The third year of training which could be taken in:
 - a. Rehabilitation medicine
 - b. Any related subspecialty of internal medicine approved by the appropriate training committees of both the RACP and the AFRM. The training experience during this year should give special emphasis to the rehabilitation aspect of that subspecialty.

4. Non-core (elective) rehabilitation training. One year of core training in one of the subspecialties of internal medicine.

Natural paired advanced training programs may include between adult rehabilitation medicine and the following specialties. These potential pairings could be further investigated:

- General medicine
- Geriatrics
- Rheumatology
- Neurology
- Cardiology
- Respiratory medicine.

9.2.2. Recommendations regarding joint training options for rehabilitation medicine

Further development, refinement, explanation and marketing of the joint training pathway is a real option to address some of the training program issues identified. This is an existing option, and would not require any structural change to the program, unlike the FRACP change. Joint training would be particularly attractive if specific negotiations regarding reciprocal recognition of advanced training terms were undertaken.

9.3. *Basic Physician Training plus Advanced Training in rehabilitation medicine (the FRACP option)*

This section describes the option of changing current training in adult rehabilitation medicine from Advanced Training via the AFRM, resulting in the Fellowship of the Australasian Faculty of Rehabilitation Medicine (referred to as 'the FAFRM option' for the remainder of this section) to divisional training via the Adult Medicine Division, with subsequent Advanced Training in rehabilitation medicine, resulting in Fellowship of the Australasian College of Physicians.

It also addresses other general questions which would arise regarding this possible model of education for adult rehabilitation medicine.

The potential move of adult rehabilitation medicine training to a training program with the post-nominal qualification of Fellow of the Royal Australasian College of Physicians (FRACP) would address several, but not all, domains identified in the analysis of the rehabilitation medicine training program. There was mixed support for this model in the member survey, with 41% of respondents in favour of this change and 49% not in favour.

In this model, three years of adult Basic Training would precede Advanced Training in rehabilitation medicine via the Adult Division of Medicine resulting in the qualification of FRACP. The FAFRM qualification would no longer be offered.

Basic Training focuses on developing core medical skills and knowledge, introducing the specialty disciplines and providing a foundation for consolidation and further study within Advanced Training. The current Basic Training Curriculum in Adult Internal Medicine includes limited reference to rehabilitation medicine. An extensive review of the Basic Training curricula is currently underway, which may provide a natural opportunity for redressing the rehabilitation medicine content in the Basic Training Curriculum. Some current rehabilitation Advanced Training curricula requirements could be covered through the completion of the Basic Training program.

Advanced Training in rehabilitation medicine would probably be three years in duration. Other than removal of Modules 1 and 2, no other significant alternation to the current training program components would be necessary. The Advanced Training Curriculum would be updated in line with the College-wide curricula renewal process, with removal of approximately 25% of content already addressed in the Basic Training Curriculum.

As with other Advanced Training programs undertaken via divisional training, governance of Advanced Training in rehabilitation medicine would be the responsibility of an Advanced Training Committee reporting to the Adult Medicine Division Education Committee. A change to this model of training would be dependent on support from the Adult Medicine Division of the College. The formation of a specialty society in rehabilitation medicine is not essential for this model, though a rehabilitation medicine specialty society could provide input into the Advanced Training Committee.

A change to this model of training would be predicated on broad-based support from AFRM members, ratification by AFRM Council, the Adult Medicine Division Council, College Education Committee and RACP Board, and approval by the Australian Medical Council, the Medical Board of Australia and Medical Council of New Zealand. Any changes to the Specialist Register in Australia require approval of Health Ministers, which has been increasingly difficult to attain in recent years.

If training moved to this model, current trainees' programs would be unaffected and a prospective change-over date would be set. It is most unlikely that individuals currently holding an FAFRM would be automatically grandfathered to the FRACP qualification because of intrinsic differences between the training programs. Options for providing truncated Basic Training for current AFRM Fellows could be explored, though the requirements for completing the Basic Training programs would remain, such as successfully sitting the written and clinical examinations and potentially other components introduced with the revision of the Basic Training curricula.

9.3.1. Framework and structure

The PREP framework is the overarching framework which is relevant for all College programs, including FAFRM and FRACP programs, and is currently under revision as part of the College-wide curricula renewal process.

Currently, FAFRM training consists of Advanced Training, without a preceding period of Basic Training.

In the FRACP model, adult Basic Training would precede Advanced Training in rehabilitation medicine.

9.3.2. Basic training

Basic Training focuses on developing core medical skills and knowledge, introducing the specialty disciplines and providing a foundation for consolidation and further study within Advanced Training, in this case, Advanced Training in rehabilitation medicine.

The aim of the Basic Training Program is to produce trainees capable of entering any of the specialty training programs offered in Advanced Training. Trainees are provided the opportunity to attain a high level of medical basic skills knowledge and generic skills development.

9.3.3. Advanced Training

Advanced Training follows Basic Training and is conducted via the Adult Internal Medicine or Paediatrics & Child Health Division.

The Advanced Training Curriculum, which follows on from Basic Training, as opposed to those from the faculties, builds on and further contextualises the knowledge and clinical skills gained during Basic Training within a chosen specialty. Specialties provide a contextual focus for the further development, and assessment, of a range of higher order learning objectives drawn from the Professional Qualities Curriculum.

9.3.4. Qualification

FAFRM	FAFRM (Fellow of the Australasian Faculty of Rehabilitation Medicine)
FRACP	FRACP (Fellow of the Royal Australasian College of Physicians), with the subspecialty of Rehabilitation Medicine (Adult)
Comment	<ul style="list-style-type: none"> - FAFRM for Adult Rehabilitation would no longer be offered by the College. - FRACP, College Fellowship (Adult Medicine and Paediatrics & Child Health) is undifferentiated. Regardless of the Advanced Training program completed all physicians (Adult Medicine and Paediatrics & Child Health) are awarded the qualification FRACP. - These changes have important implications for equity in employment opportunities for adult Rehabilitation Physicians. - Discussion regarding future of paediatrics specialist FAFRM qualification would need to be undertaken.

9.3.5. Duration, structure and content

FAFRM	48 months consisting of minimum of 36 months' experience in rehabilitation medicine and a maximum of 12 months of non-core training.
FRACP	6 years total, consisting of: <ul style="list-style-type: none"> - Basic Training – 36 months, consisting of a minimum of 24 months of core training and a maximum of 12 months of non-core training - Advanced Training in rehabilitation medicine – probably 36 months, consisting of a minimum of 24 months of core training and a maximum of 12 months of non-core training.
Comment	Duration of Advanced Training in rehabilitation would be up for negotiation. Duration of most Advanced Training programs is 3 years (e.g. neurology, geriatric medicine, and rheumatology). Duration may need to be longer to address curriculum content if this is increased.

9.3.6. Earliest completion post graduate

Current	6 years
Proposed	7 years
Comment	Duration of training longer by 1 year minimum, with implications for attractiveness of training program and overall cost of training.

9.3.7. Current entry criteria and procedure

FAFRM	<ol style="list-style-type: none"> 1. Completion of medical degree 2. Medical registration 3. 2 years' post graduate experience 4. Apply to become a registered trainee which is contingent upon obtaining a suitable training position 5. Training program prospectively approved by AFRM
FRACP	<p>Basic Training</p> <ol style="list-style-type: none"> 1. Completion of medical degree 2. Completion of an intern year, the first post-graduate year 3. Appointment in a training position in a hospital accredited by the College for Basic Training 4. Trainees receive approval from the local Director of Physician Education (DPE) to enter Basic Training 5. Once the trainee has received approval from the DPE to enter the program, an application can then be made to the College
	<p>Advanced Training in rehabilitation medicine</p> <ul style="list-style-type: none"> - The procedure for securing Advanced Training positions in rehabilitation

	<p>medicine would need to be determined. The existing system, which varies across sites and regions, would be maintained.</p> <ul style="list-style-type: none"> - The procedures for Advanced Training specialty programs differ between specialties, regions/states and year of training. Some have centralised interview processes, others have a multi-specialty matching process, and others have a process which is linked between the state health department and the RACP (New South Wales). - General procedure for Advanced Training programs: <ol style="list-style-type: none"> 1. Trainee is eligible to apply for acceptance into Advanced Training Program following their satisfactory completion of all requirements of Basic Training, including success in the divisional written and clinical examinations 2. Trainee secures a training position 3. Acceptance into an Advanced Training program is determined by relevant education/training committee 4. Trainee applies for approval with the RACP by completing an Annual Application for Approval of Advanced Training prospectively, each year.
Comment	<ul style="list-style-type: none"> - Trainees would enter undifferentiated physician training 1 year earlier, with the potential for reduction in breadth of clinical exposure and experience, especially surgical exposure, prior to entering into rehabilitation medicine training. - Trainees would enter into Advanced Training in rehabilitation medicine a minimum of 4 years after graduation. Trainees entering into rehabilitation training may have greater maturity and broader medical experience. - NB – the new RACP selection into training policy will result in changes to future entry to training criteria. - Consideration of criteria for entry to Advanced Training would need to be discussed by membership.

9.3.8. Supervision

FAFRM	For each rehabilitation medicine training rotation, trainees nominate 1 supervisor, ideally with FAFRM. For each non-core training rotation, trainees nominate 1 supervisor with FAFRM, FRACP or Fellowship of another college or faculty (appropriate to the rotation).
FRACP	Basic Training: For each year of training, basic trainees in adult medicine have the following supervision framework (details can be found in the Basic Trainee Handbook ⁴⁶):

⁴⁶ 2015 PREP Basic Training in Adult Medicine <https://members.racp.edu.au/index.cfm?objectid=11F80CCC-AD9E-26A5-C2E02E92A713513B>

	<ol style="list-style-type: none"> 1. DPE 2. Educational Supervisor(s) 3. Professional Development Advisor 4. Ward/Service Consultant (i.e. term supervisor, 1 per training rotation).
	<p>Advanced Training in rehabilitation medicine Supervisors would either hold FAFRM (as they do currently), or FRACP with Advanced Training in rehabilitation medicine as Fellows with this qualification progress through the system.</p>
Comment	<ul style="list-style-type: none"> - For Basic Training terms in rehabilitation medicine, Ward/Service Consultant (rotation/term supervisor could hold FAFRM, and would not necessarily have to hold an FRACP. A Ward/Service Consultant is a clinician, but does not need to be a Fellow of the College. - Rehabilitation supervisors with FAFRM for Basic Training rotations in rehabilitation medicine may not have the knowledge and skills in internal medicine to provide adequate supervision, disadvantaging those trainees.

9.3.9. Competencies at the end of training

FAFRM	Competencies are as outlined in background introductory section of the AFRM training requirements handbook
FRACP	<p>Basic Training: In summary, it is expected that at the completion of Basic Training, trainees will have developed:</p> <ol style="list-style-type: none"> 1. the ability to diagnose and manage all common acute medical presentations and refer as appropriate 2. good communication skills and the ability to work as part of a team when dealing with the management of complex and chronic medical conditions 3. a good 'breadth of competence' and some 'depth of competence' across the medical specialties. <p>Specific competencies are outlined in the BPT program requirements handbook⁴⁷.</p>
	<p>Advanced Training in rehabilitation medicine Current competencies would remain unchanged.</p>
Comment	Note current work being undertaken regarding college-wide educational framework which will impact on expected competencies/stages of training, and so forth as previously described.

⁴⁷ 2015 PREP Basic Training in Adult Medicine <https://members.racp.edu.au/index.cfm?objectid=11F80CCC-AD9E-26A5-C2E02E92A713513B>

9.3.10. Program requirements

<p>FAFRM</p>	<ul style="list-style-type: none"> - 36 months of core training (minimum) - 12 months of non-core training (maximum) - LNA each 6-month term - Trainee term evaluation report per each 6- month rotation - Final supervisor report for each 6-month rotation - 12 ITLCA - FIM™ training course - Module 1 – written assessment (to be completed once in first or second year of Advanced Training) - Module 2 – Clinical assessment (to be completed once in first or second year of Advanced Training) - External Training Modules: Module 3 – Clinical Research (OR research project) - Module 4 – Clinical Neuropsychology - Module 5 – Health Services Administration and Evaluation - Module 6 – Behavioural Sciences - 2 formal long case assessments - Fellowship Written Examinations - Fellowship Clinical Examinations.
<p>FRACP</p>	<p>Basic Training:</p> <ul style="list-style-type: none"> - 24 months of core training - 12 months of non-core training - LNA (minimum of 2 per year; ideally, 1 for each major substantive rotation of 10 weeks or more) - Professional qualities reflection (2 per year, one every 6 months)⁴⁸ - Ward/Service Consultant report for each rotation - Mini-clinical evaluation exercise: 4 per year⁴⁹ - 2 progress reports per year(1 mid-year, 1 annual) - At least 12 months at a Level 3 teaching hospital - At least 3 months outside a Level 3 teaching hospital - Completion of an Advanced Life Support Course or equivalent - Successful completion of the RACP written examination in adult medicine⁵⁰

⁴⁸ A professional qualities reflection involves trainees revisiting and reflecting on an event or series of events that have impacted on their professional practice. Through analysis of the event(s), trainees are able to identify and consolidate good practices leading to improved performance.

⁴⁹ The aim of the mini-clinical evaluation exercise encounter is to evaluate the performance of the trainee in real life clinical situations. Various skills are assessed during the patient consultation, including medical interviewing, physical examination, professional qualities, counselling skills, clinical judgement, organisation and efficiency

⁵⁰ The written examination is one of the two summative examinations for Basic Trainees and is blueprinted against the domains of the Basic Training Curriculum and Professional Qualities Curriculum. Its purpose is to ensure that a Basic Trainee has achieved a standard

	- Successful completion of the RACP Clinical Examination in Adult Medicine ⁵¹ .
	Advanced Training in rehabilitation medicine As per current requirements, other than removal of Modules 1 and 2
Comment	<ul style="list-style-type: none"> - Modules 1 and 2 removed. BPT written and clinical examinations take over their role. This would remove a significant time, administrative and financial cost burden from current training - Number of ITLCA could be reduced if Advanced Training duration shorter - Other program requirements would not necessarily change, but other potential changes to the program as outlined in the previous section could be considered - Currently, there are exit examinations, both written and clinical before the Rehabilitation Medicine Fellowship is granted. Whether these would be maintained is a matter of debate and would require a full discussion and analysis of the evidence regarding the benefits of exit examinations - ‘There is no clear indication for end-of-Advanced Training summative exams, as this would be contrary to the desired trend towards competency-based assessment and education, and the RACP Advanced Training assessment programs are already in line with these trends.

9.3.11. Curricula

FAFRM	<ol style="list-style-type: none"> 1. Rehabilitation Medicine Advanced Training Curriculum 2. Professional Qualities Curriculum
FRACP	<p>Basic Training</p> <ol style="list-style-type: none"> 1. The Adult Internal Medicine Basic Training Curriculum⁵² builds on the knowledge and skills acquired during initial medical school training and the pre-vocational PGY 1/2. It enables trainees to: <ul style="list-style-type: none"> - acquire a ‘breadth of competence’ that will be further developed into a ‘depth of competence’ during their subsequent specialty-specific Advanced Training. - build on their existing knowledge and skills - provide context for the Professional Qualities Curriculum.

of knowledge that will enable them to apply to enter an Advanced Training Program. The written examination for adult medicine comprises two papers taken on the same day that consist of MCQs.

⁵¹ The Clinical Examination is one of the two summative examinations for Basic Trainees, and is blueprinted against the domains of the Basic Training Curriculum and Professional Qualities Curriculum. Its purpose is to ensure that a Basic Trainee has achieved a standard of knowledge and skill that will enable them to apply to enter an Advanced Training Program. The Clinical Examination consists of two long cases and four short cases.

⁵² The Adult Internal Medicine Basic Training Curriculum – see <https://www.racp.edu.au/docs/default-source/default-document-library/basic-training-adult-internal-medicine-curricula.pdf?sfvrsn=0>

	2. Professional Qualities Curriculum
	<p>Advanced Training in rehabilitation medicine</p> <ul style="list-style-type: none"> - See following sections re potential revised curriculum for extensive details - This is similar in nature to the existing curriculum, with removal of approximately 25% of existing content which would be addressed in the Adult Internal Medicine Basic Training Curriculum
Comment	<p>Basic Training</p> <ul style="list-style-type: none"> - The current Adult Internal Medicine Basic Training Curriculum includes limited reference to rehabilitation medicine, as outlined in the curriculum mapping matrix in the following section. - If rehabilitation medicine training were to change to training via the Adult Medicine Division, the BPT curriculum would require review to ensure that it includes the relevant foundation knowledge of rehabilitation medicine which would be built upon in Advanced Training. - The Basic Training Curriculum would need to be modified to incorporate knowledge and skills in rehabilitation medicine as a foundation to future Advanced Training in this field. <p>Basic Training Curriculum review</p> <ul style="list-style-type: none"> - As previously described in the curriculum section, the Basic Training Curriculum is currently undergoing a detailed review process, which will impact the existing Basic Training Curriculum framework and content, as well as wider flow in implications for other College training programs. - If rehabilitation training were to transition to FRACP training, it is critical that members of the rehabilitation community engage with the review process to ensure that the educational needs of rehabilitation medicine within the Basic Training Curriculum are adequately represented. <p>Advanced Training in Rehabilitation Medicine Curriculum</p> <ul style="list-style-type: none"> - See following section regarding mapping of the existing Rehabilitation Medicine Curriculum against the existing Basic Training Curriculum, and potential Advanced Training Curriculum in Rehabilitation Medicine in the proposed model. - Any refinement of the curriculum would require extensive consultation with the rehabilitation medicine fraternity. - Opportunity to enhance and recognise existing content.

9.3.12. Accredited settings

FAFRM	Settings go through Training sites go through standardised accreditation process overseen by the Training and Learning Committee.
FRACP	<p>Basic Training:</p> <ul style="list-style-type: none"> - The accreditation of training settings supports the provision of quality training environments with an appropriate balance between teaching and learning, and service provision. - The Accreditation Subcommittee of the Adult Medicine Division Education Committee is responsible for the accreditation of Australian sites for Basic Training. - The New Zealand Adult Medicine Division Education Committee is responsible for the accreditation of training sites in New Zealand for Basic Training. - All Basic Training must be undertaken at an accredited setting within Australia or New Zealand (with the exception of overseas training which is assessed on a case-by-case basis). - Rehabilitation medicine terms for Basic Trainees would need to be increased.
	<p>Advanced Training in rehabilitation medicine No significant change from current position.</p>
Comment	<ul style="list-style-type: none"> - Assuming stable trainee numbers, approximately 25% of existing Advanced Training positions in rehabilitation medicine would need to change to BPT terms. - BPT terms in rehabilitation, and rehabilitation supervisors would need to meet standard accreditation criteria. - Ideally, BPT terms in rehabilitation would be in sites with multiple registrars, and in major teaching hospitals to increase attractiveness of these terms for BPT to assist with examination preparation. - Basic Training terms in rehabilitation medicine, especially in sites which are off-site from tertiary teaching settings, may be unpopular and positions potentially remain unfilled.

9.3.13. Training fees

FAFRM	Settings go through training sites go through standardised accreditation process overseen by the TLC.
FRACP	<p>Basic Training:</p> <ul style="list-style-type: none"> - The accreditation of training settings support the provision of quality training environments with an appropriate balance between teaching and learning, and service provision. - The Accreditation Subcommittee of the Adult Medicine Division Education Committee is responsible for the accreditation of Australian sites for Basic

	<p>Training.</p> <ul style="list-style-type: none"> - The New Zealand Adult Medicine Division Education Committee is responsible for the accreditation of training sites in New Zealand for Basic Training. - All Basic Training must be undertaken at an accredited setting within Australia or New Zealand (with the exception of overseas training which is assessed on a case-by-case basis).
	<p>Advanced Training in rehabilitation medicine No significant change from current position.</p>
Comment	<ul style="list-style-type: none"> - Annual training fees and examination fees are consistent across basic and Advanced Training for the Division and faculties. - The overall cost for Fellowship completion would depend on the assessment structure decided upon for Advanced Training in rehabilitation medicine, particularly as it pertains to exit examinations and modules. It is likely that the overall price to obtain specialist qualifications in rehabilitation medicine would increase marginally. - Depending on the decision regarding governance of the Advanced Training and establishing a specialty society in rehabilitation medicine, there may be additional fees for that specialty society.

9.3.14. Governance of training

FAFRM	FEC, as previously described.
FRACP	<p>Basic Training:</p> <ul style="list-style-type: none"> - The Adult Medicine Basic Training Committee (BTC) oversees Australian and New Zealand Basic Trainees in Adult Medicine. The BTC reports to the Adult Medicine Division Education Committee, which in turn reports to the Adult Medicine Division Council, which in turn reports to the College Board. - The College's Education Services provides support to the BTC through an assigned Basic Training Education Officer.
	<p>Advanced Training in rehabilitation medicine</p> <ul style="list-style-type: none"> - All Advanced Training programs are developed and supervised by an Advanced Training Committee (ATC) - The ATC formally meet twice per year and work on matters including the accreditation of training sites, curricula and assessments for Advanced Training, trainee issues and educational policy. The College's Education Services provide support to the ATC through an assigned Education Officer. - Some ATCs have partnerships with independently run incorporated Specialty society from a particular discipline (e.g. geriatrics, neurology). - Other ATCs are supervised are not associated with a specialty society (e.g. general paediatrics, which is the Advanced Training program with the largest number of trainees).

	-
Comment	<ul style="list-style-type: none"> - If the FRACP model were adopted, Advanced Training in rehabilitation medicine would be the responsibility of an ATC, as with all Advanced Training programs which are undertaken via the divisional training programs. - Advanced Training in rehabilitation medicine would not require the formation of a specialty society in rehabilitation medicine, but this would be a possibility. - Given that a faculty training program would no longer be offered, the AFRM could not technically take on the role of the STC/SAC. - Rehabilitation medicine specialty society could form a partnership with the ATC. This is not mandatory for a change to this model of training, and the decision regarding formation of a specialty society would be one which is independent of a change in training program as outlined. - If a specialty society was formed, its role in relation to input into Advanced Training via the ATC would be one of its functions, and the primary one relevant to this paper. - If a change to FRACP training were undertaken, the qualification of FAFRM would no longer be offered, and the AFRM, the primary role of which is in education, may cease to exist. - Other than education, however, the AFRM has several other key roles, as outlined in the mission, objectives and objects of the AFRM in an earlier section of this report. - A decision regarding how these other key roles would be addressed if the AFRM's education role was largely obviated. One option would be for these roles to be taken up by a specialty society. While recommendations for this are beyond the scope of this report, consideration would need to be given regarding incorporation, costs, legal status, constitution development and so forth.

9.4. If AFRM wanted to pursue the FRACP option, what would be the next steps?

In order to answer this question, a brief explanation of the key players involved in any such change-over is first needed.

Terminology – the key players

The **National Registration and Accreditation Scheme (NRAS** ‘the National Scheme’) is the national scheme for registration of health practitioners (including medical practitioners).

Health practitioners (including medical practitioners) are nationally regulated by their corresponding **national boards**, which have standards that practitioners must meet to

register. Once registered, practitioners must continue to meet the standards and renew their registration annually with the relevant board.

The National Board which regulates Medical Practitioners is the **Medical Board of Australia (MBA, 'The Medical Board')**.

AHPRA is the agency that supports the national boards to implement the NRAS.

There are several types of registration for medical practitioners, including General, Specialist, Provisional, Limited, and Non-practising.

The **Australian Medical Council (AMC)** is the national standards body for medical education and training. It accredits specialist colleges which provide specialist medical education and training, as well as the specialist medical programs they provide. The AMC also advises the Australian Minister for Health and Ageing on which disciplines of medical practice should be recognised as medical specialties in Australia. While this is an Australian process, the Medical Council of New Zealand (MCNZ) uses AMC accreditation reports to assist it to make decisions about recognising medical training programs in New Zealand. The AMC works with the MCNZ in reviewing bi-national training programs.

The Australian Health Workforce Ministerial Council approves the recognised specialties and specialist titles for each recognised specialty. This list of recognised specialties can be found here

<http://www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx>

Eligibility to bill items under **Medicare** is determined by legislation and regulations administered by the Department of Health and Ageing and the Department of Human Services. A medical practitioner is recognised as a specialist for Medicare rebate purposes via: 1) automatic recognition where the specialist medical college advises the Managing Director of the Health Insurance Commission, or by recommendation from state or territory Specialist Recognition Advisory Committees.

Specialist registration is available to medical practitioners who have been assessed by an AMC-accredited specialist college as being eligible for Fellowship. According to new determinants, Fellowship is **not** a pre-requisite for specialist registration⁵³.

Medical practitioners with the necessary qualifications in the approved specialty are included on the **Specialist Register** of the MBA. This is accessed by Medicare to verify that a practitioner's patients can obtain a specialist level rebate, and that specialists can apply to receive relevant Medicare rebates for services rendered. See <http://www.medicalboard.gov.au/News/2012-04-13-Eligibility-Specialist-Registration.aspx>

⁵³ Medical Board of Australia (2015). Specialist Registration. Available from: <http://www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx>

Specialist registration and endorsement for areas of practice are both mechanisms available under the national law. They both identify on a public register one or more subgroups or classes within a health profession whose members have specific characteristics that are different from the rest of the profession.

The next steps

1. Consultation with AFRM members

Given the enormity that this change would represent, there would need to be extensive discussion, debate and a majority agreement to change to this model of training, if there was broad based support, a decision would be needed by the AFRM Faculty Council.

2. Decision from AFRM Faculty Council

The AFRM Faculty Council holds the ultimate decision-making role regarding whether this change in training would be pursued. It will no doubt take into account members' points of view, as well as other evidence and advice. If the Faculty Council were in favour of a change, the decision would then go to the College Education Committee.

3. College Education Committee

If changing the training program is recommended by the AFRM Council, the decision would go to the College Education Committee for ratification from a College-wide educational perspective.

4. RACP Board

The next level of decision-making is the RACP Board, where the overall impact of the proposed change for the College would be considered.

5. Australian Medical Council

Changes to the training program would require approval by the AMC, and its Specialist Education Accreditation Committee, which is responsible for accrediting specialist medical education and training and professional development.

The potential changes to the rehabilitation medicine training program would constitute a major change to the accredited program (FRACP) because it is an introduction of a new sub-specialist program. There is a specific process required for the first stage of assessment of a major structured change in an established training program, with which

planning for development of the proposed change would need to comply⁵⁴. Initially, this would require:

1. A broad outline of the new program
2. Transitional arrangements for existing trainees
3. Resources (including clinical teaching resources to deliver the training program)
4. Resource implications of the proposed changes for healthcare facilities
5. Evidence of engagement of stakeholders.

If the first stage is approved, the education provider (RACP) submits an accreditation submission, including:

1. Outline of the full program of study, and details for at least the first two years
 2. Details of resources, such as clinical training resources and supervisors to implement all years of the program and to support the program when fully implemented
 3. Institutional assessment of strengths and weaknesses
 4. Impact of change on existing trainees
 5. Proposed transitional arrangements
 6. Resource implications of the proposed changes for healthcare facilities
 7. Evidence of engagement of stakeholders
 8. Detailed curriculum
 9. Implementation plan.
6. **The Australian Health Workforce Ministerial Council** would consider the recommendation from the Australian Medical Council to make the final determination regarding the request for a new/amended recognised specialty. It should be noted that recognition of new/amended specialties has been increasingly difficult to attain in recent years.

9.5. Other questions regarding implications of the FRACP option

9.5.1. What about current trainees?

The timeline for any potential change would be a minimum of at least two years, given the process and approvals that would be needed. A change-over date would be set, from which time new trainees entering into the program would commence via the new system. Current trainees would continue with the existing program.

9.5.2. Would the AFRM still exist?

⁵⁴ <http://www.amc.org.au/images/Accreditation/standards-for-specialist-medical-training-2010.pdf>,
<http://www.amc.org.au/images/Accreditation/standards-for-specialist-medical-training-2010.pdf>

It is anticipated that the AFRM would continue to exist in some form because of existing Fellows holding the FAFRM, though clearly the role and functions would be greatly diminished as the qualification of FAFRM would no longer be offered moving forward.

9.5.3. Would those with an FAFRM be “grandfathered” to receive an FRACP?

It appears most unlikely that individuals currently holding an FAFRM would be “automatically” grandfathered to holding an FRACP, though the ultimate decision regarding this would be the domain of the Adult Medicine Division.

The training underpinning the FRACP qualification, with BPT as a foundation prior to completing specialist training under the divisional training, is different in nature from the existing FAFRM training, which does not, in its current form, provide an equivalent basic training period in general medicine to that of the Basic Training of the College.

Possible scenarios for existing AFRM Fellows to receive an FRACP are as follows:

1. Those who have previously successfully completed Basic Training written and clinical examinations, but who did not complete Advanced Training via the divisions may be awarded FRACP.
2. Successful completion of Basic Training written and clinical examinations.
3. The requirements for a period of Basic Training prior to attempting these examinations, however, is not clear, and it is felt that success in the examinations would be extremely difficult without having undergone a period of Basic Training. Application for some recognition of prior learning accreditation of training time in recognition of work as a consultant in rehabilitation medicine may be possible to reduce the required Basic Training time.
4. If there were significant numbers of AFRM Fellows wanting to pursue this path, it is possible that preparation courses, and allocation of suitable clinical rotations (which may be in combination with existing roles), could be developed to assist in this process.

9.5.4. What about Advanced Training in Paediatric Rehabilitation Medicine?

As previously outlined, specialists in paediatric Rehabilitation Medicine currently undertake a joint training program, the FRACP (RACP) and the FAFRM (AFRM / RACP). If the FAFRM was no longer offered for Rehabilitation Medicine, this would have significant flow on implications for the Paediatric Rehabilitation Medicine specialty, and a decision would be required regarding whether the AFRM training program and qualification would be offered to paediatric Rehabilitation Medicine trainees, or if they would instead undertake dual specialist training, but only receive the FRACP.

9.5.5. What about those who wish to do Advanced Training in Rehabilitation Medicine coming from other specialties?

Unlike when Rehabilitation training was offered by the ACRM, with a part 1 examination and a fellowship examination, and those who had passed part 1 surgical, physician or GP training were offered exemption from the part 1 training, the only exemptions that are currently offered to Modules 1 and 2 is to those who have passed the BT written and clinical examinations. The question regarding what would happen to trainees from other specialties if Rehabilitation training changed to FRACP is thus a moot point as these credits are no longer offered, other than to Basic Physician Trainees.

9.6. Advantages and disadvantages of changing to the FRACP option

The controversial option of changing the training program structure to the FRACP option addresses several, but not all of the issues addressed in this review. While it would certainly provide trainees with important knowledge and skills in more acute aspects of medicine, there is a more fundamental underlying question which relates to the direction in which our specialty is heading and whether this model is the right fit for our specialty.

Advantages summary:

1. Provides trainees with additional knowledge and skills in acute medicine, which may be required for the future livelihood of our specialty.
It is not globally accepted that our specialty should change to embrace acute aspects of medicine and that our key focus should remain on the management of disability.
2. Enhances the reputation and image of Rehabilitation Medicine in Australasia, moving us to a first tier specialty. There would be greater awareness of Rehabilitation Medicine among all future Physicians because Rehabilitation Medicine content would be included in the Basic Training curriculum. Ultimately, there would be greater awareness and acceptance of the role of Rehabilitation Medicine among our colleagues and potentially institutions and policy makers.
Even if the issue of negative image and reputation is accepted, it does not necessarily follow that simply changing the qualification for the specialty will solve this issue. Our specialty needs to look at the fundamental reasons why our specialty is misunderstood and misrepresented. The solution does not necessarily address the problem.
3. Entry to training is outsourced to Basic training, which would ensure that trainees come into the program with an additional element of experience, maturity, knowledge and dedication as demonstrated by having satisfied the rigorous requirements of Basic Training
Outsourcing of entry to training to Basic Training is a false economy because the base for Rehabilitation Training would be grounded in training which has an inherently different approach from Rehabilitation Training

Disadvantages or arguments against changing to the FRACP option

1. There is inconsistent support for this option among the Rehabilitation community and pursuing this option before there is widespread support risks fragmentation and deep conflict within our right knit community.
Unanimous support for the move to the FRACP option is not needed because the arguments are strong enough

2. This option fundamentally changes of the role of the Rehabilitation Physician in Australasia. The Rehabilitation Physician training moves from that which embraces the ‘rehabilitation model from the outset of training to being founded in the ‘medical model’ which then needs to be unlearnt at the outset of Advanced Training.
In recent years, Basic Training has evolved to honour many of the values key to Rehabilitation Medicine, incorporating consideration of the biopsychosocial model, the importance of communication, holistic, multi-disciplinary and patient centred care.

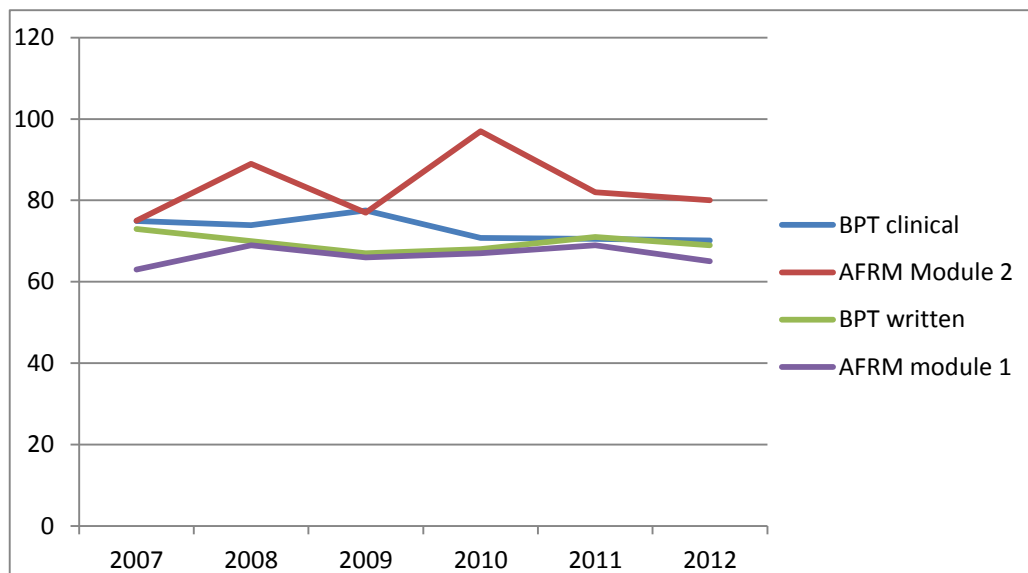
3. Taking up the FRACP model of training would threaten the future supply of Rehabilitation Specialists.; it is likely the Rehabilitation Medicine will remain an unpopular choice for advanced training with significant risk and threat to the future workforce of Rehabilitation Medicine in Australasia, the demand for which will increase in coming years. This is of particular concern for the regional and rural workforce.
Concern regarding trainee numbers in the FRACP option is overstated – there will be more exposure of trainees to Rehabilitation Medicine during the period of Basic Training, and that there will be more competition for any specialist places because of the ‘tsunami’ of medical students

4. Without the option of grandfathering to the FRACP of current FAFRM holders, changing to the FRACP option would result in a ‘two tiered pool of Rehabilitation Specialists in Australasia, those with FAFRM and those with FRACP. This would have important negative implications for those with the FAFRM who may face employment; scope of practice and financial disadvantage compared to those with the more widely accepted FRACP qualification.
For those with the FAFRM qualification wishing to transition to the FRACP, there may be an option to develop a specifically tailored intensive course which would culminate in Basic Training examinations, which may enable those with the FAFRM qualification to be awarded the FRACP qualification. The employment question would be of lesser concern for those Rehabilitation specialists already secure in specialist positions and private practice

5. The results seen in the Adult Basic Physician Training examinations are inconsistent and unpredictable and are not a true reflection of the quality and calibre of the candidates.
Recent years has seen substantial stabilisation of the results achieved in the Part 1 Basic Physician Training clinical examinations as shown in the table below. Indeed,

the results for the Part 1 Physician examination results have shown greater stability than the Module 1 and 2 Rehabilitation examinations

Figure 13 – pass rates for BPT written and clinical examinations, and AFRM Module 1 and 2 examinations from 2007 to 2012



6. Many of the advantages of changing to the FRACP option could be achieved by promoting the joint training option, which is currently available and which would not require significant and controversial structural alternation to the training program.
7. Changing to this option without addressing other important elements of concern in our training program will mean that, while we have a shiny new model of training, that other issues, such as distribution of the workforce, coordination of teaching and learning and oversight of the breadth of training are not addressed.

In the table which follows, the advantages and disadvantages of changing to the FRACP model are delineated specifically with reference to the elements identified in the SWOT analysis.

Table 9 – Advantages and disadvantages of FRACP model

	Advantage Addresses this concern	Disadvantage Does not address this concern
Strengths		
1. Quality of the rehabilitation medicine training program	The qualification of FRACP is widely recognised, accepted and respected. Addition of this element into training would augment the existing quality of the rehabilitation medicine training program.	

	Removing Modules 1 and 2 would provide more resources for augmenting the quality of the Advanced Training program in rehabilitation medicine.	
2. Relevance of the rehabilitation medicine training program		Relevance of Basic Training to rehabilitation medicine is not globally accepted and addition of this element dilutes the quality of the training program overall as trainees must unlearn the medical model before adopting the rehabilitation model.
3. Increasing adequacy of trainee numbers While changing to the FRACP option would increase exposure by Basic Trainees to rehabilitation medicine, the potential threat to Rehabilitation Medicine Trainee numbers is felt to be one of the greatest disadvantages of a move to this model of training	With the FRACP option, Basic Trainees would rotate through terms in rehabilitation medicine, increasing exposure to this specialty as a potential future career option, thereby potentially enhancing trainee numbers.	There are a number of reasons why a move to Basic Training will threaten Rehabilitation Trainee numbers: 1. Having completed Basic Training requirements, trainees more likely to pursue specialty options which have a higher profile, and even if they do commence training in rehabilitation medicine, this may be given up in preference for a more attractive specialty place when and if available. 2. Workload requirements for Basic Training e.g. on-call, secondments 3. Unpredictability of the Basic Training examinations (not borne out by actual trends) 4. Longer duration and cost of training 5. Disinterest in acute medicine 6. Dissuade those with surgical interest 7. Additional assessment burden with requirements for Basic Training and Advanced Training examinations.
4. Strong engagement of rehabilitation medicine community in the training program		If the FRACP option is pursued without broad-based support from the rehabilitation medicine community, there is a real fragmentation and deep conflict.
5. Effectiveness and responsiveness of the AFRM	If the FRACP option were adopted, there would be limited role for the AFRM as the faculty training program would no longer exist. It is likely that there would be a strong role for a rehabilitation specialty society in the Advanced Training program.	
6. Advantages of the AFRM being under the RACP umbrella	The rehabilitation Advanced Training program would continue under the auspices of the RACP.	
Weaknesses		
1. Concerns regarding Entry to training criteria With the FRACP option, the entry to training criteria would be largely outsourced to the Basic Training	With successful completion of Basic Training as a requirement for entry to rehabilitation training, the knowledge and skills of trainees in medicine would be	While Basic Training screens for medical knowledge/skills, it does not necessarily screen for the qualities and pre-requisite knowledge/skills required for rehabilitation medicine.

program, with successful completion of this as a requirement for entry to the Advanced Training program. There would be the option of augmenting this with additional requirements such as interview.	strongly enhanced.	
2. Rehabilitation Medicine Clinical Curriculum due for review and update	Moving to the FRACP option would necessitate extensive review and update of the clinical curriculum, which is well due.	
3. Quality of and access to consistent teaching and learning opportunities	This area would still need to be addressed.	
4. Breadth and oversight of individual clinical training	This area would still need to be addressed.	
5. Density of training program requirements	With curriculum content reduced by 25% and Modules 1 and 2 removed, training duration shorter (3 years).	
6. Timing and Content of Modules 1 and 2	Modules 1 and 2 no longer exist.	Modules 1 and 2 screen for rehabilitation medicine specific knowledge pre-requisites (e.g. surgery, anatomy, physiology) though these could be added to Advanced Training Curriculum.
7. Fellowship examinations: timing, content and results fluctuations	This area would still need to be addressed. It is noted that if the AFRM moved to the FRACP option that retention of the Fellowship examinations would make rehabilitation inconsistent with the other Advanced Training programs.	
8. Utility of some aspects of other training elements	This area would still need to be addressed.	
9. Concerns about some training settings and supervision	This area should still need to be addressed.	
Opportunities		
1. Future workforce demands for Rehabilitation Medicine Fellows	Enhances employability of Rehabilitation Physicians.	Could threaten certainty of future rehabilitation medicine workforce if inadequate trainee numbers.
2. Expansion of the role of rehabilitation medicine	Basic Training equips trainees with relevant knowledge and skills.	
Threats		
1. Institutions other than RACP offering specialist training in rehabilitation medicine	This area would still need to be addressed.	
2. Adequacy of geographic distribution of Rehabilitation Medicine Trainees		Risk to trainee numbers.
3. Rehabilitation Medicine Fellows not equipped to meet the evolving trends of the specialty	BT equips trainees with relevant knowledge and skills, mitigating these risks. FAFRM enhances image/credibility of rehabilitation medicine.	

10. Curriculum Mapping – Current Rehabilitation Medicine Curriculum mapped against Basic Training Curriculum

This section is Authored by Andrew Dostine, an educationalist who was appointed to perform a competency mapping analysis between the 2007 edition of the Adult Internal Medicine Basic Training Curriculum and the 2010 edition of the Adult Rehabilitation Medicine Advanced Training Curriculum as a preliminary body of work which could be utilised if the FRACP option was undertaken by the AFRM for future rehabilitation medicine training.

10.1. Initial observations

The Rehabilitation Medicine Advanced Training Curriculum and RACP Basic Training Curriculum have a number of similarities in structure and subject. This is not surprising given the rehabilitation curriculum is intended to cover many of the same basic topics (and act as a potential alternative to direct admission to the College through the Basic Training program). Such similarities, though, are not as obvious between the Basic Training Curriculum and other advanced curricula from other specialty areas. Again, this is unsurprising as most trainees enrolled in the College will complete the Basic Training Curriculum first before moving on to their respective advanced specialisations. This difference is perhaps most obvious in the area of professional development activities and assessments which is given extensive consideration in the Rehabilitation Medicine Advanced Training Curriculum.

As with all curriculum programs and documents developed by the College, the two programs (Basic Training Curriculum and rehabilitation medicine) adopt a similar cascading format with *domains* that contain various *themes*. These themes each have their own *learning objectives* which yield both certain *knowledge* and *skills* that are described in detail.

Both curricula have two domain areas: one which addresses areas of professional development and generic processes and activities relating to dealing with patients; and the other addressing medical expertise or clinical functions.

Given that the aim of the project is to identify areas where the two curricula overlap, and that a likely outcome of the project will be the aggregation of elements of the rehabilitation medicine curriculum into the Basic Training program, the focus will be on where the rehabilitation medicine curriculum overlaps with the Basic Training Curriculum, rather than the other way round. This will effectively identify those areas of duplication that might then be omitted from any revised Rehabilitation Medicine Advanced Training Curriculum.

The outcome of this initial mapping stage will be a matrix or table which identifies these duplications, and which then comments upon the appropriate location of the duplicated

material within the Basic Training Curriculum – whether it should remain where it is or whether it might be relocated. I will also address those elements of the current advanced rehabilitation medicine curriculum that are not found in the Basic Training Curriculum, but which might be suitable to be transferred from one to the other.

The mapping component of the project, therefore, will result in the identification or nomination of three types of curriculum information:

1. Information that is duplicated in both the Rehabilitation Medicine Advanced Training Curriculum and the Basic Training Curriculum - this information might be removed from the Rehabilitation Medicine Advanced Training Curriculum and retained in the BPT. A recommendation might also be made as to the appropriate location of the BPT material, whether it stays where it is or should be moved elsewhere in the curriculum structure
2. Information that is found in the Rehabilitation Medicine Advanced Training Curriculum that is not currently in the BPT, but should be. A recommendation would then be made as to the most appropriate location of that information within the BPT. I assume there will not be a lot of this information.
3. Information that is currently in the Rehabilitation Medicine Advanced Training Curriculum that is not in the BPT, and which is at a level which should be retained in any new advanced rehabilitation medicine curriculum specialisation.

A potential fourth type of curriculum information is information not currently located in either the Basic Training Curriculum or the current Rehabilitation Medicine Advanced Training Curriculum, but which should be included in a future advanced rehabilitation medicine curriculum specialisation. Again, I do not anticipate there will be much of this type of information

10.2. The project mapping matrix

The curriculum mapping matrix will consist of a table featuring a column listing all rehabilitation themes and learning objectives and another identifying where and when these learning objectives are reflected in the Basic Training Curriculum. A third column will provide a comment on the nature of any similarities or duplications and the location of duplicate material. This work addresses information types 1 and 2 above.

A narrative/commentary following the matrix will identify any material that is currently in the rehabilitation medicine curriculum, but not in the Basic Training Curriculum, but should be, as well as any other information of training material that is in neither curricula, but which should be included in either the Basic Training Curriculum or any revised Rehabilitation Medicine Advanced Training Curriculum.

10.3. Proposed advanced program

While the mapping matrix is being considered/reviewed I will begin developing a revised Rehabilitation Medicine Advanced Training Curriculum. This will largely consist of the current curriculum following the removal and relocation of learning materials to the Basic Training Curriculum.

In developing the revised advanced curriculum I will give particular consideration to the issues and concerns of current Fellows of the faculty and the desire to emphasise the importance and relevance of the specialty as it now stands.

In order to align the revised Advanced Training program with other existing advanced curricula the new program will need to be accommodated and delivered over a three-year period. This will necessarily require considering the amount of time (hours of study, face-to-face supervision and assessment, etc.) currently required for the existing advanced program. This work addresses information type 3 above.

In developing the revised advanced curriculum I will also assess and consider those training elements that are not currently included in the Rehabilitation Medicine Advanced Training Curriculum. This work addresses information type 4 mentioned above.

10.4. Additional issues for discussion or consideration

An important element of integrating elements of the current Rehabilitation Medicine Advanced Training Curriculum into the current Basic Training Curriculum is recognition of the specialised nature of rehabilitation medicine. Any transfer of material from the current rehabilitation medicine curriculum, therefore, should seek to stress the philosophical imperatives of rehabilitation medicine and how early integration can improve patient outcomes. The transfer/inclusion of material into the Basic Training Curriculum, therefore, requires a somewhat *nuanced* approach.

While not a direct concern for the current project, one issue I believe would benefit the presentation and articulation of all curriculum documents would be the inclusion of information relating to how learning objectives are measured and assessed. Current curriculum documents list knowledge and skills that trainees are supposed to acquire throughout the training program, but they do not identify how this knowledge and these skills will be assessed or measured.

This issue has, I understand, been touched upon in the current Professional Standards Framework Project. A similar issue exists with the Professional Qualities Curriculum. While the structure and content of the curriculum are excellent, the learning objectives appropriate, and the identified knowledge and skills relevant, it is not immediately apparent how acquisition of such is to be measured or assessed.

With continuing debates about standards and quality across all educational fields today it would help 'close the circle' to include reference to this material in curriculum documents.

10.5. Curriculum mapping matrix identifying elements of duplication between the RACP Basic Training Curriculum and the Rehabilitation Medicine Advanced Training Curriculum

This curriculum mapping matrix seeks to identify where, and to what extent, elements of the Rehabilitation Medicine Advanced Training Curriculum are evidenced or duplicated in the RACP Basic Training Curriculum.

The mapping matrix provided above seeks to identify areas of commonality and duplication between the current Basic Training Curriculum (Adult Medicine) and the Rehabilitation Medicine Advanced Training Curriculum, offered through the AFRM. Successful completion of the Basic Training Curriculum leads to entry into an Advanced Training program and eventually onto admission to Fellowship of the Royal Australasian College of Physicians while successful completion of the Rehabilitation Medicine Advanced Training Curriculum leads to admission to Fellowship of the faculty.

A tacit aim of the present mapping matrix is to assess the potential for removing duplicate material from the rehabilitation medicine advanced curriculum so that Rehabilitation Medicine Trainees would undertake Basic Training, and thus complete Basic Training, as current Basic Trainees. The remaining, rehabilitation medicine-specific curriculum material would then be retained to form the basis of a new, revised (three-year) rehabilitation medicine advanced curriculum.

In order to determine the level of similarity and duplication it is important to appreciate the differences in structure and design of the two curricula. Both curricula employ a similar structure cascading down from broad topic fields (*domains*), to *themes*, which link specific aspects of learning into logical related groups, to *learning objectives*, which outline the specific requirements of learning for each theme and which identify the necessary knowledge and skills for such.

Similarly, each curriculum addresses similar (though not identical) professional and medical areas. From here, though, the focus of each curriculum differs sharply. The Basic Training Curriculum e.g. might describe in considerable detail the knowledge and skills required to *manage patients with disorders of the cardiovascular system* (Learning Objective 2.3.1), but the corresponding rehabilitation medicine theme (Theme 2.1 *Cardiac disease*) approaches the subject with a narrower, specific focus on the types of dysfunction and impairment that people might experience as a result of cardiac disease, together with how patients might be assessed for the potential for rehabilitation and how subsequent care might be managed and provided.

As a result of this structural similarity but contextual difference is the duplication and repetition of a range of professional knowledge, skills, and learning. These duplications are most apparent in the Basic Training Curriculum Domain 1 *Clinical process* and Rehabilitation Medicine Advanced Training Curriculum Domain 1 *Physician competencies*.

The themes and associated learning objectives repeated in each curriculum at these domains address topics of professional practice and development including:

- Completing patient assessments
- Developing treatment plans
- Communicating with patients, families, general practitioners, allied health professionals, and members of interdisciplinary teams
- Referring patients to additional medical services
- Ethics
- Continuing medical education
- Conducting medical research.

As the matrix below indicates, there would appear to be considerable scope then to remove much of this 'professional education' information from the rehabilitation curriculum if trainees were required to first complete the Basic Training Curriculum. In addition, assessment of this material (e.g. Learning Objectives 1.3.1, 1.3.2, 1.3.2 and 1.3.4) presents its own difficulties. This theme in particular seems somewhat out of place. (As an aside, it would be interesting to know how these objectives are assessed and what results or outcomes trainees are achieving.)

Removing this level of duplication from the rehabilitation medicine curriculum may also allow for the amalgamation or consolidation of remaining themes, e.g. *Lower limb and upper limb amputation* (Themes 2.6 and 2.13) where learning objectives are largely repeated, and also *Illness and injury of the child and adolescent* (Theme 2.4) and *Illness and injury in older people* (Theme 2.5).

Refinements for a future Rehabilitation Medicine Advanced Training Curriculum

Having reviewed the curriculum structure in some detail, I believe any future curriculum would benefit from the inclusive of a device for allocating a weighting to each theme or field of study. The assessment weighting tool might be as simple as a figure indicating the relative importance of topics within the curriculum based upon the amount of time trainees might be expected to spend in an area of study and also the weight the area is given in written and clinical assessments.

Possible topics for a revised Rehabilitation Medicine Advanced Training Curriculum

As well as areas that might be removed from the current rehabilitation medicine curriculum, there are a numbers of topics that might be considered for potential inclusion in any revised curriculum. These topics might include rehabilitation relating to:

- Mental health and psychiatric disorders
- Pulmonary and respiratory disease and injury
- Burns.

Andrew Dostine

2 December, 2013

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Present or duplicated in the RACP Basic Training Curriculum (BTC) at...	Comment
Domain 1 Physician competencies		
Theme 1.1 Patient evaluation		
1.1.1 Describe the potentially disabling consequences of disease, disorders, and injury	<p>General principles of rehabilitation medicine are described in Domain 1 <i>Clinical process</i>, Theme 1.2 <i>Patient care and therapeutics</i>, Learning objective 1.2.5 <i>Ongoing care planning</i>.</p> <p>Other diseases, disorders, and conditions referred to in the rehabilitation medicine advanced curriculum are found in several learning objectives across the Theme 2.3 <i>Manage patients with disorders of organ systems</i>.</p> <p>The BTC does not appear to make explicit or substantive reference to occupational injury, spinal cord injury, traumatic brain injury, or limb amputation and prosthetics.</p>	<p>This learning objective provides a wide-ranging overview of how disease, disorders, and injury can contribute to impairment and dysfunction. It offers trainees an understanding of the scope and focus of rehabilitation medicine.</p> <p>Despite the different focus of the two curricula and the exceptions noted to the left it would appear the level of duplication between the two curricula with regards to this learning objective would result in a similar breadth of competence and understanding.</p> <p>Were Rehabilitation Trainees required to first complete the BTC this learning objective may, therefore, be rationalised or rolled into other (new objectives) in this theme to create a new, advanced curriculum.</p>
1.1.2 Determine the nature and extent of disability and activity limitation or participation restriction	<p>The 'knowledge' discussed in this learning objective is not specifically addressed in the BTC, however, it expects that trainees will have an understanding and knowledge of key diseases, disorders, and injuries and an 'appreciation of their significance'; presumably, that is, their consequences and ramifications.</p> <p>The technical 'skills' described in this learning objective are essentially similar to those identified and described in the BTC Theme 1.1 <i>Clinical skills</i>.</p>	<p>This learning objective describes the concepts of impairment and disability and discusses the various factors that can influence rehabilitation outcomes. It also describes how disability, impairment, and restricted activity and participation are measured.</p> <p>Despite the different focus of the two curricula it would appear the level of duplication between the two curricula with regards to this learning objective would result in a similar breadth of competence and understanding.</p> <p>Were Rehabilitation Medicine Trainees required to first complete the BTC this learning objective may, therefore, be rationalised or rolled into other (new objectives) in this theme to create a new, advanced curriculum.</p>

<p>1.1.3 Predict the degree of functional improvement that may be achieved with appropriate rehabilitation</p>	<p>The knowledge described in this learning objective is partially described in Domain 1 <i>Clinical process</i>, Theme 1.2 <i>Patient care and therapeutics</i>, Learning objective 1.2.5 <i>Ongoing care planning</i>.</p> <p>The skills described in this learning objective are not specifically addressed in the BTC. The BTC e.g. while teaching and practising generic clinical skills in Theme 1.1 <i>Clinical skills</i>, does not specifically examine how to formulate a rehabilitation management plan relevant to a patient's disability or his or her potential for rehabilitation.</p>	<p>This learning objective describes the benefits to patients accruing from the formulation of a rehabilitation management plan relevant to a patient's level of disability or impairment.</p> <p>It teaches how to write a rehabilitation management plan and medical or medico-legal reports outlining results of evaluation and recommendations for rehabilitation management.</p> <p>While the 'knowledge' discussed in this learning objective is touched upon in the BTC, the specific skills referred to are not. It is appropriate, therefore, that this learning objective remain in some form in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>Theme 1.2 Patient management</p>		
<p>1.2.1 Plan and implement a realistic and appropriate rehabilitation program that is problem-oriented, goal-driven, time-limited, and directly addresses the needs and expectations of the patient and family</p>	<p>The knowledge described in this learning objective, while focused on rehabilitation medicine, is addressed more generally in the BTC Theme 1.2 <i>Patient care and therapeutics</i>. Psychosocial factors, depression, and anxiety are addressed at learning objectives 1.2.1 and 1.2.3, pharmacological treatments are discussed at 1.2.2, physical therapies are addressed at 1.2.3, and surgical interventions are discussed at 1.2.4.</p> <p>The BTC does not, however, discuss the use of prosthetics, orthotics, or adaptive equipment, and discussion of the roles of government and advocacy groups is only briefly addressed at 1.2.5.</p> <p>The skills, though focusing on rehabilitation medicine and the production of rehabilitation-related plans and reports, are often, generic in nature.</p>	<p>This learning objective describes the development of realistic and appropriate rehabilitation programs with an emphasis on sound clinical knowledge and practice and the effective communication and liaison with patients and their families.</p> <p>Despite the different focus of the two curricula and the exceptions noted to the left it would appear the level of duplication between the two curricula with regards to this learning objective would result in a similar breadth of competence and understanding.</p> <p>Were Rehabilitation Trainees required to first complete the BTC this learning objective may, therefore, be rationalised or rolled into other (new objectives) in this theme to create a new, advanced curriculum.</p>

<p>1.2.2 Describe, use, and coordinate assessments and therapies of the interdisciplinary team</p>	<p>The knowledge described in this learning objective is briefly discussed in the Learning objective 1.2.5 <i>Facilitate ongoing care planning</i> where it describes aspects of functional rehabilitation and the roles of individual members of the rehabilitation team and examines working in a multi-disciplinary team to facilitate goal setting and to formulate care planning.</p> <p>It also discusses the use of appropriate referrals to rehabilitation services.</p>	<p>This learning objective explores the roles of individual members of rehabilitation teams including the use, coordination, and assessment of various therapies, as well as managing all aspects of communication (and conflict) with other team members and medical professionals.</p> <p>Despite the different focus of the two curricula it would appear the level of duplication between this learning objective and the BTC learning objective 1.2.5 would result in a similar breadth of competence and understanding.</p> <p>Were Rehabilitation Medicine Trainees required to first complete the BTC this learning objective may, therefore, be rationalised or rolled into other (new objectives) in this theme to create a new, advanced curriculum.</p>
<p>Theme 1.3 Administration and leadership</p>		
<p>1.3.1 Discuss the global organisation of health services at the national level, and the impact of government policy on the provision of rehabilitation medicine services and services for people with disabilities</p>	<p>The knowledge described in this learning objective is not discussed or assessed in the BTC.</p>	<p>This learning objective describes how government policies, legislation, and funding impacts both acute and subacute health care practice. Specifically it addresses topics including freedom of information, privacy and confidentiality, guardianship, mental health, and workers compensation.</p> <p>Importantly, it does not focus exclusively on rehabilitation medicine therapies, or services.</p> <p>The knowledge described in this learning objective should be retained in any revised advanced rehabilitation medicine curriculum. Alternatively, consideration may be given to transferring it to any new or revised BTC.</p>
<p>1.3.2 Discuss ethical and legal issues relevant to rehabilitation service management</p>	<p>The knowledge described in this learning objective is not discussed or assessed in the BTC.</p>	<p>This learning objective examines the ethical and legal issues relevant to the management of rehabilitation services, including how culture impacts health services planning and management and the accreditation requirements for rehabilitation specialists.</p> <p>The knowledge described in this learning objective should be retained in any revised advanced rehabilitation curriculum and perhaps rolled into a revised objective within this theme.</p>

<p>1.3.3 Relate appropriate management principles to effective staff and team management</p>	<p>The knowledge and skills described in this learning objective are not discussed or assessed in the BTC.</p>	<p>This learning objective describes the management and administrative knowledge and skills that Rehabilitation Trainees are expected to have or acquire throughout the advanced curriculum. These are include general skills relating to selecting and training staff, participating in and leading teams and demonstrating effective personal skills.</p> <p>The knowledge and skills described in this learning objective should be retained in any revised advanced rehabilitation medicine curriculum and perhaps rolled into a revised objective within this theme.</p>
<p>1.3.4 Design, implement, and monitor service delivery</p>	<p>The knowledge and skills described in this learning objective are not discussed or assessed in the BTC.</p>	<p>This learning objective seeks to provide trainees with the knowledge and skills to be able to discuss the principles of program development, and to demonstrate the skills necessary to plan, write, and monitor quality rehabilitation management programs.</p> <p>The knowledge and skills described in this learning objective should be retained in any revised advanced RM curriculum and perhaps rolled into a revised objective within this theme.</p>
<p>1.3.5 Use new trends and technology in health service management</p>	<p>The knowledge and skills described in this learning objective are not discussed or assessed in the BTC.</p>	<p>This learning objective seeks to provide trainees with the knowledge and skills to be able to explain new initiatives in health service delivery and use data and information technology in order to report on and evaluate patient information.</p> <p>The knowledge and skills described in this learning objective should be retained in any revised advanced rehabilitation medicine curriculum and perhaps rolled into a revised objective within this theme.</p>

Theme 1.4 Prevention		
1.4.1 Promote preventive strategies with regard to diseases and injuries that may cause significant disability	<p>The knowledge and skills described in this learning objective are briefly explored in Learning objectives 1.2.1 and 1.2.3 in the BTC.</p> <p>These references in the BTC are, however, generic in nature and do not make specific reference to disability or physical impairment.</p>	<p>This learning objective discusses the principles of preventative strategies as they apply to rehabilitation medicine. It touches upon risk factors including age, sex, fitness, lifestyle cultural background, occupation and psychological factors.</p> <p>While the knowledge described in this learning objective may offer a similar breadth of competence and understanding as those areas identified in the BTC, the skills provided in the rehabilitation medicine advanced curriculum provide trainees with greater depth of experience.</p> <p>This learning objective, therefore, should be retained in any revised advanced rehabilitation medicine curriculum, but incorporated into a broader learning objective or associated theme.</p>
Theme 1.5 Continuing medical education		
1.5.1 Self-evaluate personal professional competence and identify areas requiring further development	<p>The knowledge and skills described in this learning objective are not discussed or assessed in the BTC.</p>	<p>This learning objective seeks to describe the continuing medical training requirements for rehabilitation medicine and identifies methods of self-evaluation and how to maintain effective professional standards.</p> <p>The skills described in this learning objective are generic; however, they are not specifically addressed in the BTC.</p> <p>This learning objective, therefore, should be retained in any revised advanced rehabilitation medicine curriculum, but perhaps incorporated into a broader learning objective or associated theme.</p>
1.5.2 Use appropriate methods and resources to acquire further knowledge and skills	<p>The knowledge and skills described in this learning objective are not discussed or assessed in the BTC.</p>	<p>This learning objective largely builds upon the previous objective and might reasonably be incorporated into a broader learning objective or associated theme in any revised advanced rehabilitation medicine curriculum.</p>

1.5.3 Educate other health professionals on the principles and practices of rehabilitation medicine	The knowledge and skills described in this learning objective are not discussed or assessed in the BTC.	This learning objective builds upon the previous two objectives, however, its relevance and appropriateness is perhaps questionable. Without specific information about how it is taught and assessed it would seem appropriate to delete it from the curriculum.
Theme 1.6 Clinical research		
1.6.1 Apply principles of clinical research	The knowledge and skills described in this learning objective are not discussed or assessed in the BTC.	This learning objective provides trainees with an introduction to clinical research principles and practices. It also forms the focus of one of the training module assessments. This learning objective should be retained in any revised advanced rehabilitation medicine curriculum.
Theme 1.7 Quality management		
1.7.1 Monitor the quality of processes and outcomes of rehabilitation and undertake quality activities to improve service delivery and clinical management	The knowledge and skills described in this learning objective are not discussed or assessed in the BTC.	This learning objective aims to describe the quality processes and outcomes associated with rehabilitation medicine as a means of improving service delivery. Much of the knowledge and skills associated with this learning objective, however, would appear to be addressed in other areas of the rehabilitation medicine curriculum, for example, at 1.1.2, 1.2.1, and 1.2.2. On this basis it is would be appropriate to consider deleting it from any revised advanced rehabilitation medicine curriculum.

Domain 2 Clinical curricula		
Theme 2.1 Cardiac disease		
2.1.1 Recall basic knowledge of cardiac disease	<p>The knowledge described in this learning objective is discussed extensively in the BTC at Learning Objective 2.3.1 <i>Manage patients with disorders of the cardiovascular system</i> including addressing that information which must be known on a basic level and that which represents essential knowledge. The BTC also provides trainees with essential practical and procedural skills and training.</p>	<p>This learning objective requires trainees to ‘recall’ previous training regarding cardiac disease. It appears to provide only limited knowledge.</p> <p>Were Rehabilitation Medicine Trainees required to first complete the BTC it is likely they would obtain a greater breadth of competence and understanding of issues relating to cardiac disease and similar disorders.</p> <p>In any revised rehabilitation advanced curriculum, therefore, it would be appropriate to delete this learning objective.</p>
2.1.2 Complete a comprehensive assessment of a patient presenting with cardiac disease and evaluate the potential for rehabilitation	<p>The knowledge described in this learning objective is discussed in the BTC at Learning Objective 2.3.1 <i>Manage patients with disorders of the cardiovascular system</i> including planning and arranging appropriate investigations, evaluations, and associated therapies.</p>	<p>This learning objective describes the role of investigations in the evaluation of cardiac disease and provides opportunities for trainees to gain experience in undertaking a comprehensive cardiac examination, history, and evaluation so as to determine the degree of cardiac impairment.</p> <p>Were Rehabilitation Medicine Trainees required to first complete the BTC it is likely they would obtain appropriate breadth of competence and understanding of issues relating to cardiac disease and similar disorders.</p> <p>In any revised rehabilitation medicine advanced curriculum, therefore, it would be appropriate to roll this learning objective into other objectives within the theme.</p>
2.1.3 Formulate a cardiac rehabilitation program	<p>This skills described in this learning objective are largely generic in nature and are addressed in numerous places in the BTC. The knowledge specific to this learning objective, however, is only briefly addressed in the BTC. There appears to be little or no discussion e.g. of cardiac rehabilitation.</p>	<p>This learning objective explores key aspects of cardiac rehabilitation and offers trainee’s opportunities to develop skills in communicating with patients and their families.</p> <p>While the skills described in this learning objective are largely generic and would offer a similar breadth of competence and understanding as those areas identified in relevant BTC learning objectives, the knowledge provided in the rehabilitation medicine advanced curriculum may provide trainees with a greater depth of experience.</p>

		Knowledge elements of this learning objective, therefore, should be retained in any revised advanced rehabilitation curriculum, but incorporated into a broader learning objective or associated theme.
2.1.4 Provide acute/subacute hospital (phase I) care to a patient with a cardiac disease	The skills and knowledge in this learning objective are explored in the BTC Learning objective 2.3.1, however, they do not have a specific emphasis on rehabilitation.	The focus of this learning objective is on the acquisition and deployment of skills relating to the rehabilitation of those suffering acute /subacute cardiac disease or associated impairment. This learning objective should be retained in any revised advanced rehabilitation medicine curriculum, but perhaps incorporated into a broader learning objective or associated theme.
2.1.5 Provide post-charge (phase II) care to a patient with cardiac disease	The skills and knowledge in this learning objective are explored in the BTC Learning objective 2.3.1, however, they do not have a specific emphasis on rehabilitation.	The focus of this learning objective is on the acquisition and deployment of skills relating to the post-discharge rehabilitation of those suffering cardiac disease or associated impairment. This learning objective should be retained in any revised advanced rehabilitation medicine curriculum, but perhaps incorporated with the previous item into a broader learning objective.
2.1.6 Provide maintenance (phase II) care to a patient with cardiac disease	The skills and knowledge in this learning objective are not specifically addressed in the BTC.	This learning objective builds on the previous two objectives and focuses on the acquisition and deployment of skills to maintain wellbeing in those who have experienced cardiac disease or associated impairment. This learning objective should be retained in any revised advanced rehabilitation medicine curriculum, but perhaps incorporated with the previous items into a broader learning objective.

Theme 2.2 Chronic pain		
2.2.1 Recall basic knowledge of chronic pain	The knowledge and skills in this theme are not substantively addressed in the BTC – pain is only touched upon briefly at Learning objective 2.2.1, and at 2.5.5 <i>Manage patients at the end of life</i> .	This learning objective requires trainees to ‘recall’ previous training regarding chronic pain. It appears to provide only limited knowledge. Given that the subject of pain is not substantively addressed in the BTC it is appropriate to retain this learning objective in any revised advanced rehabilitation medicine curriculum.
2.2.2 Complete a comprehensive assessment of a patient presenting with chronic pain and determine the potential for rehabilitation	The knowledge and skills in this theme are not substantively addressed in the BTC.	This learning objective describes the knowledge and skills necessary for trainees to complete a comprehensive assessment of a patient presenting with chronic pain and to determine the potential for rehabilitation. Given that the subject of pain is not substantively addressed in the BTC it is appropriate to retain this learning objective in any revised advanced rehabilitation medicine curriculum.
2.2.3 Formulate a rehabilitation management plan specifying appropriate modalities of assessment and treatment	The knowledge and skills in this theme are not substantively addressed in the BTC.	This learning objective describes the knowledge and skills necessary for trainees to formulate a rehabilitation management plan specifying appropriate modalities of assessment and treatment. Given that the subject of pain is not substantively addressed in the BTC it is appropriate to retain this learning objective in any revised advanced rehabilitation medicine curriculum.
2.2.4 Coordinate and review team-based interdisciplinary patient management, including the integration of appropriate physical and psychological interventions	The knowledge and skills in this theme are not substantively addressed in the BTC.	This learning objective describes the role of interdisciplinary teams in the management of pain, including the integration of appropriate physical and psychological interventions. Given that the subject of pain is not substantively addressed in the BTC it is appropriate to retain this learning objective in any revised advanced rehabilitation medicine curriculum.

Theme 2.3 Developmental and intellectual disability in adults		
2.3.1 Recall basic knowledge of developmental and lifelong intellectual disability which had arisen in childhood	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed substantively in the BTC.</p> <p>Reference to a number of elements identified within this theme, however, are located at Learning objectives 2.4.2 <i>Manage patients with genetic disorders</i>; 2.5.1 <i>Manage common presentations in adolescents</i>; and 2.5.4 <i>Manage problems in the older patient</i>.</p>	<p>This learning objective requires trainees to ‘recall’ previous knowledge regarding developmental and lifelong intellectual disability. It requires trainees to describe and define a range of diseases and conditions, and also examines the transition from paediatric to adult care and support for the elderly and dying who suffer intellectual impairment. It examines issues of guardianship and consent and government policies associated with mental health and institutionalisation.</p> <p>Given that the subject of intellectual disability is not substantively addressed in the BTC it is appropriate to retain this learning objective in any revised advanced rehabilitation medicine curriculum.</p>
2.3.2 Complete a comprehensive assessment of an adult with developmental/intellectual disability	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed substantively in the BTC.</p> <p>Generic knowledge and skills are developed, however, throughout the BTC with regard to completing a comprehensive patient assessment in a variety of circumstances and for a range of conditions.</p>	<p>This learning objective describes the knowledge and skills required to complete a comprehensive assessment plan for an adult suffering from a developmental or intellectual disability.</p> <p>Given that the subject of intellectual disability is not substantively addressed in the BTC it is appropriate to retain this learning objective in any revised advanced rehabilitation medicine curriculum.</p>
2.3.3 Form a rehabilitation plan in consultation with persons responsible and carers who are able to facilitate the patient’s participation in the plan	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed substantively in the BTC.</p>	<p>This learning objective describes the knowledge and skills required to form a rehabilitation plan in consultation with appropriate (allied) health professionals for adults suffering from a developmental or intellectual disability.</p> <p>Given that the subject of intellectual disability is not substantively addressed in the BTC it is appropriate to retain this learning objective in any revised advanced rehabilitation medicine curriculum.</p>

Theme 2.4 Illness and injury of the child and adolescent		
2.4.1 Describe illnesses and injuries that result in disability and activity limitation or participation restriction in childhood and adolescence	<p>The knowledge and skills described in this theme and associated learning objective are not substantively addressed in the BTC.</p> <p>Some reference is made, however, to topics such as 'illness on adolescent development' at Learning objective 2.5.1 <i>Manage common presentations in adolescents</i>. Other relevant references are found at Learning objective 2.3.7 <i>Manage patients with disorders of the musculoskeletal system</i>, and Learning objective 2.3.8 <i>Manage patients with disorders of the neurological system</i>.</p>	<p>This learning objective describes the illnesses and injuries that can result in disability and impairment in childhood and adolescence.</p> <p>Given that the subject of illness and injury in childhood and adolescence is not substantively addressed in the BTC (and that when it is it is not with a view to rehabilitation), it is appropriate to retain this learning objective in any revised advanced rehabilitation medicine curriculum.</p>
2.4.2 Apply basic principles of rehabilitation management for children and adolescents, considering the importance of social, educational, and vocational factors	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed substantively in the BTC.</p> <p>Generic knowledge and skills are developed, however, throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the principles of rehabilitation management for children and adolescents.</p> <p>Given that the subject of illness and injury in childhood and adolescence is not substantively addressed in the BTC (and that when it is it is not with a view to rehabilitation), it is appropriate to retain this learning objective in any revised advanced rehabilitation medicine curriculum.</p>
Theme 2.5 Illness and injury in older people		
2.5.1 Outline the basis and management of illness and injury in older people	<p>The knowledge and skills described in this theme are discussed in a tangential way in the BTC. Illness and injury in older people is addressed at Learning objectives 2.5.4 <i>Manage problems in the older patient</i>, and 2.5.5 <i>Manage patients at the end of life</i>.</p>	<p>This learning objective describes the knowledge that Rehabilitation Trainees are required to possess with regard to illness and injury in older people.</p> <p>This learning objective should be retained in any revised rehabilitation medicine advanced curriculum, but perhaps be incorporated into a broader (new) learning objective.</p>

<p>2.5.2 Complete a comprehensive patient assessment that identifies disability resulting from illness and/or injury in old age and evaluate the potential for rehabilitation</p>	<p>The knowledge and skills described in this theme are discussed in a tangential way in the BTC. Illness and injury in older people is addressed at Learning objectives 2.5.4 <i>Manage problems in the older patient</i>, and 2.5.5 <i>Manage patients at the end of life</i>.</p> <p>Generic knowledge and skills are also developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills Rehabilitation Medicine Trainees require in order to complete a comprehensive patient assessment and evaluation of those suffering disability or impairment in old age.</p> <p>Despite the development of generic skills through the BTC this learning objective has a particular focus on rehabilitation and the management of disability and impairment in older people and should, therefore, be retained in any revised advanced rehabilitation medicine curriculum. It may be appropriate, though, to incorporate it in a new, broader learning objective.</p>
<p>2.5.3 Formulate a rehabilitation management plan in consultation with the patient, family, and general practitioner</p>	<p>The knowledge and skills described in this theme are discussed in a tangential way in the BTC. Illness and injury in older people is addressed at <i>Learning Objectives 2.5.4, Manage problems in the older patient</i>, and 2.5.5, <i>Manage patients at the end of life</i>.</p> <p>Generic knowledge and skills are also developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, and referring patients to appropriate support teams.</p>	<p>The focus of this learning objective is in providing Rehabilitation Medicine Trainees with the knowledge and skills to manage the rehabilitation of older people with appropriate consultation and communication with the patient, the patient's family, and the patient's general practitioner.</p> <p>Despite the development of generic skills through the BTC this learning objective has a particular focus on rehabilitation and the management of disability and impairment in older people and should, therefore, be retained in any revised advanced rehabilitation medicine curriculum. It may be appropriate, though, to incorporate it in a new, broader learning objective.</p>

Theme 2.6 Lower limb amputation		
<p>2.6.1 Recall basic knowledge of lower limb amputation</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective reviews and summarises basic knowledge associated with lower limb amputation. It also discusses the principles of operation for amputee clinics and offers an overview of artificial limb schemes.</p> <p>Given the absence of discussion about lower limb amputation and prosthetic devices in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.6.2 Complete a comprehensive patient assessment that identifies the type of lower limb amputation and any medical factors relevant to prosthetic rehabilitation</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills required for trainees to complete a comprehensive patient assessment identifying the type of lower limb amputation and associated medical factors.</p> <p>Given the absence of discussion about lower limb amputation and prosthetic devices in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.6.3 Prescribe appropriate temporary and definitive prostheses</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the principles of prosthetic management and the prescription of lower limb prostheses and stump analysis and assessment.</p> <p>Given the absence of discussion about lower limb amputation and prosthetic devices in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>

<p>2.6.4 Formulate an interdisciplinary rehabilitation management plan including review and coordination of patient care</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills required to develop an interdisciplinary rehabilitation plan and review and coordination of patient care.</p> <p>Given the absence of discussion about lower limb amputation and prosthetic devices in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>Theme 2.7 Lymphoedema and related disorders</p>		
<p>2.7.1 Recall basic knowledge of lymphoedema and related disorders</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not substantively discussed in the BTC. Brief reference is made to the lymphatic system and associated disorders at Learning objective 2.3.5 <i>Manage patients with disorders of the immune system</i>, and perhaps 2.2.1 <i>Manage patients with undifferentiated presentations</i>.</p>	<p>This learning objective reviews and summarises the basic knowledge associated with lymphoedema and related disorders.</p> <p>Given the absence of discussion about lymphoedema and related disorders in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.7.2 Complete a comprehensive assessment of a patient presenting with a lymphoedema and/or related disorders, and evaluate the potential for rehabilitation</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not substantively discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to complete a comprehensive assessment of patients presenting with lymphoedema or related disorders, including their potential for rehabilitation.</p> <p>Given the absence of discussion about lymphoedema and related disorders in the BTC this learning objective should be retained in any new or revised advanced rehabilitation curriculum.</p>

<p>2.7.3 Formulate a lymphoedema management program</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not substantively discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to formulate a lymphoedema management plan.</p> <p>Given the absence of discussion about lymphoedema and related disorders in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.7.4 Provide subacute hospital (phase I) care to a patient with lymphoedema and/or related disorders</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not substantively discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to provide patients with subacute hospital (phase I) care, including assessing the patients' lifestyle habits and practices.</p> <p>Given the absence of discussion about lymphoedema and related disorders in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.7.5 Provide ongoing (phase II) care to a patient with lymphoedema and/or related disorders</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not substantively discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to provide patients with subacute hospital (phase II) care, including assessing suitable facilities for phase II care and monitoring patient participation in self-management.</p> <p>Given the absence of discussion about lymphoedema and related disorders in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>

Theme 2.8 Musculoskeletal medicine		
<p>2.8.1 Recall basic anatomy and physiology of the musculoskeletal system</p>	<p>The knowledge and skills described in this learning objective are discussed in good detail in the BTC at Learning objective 2.3.7 <i>Manage patients with disorders of the musculoskeletal system</i>.</p> <p>The learning objective does not, unsurprisingly, have a rehabilitation focus and as such appears to gloss over associated factors such as determinants of normal gait.</p>	<p>This learning objective reviews and summarises the basic principles of physiology and the musculoskeletal system.</p> <p>This learning objective should be retained in any revised rehabilitation medicine advanced curriculum, but perhaps be incorporated into a broader (new) learning objective.</p>
<p>2.8.2 Complete a comprehensive assessment of a patient presenting with musculoskeletal disease or injury, and evaluate the potential for rehabilitation</p>	<p>The knowledge and skills described in this learning objective are discussed on a tangential level in the BTC at Learning objective 2.3.7 <i>Manage patients with disorders of the musculoskeletal system</i>.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to complete a comprehensive assessment of a patient presenting with musculoskeletal disease or injury.</p> <p>Given the relatively thin discussion of relevant musculoskeletal disease and injury in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum, but perhaps be incorporated into a broader learning objective.</p>
<p>2.8.3 Formulate a rehabilitation management plan specifying appropriate modalities of assessment and treatment</p>	<p>The knowledge and skills described in this learning objective are discussed on a tangential level in the BTC at Learning objective 2.3.7 <i>Manage patients with disorders of the musculoskeletal system</i>.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to formulate a rehabilitation plan specifying appropriate modalities and treatments for patients presenting with musculoskeletal disease or injury.</p> <p>Given the relatively thin discussion of relevant musculoskeletal disease and injury in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum, but perhaps be incorporated into a broader learning objective.</p>

Theme 2.9 Neurological disease		
<p>2.9.1 Recall basic knowledge of neurological disease</p>	<p>The knowledge and skills described in this learning objective are discussed in good detail in the BTC at Learning objective 2.3.8 <i>Manage patients with disorders of the neurological system</i>.</p> <p>The focus of the learning objective, not surprisingly, has a strong focus on impairment and rehabilitation which is not present in the BTC objective.</p>	<p>This learning objective reviews and summarises the nature and consequences of neurological disorders that result in major disability and activity limitation.</p> <p>This learning objective should be retained in any revised RM advanced curriculum, but perhaps be incorporated into a broader (new) learning objective.</p>
<p>2.9.2 Complete a comprehensive assessment of a patient with neurological disease and evaluate the potential for rehabilitation</p>	<p>The knowledge and skills described in this learning objective are discussed on a tangential level in the BTC at Learning objective 2.3.8 <i>Manage patients with disorders of the neurological system</i>.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to complete a comprehensive assessment of a patient with a neurological disease, and to evaluate the potential for rehabilitation.</p> <p>Given the significantly different focus of this learning objective on neurological related disability, impairment, and rehabilitation as compared with the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.9.3 Formulate a rehabilitation management plan that specifies appropriate modalities of assessment and treatment</p>	<p>The knowledge and skills described in this learning objective are discussed on a tangential level in the BTC at Learning objective 2.3.8 <i>Manage patients with disorders of the neurological system</i>.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to formulate a rehabilitation management plan that specifies appropriate modalities of assessment and treatment.</p> <p>Given the significantly different focus of this learning objective on neurological related disability, impairment, and rehabilitation as compared with the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>

<p>2.9.4 Assess and manage the rehabilitation of a patient with cerebrovascular disease</p>	<p>The knowledge and skills described in this learning objective are not discussed or addressed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to assess and manage the rehabilitation of a patient with cerebrovascular disease.</p> <p>Given the significantly different focus of this learning objective on neurological related disability, impairment, and rehabilitation as compared with the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.9.5 Assess and manage the rehabilitation of a patient with multiple sclerosis</p>	<p>The knowledge and skills described in this learning objective are not discussed or addressed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to assess and manage the rehabilitation of a patient with multiple sclerosis.</p> <p>Given the significantly different focus of this learning objective on neurological related disability, impairment, and rehabilitation as compared with the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.9.6 Assess and manage the rehabilitation of a patient with motor neurone disease</p>	<p>The knowledge and skills described in this learning objective are not discussed or addressed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to assess and manage the rehabilitation of a patient with motor neurone disease.</p> <p>Given the significantly different focus of this learning objective on neurological related disability, impairment, and rehabilitation as compared with the BTC, this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>

<p>2.9.7 Assess and manage the rehabilitation of a patient with poliomyelitis and post-polio syndrome</p>	<p>The knowledge and skills described in this learning objective are not discussed or addressed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to assess and manage the rehabilitation of a patient with poliomyelitis and post-polio syndrome.</p> <p>Given the significantly different focus of this learning objective on neurological related disability, impairment, and rehabilitation as compared with the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.9.8 Assess and manage the rehabilitation of a patient with myopathy and neuropathy</p>	<p>The knowledge and skills described in this learning objective are not discussed or addressed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to assess and manage the rehabilitation of a patient with myopathy and neuropathy.</p> <p>Given the significantly different focus of this learning objective on neurological related disability, impairment, and rehabilitation as compared with the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>Theme 2.10 Occupational injury</p>		
<p>2.10.1 Complete a comprehensive evaluation of an injured worker that identifies the nature and severity of injury</p>	<p>The knowledge and skills described in this learning objective and associated with occupational injuries are not specifically addressed in the BTC. Specific types of injury are, however, discussed at various locations throughout the BTC. (Identifying duplications is made more difficult as a result of how the two curricula have been organised)</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a</p>	<p>This learning objective describes the knowledge and skills trainees require in order to complete a comprehensive evaluation of an injured worker. The objective describes current practices and technologies for assessing injuries to workers, as well as exploring relevant aspects of worker's compensation legislation and the rights of workers.</p> <p>Given the absence of discussion regarding occupational injuries in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>

	comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.	
2.10.2 Prescribe rehabilitation treatment for occupational therapy	The knowledge and skills described in this learning objective are not specifically addressed in the BTC. Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.	This learning objective describes the knowledge and skills trainees require in order to prescribe rehabilitation treatment for occupational therapy. It describes the goals of occupational therapy and medicine and the nexus with rehabilitation medicine. While the skills referred to in this learning objective are generic in nature the knowledge is specific to occupational injury and associated therapy. It is recommended, therefore, that this learning objective be retained, though perhaps be incorporated into a broadened learning objective in any revised rehabilitation medicine curriculum.
Theme 2.11 Spinal cord injury and disease		
2.11.1 Recall basic knowledge of spinal cord injury and disease	The knowledge and skills described in this learning objective are discussed in only a very limited way in the BTC at Learning objective 2.1.2 <i>Manage specific acute medical problems</i> , and 2.2.1 <i>Manage patients with undifferentiated presentations</i> .	This learning objective reviews and summarises the nature and consequences of spinal cord injury and disease that result in major disability and activity limitation. Given the relative absence of specific consideration of spinal cord injury and disease in the BTC this learning objective should be retained in any revised rehabilitation medicine advanced curriculum.
2.11.2 Complete a comprehensive assessment of a patient with stable spinal cord injury/disease and evaluate potential for rehabilitation	The knowledge and skills described in this learning objective are discussed in only a very limited way in the BTC at Learning objectives 2.1.2 <i>Manage specific acute medical problems</i> , and 2.2.1 <i>Manage patients with undifferentiated presentations</i> . Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing	This learning objective describes the knowledge and skills trainees require in order to complete a comprehensive assessment of a patient suffering from spinal disease or injury and their potential for rehabilitation. It describes the knowledge necessary to assess the level and management of dysfunction and the skills required interpret relevant diagnostic investigations. Given the relative absence of specific consideration of spinal cord injury and disease in the BTC this learning objective should be retained in any revised rehabilitation advanced

	or working with interdisciplinary teams, and referring patients to appropriate support teams.	curriculum.
2.11.3 Formulate a management plan that specifies necessary medical, physical and functional rehabilitation goals and treatments in inpatient, outpatient, and community settings	<p>The knowledge and skills described in this learning objective are discussed in only a very limited way in the BTC at Learning objectives 2.1.2 <i>Manage specific acute medical problems</i>, and 2.2.1 <i>Manage patients with undifferentiated presentations</i>.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to formulate a management plan that addresses the medical, physical, and functional rehabilitation goals of patients experiencing spinal cord disease and injury. Specific reference is made to the requirements and treatments of patients in inpatient, outpatient, and community settings.</p> <p>Given the relative absence of specific consideration of spinal cord injury and disease in the BTC this learning objective should be retained in any revised rehabilitation medicine advanced curriculum.</p>
Theme 2.12 Traumatic brain injury		
2.12.1 Outline the epidemiology, pathophysiology, prognostication, acute treatment, and prevention of traumatic brain injury	<p>The knowledge and skills described in this learning objective are not specifically discussed in the BTC, although some tangential links are present at Learning objectives 1.2.3 <i>Incorporate health and wellness promotion in clinical practice</i>, 1.2.5 <i>Facilitate ongoing care planning</i>, and 2.1.2 <i>Manage specific acute medical problems</i>.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge trainees require in order to outline and identify the extent, nature, causes, progress, prognostication, treatment, and prevention of traumatic brain injuries.</p> <p>It describes the specific types and nature of dysfunction and impairment experienced by people suffering traumatic brain injury.</p> <p>Given the relative absence of specific consideration of traumatic brain injury and disease in the BTC this learning objective should be retained in any revised rehabilitation medicine advanced curriculum.</p>
2.12.2 Complete a comprehensive assessment of a patient with traumatic brain injury and evaluate the potential for rehabilitation	<p>The knowledge and skills described in this learning objective are not specifically discussed in the BTC, although some tangential links are present at</p>	<p>This learning objective describes the knowledge and skills trainees require in order to complete a comprehensive assessment of a patient suffering from traumatic brain injury</p>

	<p>Learning objectives 1.2.3 <i>Incorporate health and wellness promotion in clinical practice</i>, 1.2.5 <i>Facilitate ongoing care planning</i>, and 2.1.2 <i>Manage specific acute medical problems</i>.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>and their potential for rehabilitation. It describes the knowledge necessary to assess the level and management of dysfunction and to how differentiate measures of impairment.</p> <p>Given the relative absence of specific consideration of traumatic brain injury and disease in the BTC this learning objective should be retained in any revised rehabilitation medicine advanced curriculum.</p>
<p>2.12.3 Formulate a management plan that specifies necessary medical, physical, and functional rehabilitation goals and treatments in inpatient, outpatient, and community settings</p>	<p>The knowledge and skills described in this learning objective are not specifically discussed in the BTC, although some tangential links are present at Learning objectives 1.2.3 <i>Incorporate health and wellness promotion in clinical practice</i>, 1.2.5 <i>Facilitate ongoing care planning</i>, and 2.1.2 <i>Manage specific acute medical problems</i>.</p> <p>Generic knowledge and skills are, however developed and practised throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills trainees require in order to formulate a management plan that addresses the medical, physical, and functional rehabilitation goals of patients experiencing traumatic brain injury. Specific reference is made to the requirements and treatments of patients in inpatient, outpatient, and community settings</p> <p>Given the relative absence of specific consideration of traumatic brain injury and disease in the BTC this learning objective should be retained in any revised rehabilitation medicine advanced curriculum.</p>
<p>Theme 2.13 Upper limb amputation</p>		
<p>2.13.1 Recall basic knowledge of upper limb amputation</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed in the BTC.</p>	<p>This learning objective reviews and summarises basic knowledge associated with upper limb amputation. It summarises the surgical principles of upper limb amputation and the levels of amputation.</p> <p>Given the absence of discussion of upper limb amputation in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>

<p>2.13.2 Complete a comprehensive patient assessment that identifies the type of upper limb amputation and any medical factors relevant to prosthetic rehabilitation</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills required for trainees to complete a comprehensive patient assessment identifying the type of upper limb amputation and associated medical factors.</p> <p>Given the absence of discussion about upper limb amputation and prosthetic devices in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.13.3 Prescribe appropriate temporary and definitive prostheses</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the principles of prosthetic management and the prescription of upper limb prostheses and stump analysis and assessment.</p> <p>Given the absence of discussion about upper limb amputation and prosthetic devices in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>
<p>2.13.4 Formulate an interdisciplinary rehabilitation management plan including review and coordination of patient care</p>	<p>The knowledge and skills described in this theme and associated learning objectives are not discussed in the BTC.</p> <p>Generic knowledge and skills are, however, developed throughout the BTC in the areas of completing a comprehensive patient assessment, developing a management plan, taking a comprehensive patient history, synthesising findings, conducting patient evaluations, managing or working with interdisciplinary teams, and referring patients to appropriate support teams.</p>	<p>This learning objective describes the knowledge and skills required to develop an interdisciplinary rehabilitation plan and review and coordination of patient care.</p> <p>Given the absence of discussion about upper limb amputation and prosthetic devices in the BTC this learning objective should be retained in any new or revised advanced rehabilitation medicine curriculum.</p>

11. Possible revised Rehabilitation Medicine Advanced Training Curriculum if FRACP option adopted.

This section is authored by Andrew Dostine, an educationalist who was appointed to delineate the curriculum specifications for advanced training in adult rehabilitation Medicine under the FRACP option.

11.1. *Introductory comments*

The following constitutes an example of a possible new three-year Rehabilitation Medicine Advanced Training Curriculum. It has been developed specifically to reflect potential changes that may be possible were Rehabilitation Trainees required to first complete a foundational three-year RACP BTC. In an earlier review and mapping exercise areas of duplication between the existing RACP BTC and Rehabilitation Medicine Advanced Training Curriculum were identified. The present example, or *model curriculum*, therefore, has removed or consolidated those areas of duplication and offers a potential alternative in light of current curriculum reviews and discussions taking place within the College.

The model curriculum is similar in structure to current RACP curriculum offerings, but has been developed with awareness of current moves to develop a new RACP standards framework and associated curriculum guidelines. Accordingly, the model curriculum consists of:

- **Domains** – the broad, overarching topic areas in which trainees must develop competence, expertise, and professional ability
- **Learning objectives and required competencies** – the more specific activities, practices, and professional procedures within each domain that trainees are expected to achieve or acquire in the course of their training
- **Element weighting** – the relative value or weighting of each learning objective or domain against others as expressed by a numerical value. The assigned numerical value used in the model curriculum represents the expected (relative) proportion of study **and** assessment of a particular learning objective within the overall program of training. Level 1 objectives, for instance, are those that, **as a group**, represent approximately 20% of the program; level 2 objectives are those that represent approximately 30% of the program; while level 3 objectives are those that represent approximately 50% of the program.
- **Assessment methods** – examples of the types of methods by which the learning objectives will be assessed or measured.

The aim of the model curriculum (and the features and changes it includes) is to provide both educators and students with a comprehensive body of information about the scope of the course of study in which they are involved, including its objectives, required skills and competencies, and how those skills and knowledge will be assessed or tested. An important additional aim is to demonstrate the viability or appropriateness of a new three-

year Rehabilitation Medicine Advanced Training Curriculum developed on the assumption of trainees having first completed the existing (or an amended) RACP BTC.

11.2. Potential curriculum for Advanced Training in Rehabilitation Medicine if the RACP option is adopted

The model curriculum presented above has been developed following discussion with rehabilitation medicine experts and consideration of existing documentation and curricula from the RACP. It has been informed by a recent curriculum mapping exercise in which duplication between the current RACP BTC and the current Rehabilitation Medicine Advanced Training Curriculum has been identified and removed or consolidating in the present model curriculum.

The driving impetus for the production of this model curriculum was the desire to demonstrate how the current four-year Rehabilitation Medicine Advanced Training Curriculum might be rationalised, through the removal of duplicate material, to produce a coherent three-year curriculum which trainees would embark upon following the successful completion of the current (or a slightly amended) RACP BTC. The proposed model curriculum manages to address all key areas of the existing Rehabilitation Medicine Advanced Training Curriculum. Additional information is provided which aims to provide an indicative idea of the 'weighting' of each learning objective. This weighting device uses a numerical value to offer trainees an indication of the relative emphasis (both the amount of study/lecture time required and the assessment value) of each program element.

A final column in the model curriculum provides a generic indication of the types of assessment methods that might be used for each program element.

The model curriculum has been developed with an awareness of current curriculum reviews that are taking place within the College, but, which I hope, might be accommodated in any new curriculum standards framework. The model curriculum aims primarily to offer a starting point for future discussions on the nature, scope, and content of any new rehabilitation medicine advanced curriculum. It assumes that learning content will be augmented and supplemented by topic specific learning resources, including lectures, notes, workshops, etc. With this in mind, you will notice that there are a number of areas within the model curriculum where specific learning content and skills will need to be added or expanded by appropriate subject matter experts.

Andrew Dostine

10 February, 2014

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
Domain 1 Foundations of rehabilitation medicine			
Learning objectives			
1.1 Describe and demonstrate a detailed knowledge of rehabilitation medicine, the disabling consequences of disease, disorders, and injury, and the nature and extent of disability and activity limitation or participation	<ul style="list-style-type: none"> • The ability to describe epidemiology, pathophysiology, history, clinical features and complications of diseases and disorders and injuries that lead to impairment and dysfunction • Describe concepts of impairment and the influence medical, physical, psychological, social, and cultural factors on the determination of disability and their effects on the outcomes of rehabilitation • Demonstrate an understanding of, and the ability to effectively use and interpret relevant tools for the measurement of impairment and diagnostic investigations • Demonstrate an understanding of the concepts of primary, secondary, and tertiary prevention in the context of rehabilitation medicine • Promote the early identification and treatment of disability, including secondary physical and psychological disabilities. 	1	Case-based discussions Research projects Mini-clinical evaluation exercises Direct observation of procedural skills Examinations
1.2 Plan and implement a realistic and appropriate rehabilitation assessment and treatment program that is problem-oriented, goal-driven, time-limited, and directly addresses the needs and expectations of the patient and family	<ul style="list-style-type: none"> • Describe and discuss the role of pharmacological treatments, including potential side-effects, in the management of impairment and disability • Describe and discuss the role of surgical interventions in the management of disability • Describe and discuss the use of prosthetics, orthotics, and adaptive equipment in the management of impairment and disability • Demonstrate an understanding of, and ability to 	1	Case-based discussions Research projects Mini-clinical evaluation exercises Direct observation of procedural skills Examinations

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	<p>effectively use, relevant investigations, assessment tools, and modalities (including technologies) in the practice of rehabilitation medicine</p> <ul style="list-style-type: none"> • Describe and discuss the management of psychological factors in the management of rehabilitation, including anxiety, depression, and cognitive/behavioural disorders • Describe and discuss the roles of government agencies, private organisations, and volunteer and community groups in the care and management of people with disability and impairment • Apply basic clinical procedures as required • Communicate rehabilitation plans and planning to the patient and family • Write adequate, timely, and legible medical records • Review patient progress and rehabilitation goals. 		
<p>1.3 Demonstrate an understanding of the nature and availability of health services at the global, national, and state levels, along with the legal and ethical issues associated with the delivery of rehabilitation medicine services</p>	<ul style="list-style-type: none"> • Describe and discuss the organisation of health services in Australia and New Zealand at the national, state, and local levels • Describe and discuss the current models of health care funding and associated reforms • List and interpret the legislation relevant to the provision of health service delivery, specifically as it applies to rehabilitation medicine e.g. worker's compensation and third party compensation • Describe and discuss the roles of major government and non-government organisations in the support of people with disabilities • Differentiate ethical and legal issues to health services 	<p>1</p>	<p>Case-based discussions Research projects Essays and reports Examinations</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	management <ul style="list-style-type: none"> Describe and discuss the social, ethnic, and cultural issues affecting health service planning and management. 		
Domain 2 rehabilitation medicine sub-specialties			
Learning objectives			
2.1 Traumatic brain injury Describe and demonstrate a detailed knowledge of the assessment, treatment, and management of the disabling consequences of traumatic brain injury	<ul style="list-style-type: none"> Describe and discuss the epidemiology, pathophysiology, prognostication, acute treatment, and prevention of traumatic brain injury, including integrative functions and long-term outcomes (e.g. on employment, interpersonal relationships, and leisure and recreation activities) Explain neurological evaluation techniques including demonstrating the significance of clinical observations such as the Glasgow Coma Scale, the duration of coma, intracranial pressure, brainstem signs (pupillary reflexes), and autonomic disturbances Complete a comprehensive assessment of a patient with a traumatic brain injury Explain the assessment of rehabilitation potential in cases of traumatic brain injury including consideration of pre-injury, injury, and post-injury factors Demonstrate the ability to differentiate between measures of impairment and disability using a range of methods Demonstrate an advanced knowledge of functional anatomy and physiology as they pertain to the study of rehabilitation medicine Demonstrate the ability to formulate a rehabilitation 	3	Case-based discussions Research projects Mini-clinical evaluation exercises Direct observation of procedural skills Examinations

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	<p>management plan following a traumatic brain injury including: a summary of acute management measures and a list of common medical complications and associated medical responses; the use of any drugs or medications; the prescription of orthotics or other aids; how you might achieve community reintegration; and a list of rehabilitation services or agencies</p> <ul style="list-style-type: none"> • Communicate effectively with the patient, family, and members of the rehabilitation team. 		
<p>2.2 Cardiac and pulmonary disease Describe and demonstrate a detailed knowledge of the assessment, treatment, and management of the disabling consequences of cardiac and pulmonary disease</p>	<ul style="list-style-type: none"> • Describe and discuss the epidemiology, aetiology, incidence and prevalence, mortality, and morbidity of cardiac and pulmonary disease • Describe the role of investigations in the evaluation of cardiac and pulmonary disease including electrocardiography, echocardiography, coronary angiography, radionuclide imaging, exercise testing • Demonstrate the ability to professional use, analyse, and interpret technologies and investigations such as chest x-ray, exercise-electrocardiography, and other imaging techniques to determine the level of cardiac impairment • Explain the principles and phases of cardiac rehabilitation including acute care (phase I), post discharge care (phase II), and maintenance care in the community (phase III) • Describe and discuss the medical and surgical management of cardiac disease • Describe and discuss the indications and contraindications and side effects of cardio active drugs 	<p>3</p>	<p>Case-based discussions Research projects Mini-clinical evaluation exercises Direct observation of procedural skills Examinations</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	<p>such as diuretics, beta-blockers, calcium blockers, angiotensin-converting enzyme inhibitors, digoxin, and antiarrhythmic</p> <ul style="list-style-type: none"> • Identify, explain, and manage the risk factors of cardiac disease including hypertension, hyperlipidaemia, smoking, and diabetes • Describe and discuss the causes, treatment and management of pulmonary and respiratory disease in the context of rehabilitation medicine • Demonstrate an advanced knowledge of functional anatomy and physiology as they pertain to the study of rehabilitation medicine • Evaluate a patient's risk profile and provide dietary and nutritional advice as required • Assist patients in identifying appropriate support from rehabilitation services or agencies and appropriate community groups • Communicate effectively with the patient, family, and members of the rehabilitation team. 		
<p>2.3 Upper and lower limb amputation Describe and demonstrate a detailed knowledge of the assessment, treatment, and management of the disabling consequences of upper and lower limb amputation</p>	<ul style="list-style-type: none"> • Describe and discuss the epidemiology, aetiology, incidence and prevalence, mortality, and morbidity of acquired major limb loss • Demonstrate the ability to formulate a comprehensive patient assessment and rehabilitation management plan for people suffering upper or lower limb amputation including: differentiating between methods of 	3	<p>Case-based discussions Research projects Mini-clinical evaluation exercises Direct observation of procedural skills Examinations</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	<p>amputation; promoting wound and stump healing; explaining the use of ultrasound and angiography; describing the principles of prosthetic management including prescribing and fitting temporary prostheses; interpreting causes and management of stump and phantom pain</p> <ul style="list-style-type: none"> • Describe and discuss the goals of prosthetic training (e.g. cosmetic, functional, vocational, recreational, social) • Describe and discuss postoperative patient (and wound) management • Demonstrate an advanced knowledge of functional anatomy and physiology as they pertain to the study of rehabilitation medicine • Describe and discuss the management of peripheral vascular disease • Communicate effectively with the patient, family, and members of the rehabilitation team. 		
<p>2.4 Spinal cord injury Describe and demonstrate a detailed knowledge of the assessment, treatment, and management of the disabling consequences of spinal cord injury</p>	<ul style="list-style-type: none"> • Describe and discuss the anatomy, epidemiology, aetiology, physiology, and pathophysiology of spinal cord injury • Demonstrate the ability to formulate a comprehensive patient assessment and rehabilitation management plan for people suffering spinal cord injury including: identifying the types of permanent dysfunction that arise from spinal cord injury (e.g. neurogenic bladder and bowel, autonomic dysreflexia); evaluating activity limitations and participation restrictions; using and interpreting relevant diagnostic investigations such as 	3	<p>Case-based discussions Research projects Mini-clinical evaluation exercises Direct observation of procedural skills Examinations</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	<p>radiological (x-ray, CT, MRI) and electro diagnostic tests; types of pain management; how you might achieve community reintegration; and a list of rehabilitation services or agencies (post-discharge/community care)</p> <ul style="list-style-type: none"> • Describe and discuss the principles of operative and non-operative surgical management including late-stage surgical interventions • Identify and discuss the psychological aspects of spinal cord injury and impairment including sexuality, sexual dysfunction, adjusting to disability, and the impacts on family • Demonstrate an advanced knowledge of functional anatomy and physiology as they pertain to the study of rehabilitation medicine • Describe and discuss the use of adaptive techniques and assistive devices • Communicate effectively with the patient, family, and members of the rehabilitation team. 		
<p>2.5 Neurological disease Describe and demonstrate a detailed knowledge of the assessment, treatment, and management of the disabling consequences of neurological disease</p>	<ul style="list-style-type: none"> • Describe and discuss the epidemiology, aetiology, physiology, pathophysiology, mortality, and morbidity of commonly encountered neurological diseases including: cerebrovascular disease; multiple sclerosis; motor neurone disease; poliomyelitis and post-polio syndrome; and myopathy and neuropathy • Describe and discuss the nature and impact of cognitive/perceptual dysfunction including: the types of impairment, methods of assessment, techniques for management, techniques for retraining, and the social 		<p>Case-based discussions Mini-clinical evaluation exercises Direct observation of procedural skills Examinations</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	<p>and cultural effects of cognitive dysfunction</p> <ul style="list-style-type: none"> • Identify and explain specific types of common dysfunction associated with various neurological disorders including: bladder and bowel dysfunction; sexual dysfunction; nutritional problems; and communication disorders, such as dysphasia, apraxia, and dysarthria • Demonstrate the ability to conduct clinical examinations to assess cognitive and physical functioning • Demonstrate the ability to use and interpret relevant technologies and diagnostic techniques including CT and MRI scans, angiography, ultrasonography positron emission tomography, single photon emission computed tomography and others • Demonstrate an advanced knowledge of functional anatomy and physiology as they pertain to the study of rehabilitation medicine • Describe and discuss the rehabilitation strategies employed to manage patients with the neurological disease/disorders listed above • Assist patients in identifying appropriate support from rehabilitation services or agencies and appropriate community groups • Communicate effectively with the patient, family, and members of the rehabilitation team. 		
<p>2.6 De-conditioning Demonstrate an understanding and awareness of the concept of de-conditioning, how it manifests in patients who acquire a disability or limited activity or participation through injury or illness,</p>	<ul style="list-style-type: none"> • Describe and discuss the various manifestations of de-conditioning in patients experience disability or impairment such as reduced physical capacity, decreased muscle mass and strength, reduced heart 	2	<p>Case-based discussions Research projects Essays and reports</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
<p>and the interventions that are available to rehabilitation medicine specialists</p>	<p>and lung function and capacity, and depressed or impaired mental status</p> <ul style="list-style-type: none"> • Assist patients in identifying appropriate support from rehabilitation services or agencies and appropriate community groups • Communicate effectively with the patient, family, and members of the rehabilitation team. 		
<p>2.7 Intellectual disability in children and adults Describe and demonstrate a detailed knowledge of the assessment, treatment, and management of the disabling consequences of intellectual disability and impairment in children and adults</p>	<ul style="list-style-type: none"> • Describe and discuss the epidemiology, aetiology, physiology, and pathophysiology of intellectual disability and impairment in both children and adults including demonstrating a detailed understanding of the principles of growth, development, and aging with an emphasis neurological and musculoskeletal systems • Define and explain genetic and chromosomal disorders as they pertain to intellectual disability • Explain and differentiate the different types and manifestations of intellectual disability and impairment experienced by children and adults • Demonstrate an awareness and understanding of the social and psychological implications of intellectual disability and impairment • Describe and discuss the special needs considerations when treating and managing young and old people with intellectual disability e.g. the development of other disabling conditions; dementia; stroke; incontinence • Describe and discuss the medical management of common problems in the elderly including: dementia, stroke • Assist patients in identifying appropriate support from 	<p>3</p>	<p>Case-based discussions Research projects Mini-clinical evaluation exercises Examinations</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	<p>rehabilitation services or agencies and appropriate community groups</p> <ul style="list-style-type: none"> • Communicate effectively with the patient, family, and members of the rehabilitation team. 		
<p>2.8 Musculoskeletal injuries and trauma Describe and demonstrate a detailed knowledge of the assessment, treatment, and management of the disabling consequences of musculoskeletal injuries and trauma</p>	<ul style="list-style-type: none"> • Describe and discuss the epidemiology, aetiology, physiology, and pathophysiology of musculoskeletal injuries and trauma including reference to: sprains and strains; degenerative disorders; subacute fractures; subacute and chronic arthritis; soft tissue disorders; subacute care following spinal, joint, and tendon surgery; peripheral nerve injury; systemic diseases such as systemic lupus erythematosus, visceral disease presenting as musculoskeletal pain/dysfunction, and neurological disease involving the musculoskeletal system • Demonstrate the ability to use and interpret diagnostic tests and tools including: x-rays; CT scans; MRI; diagnostic ultrasound; myelography; discography; joint aspiration • Demonstrate an understanding and awareness of the role and impact of surgical interventions including indications, benefits, and adverse effects • Demonstrate an advanced knowledge of functional anatomy and physiology as they pertain to the study of rehabilitation medicine • Explain the roles of rest and exercise in the management and rehabilitation of musculoskeletal disease and injury • Assist patients in identifying appropriate support from 	3	<p>Case-based discussions Research projects Mini-clinical evaluation exercises Direct observation of procedural skills Examinations</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	rehabilitation services or agencies and appropriate community groups <ul style="list-style-type: none"> • Communicate effectively with the patient, family, and members of the rehabilitation team. 		
2.9 Lymphoedema and related disorders Describe and demonstrate a detailed knowledge of the assessment, treatment, and management of the disabling consequences of lymphoedema and related disorders	<ul style="list-style-type: none"> • Describe and discuss the epidemiology, aetiology, physiology, and pathophysiology of lymphoedema and related disorders • Explain the role and function of investigations such as lymphoscintigrams, vascular investigations, and imaging for obstructions in the evaluation of lymphatic impairment • Explain and identify the nature and severity of primary and secondary lymphoedema and related disorders and functional disability • Describe the medical and surgical management of lymphatic diseases including indications and contraindications, the side effects of drugs, and the risk factors for lymphoedema including obesity and cellulitis • Demonstrate an awareness of the role and use of rehabilitation management techniques such as decongestive massage, bandaging, compression garmenting, exercise, nutrition, psychological support, education, and vocational resettlement • Identify and explain personal and lifestyle risk factors associated with lymphoedema including diet, weight, exercise, stress, and anxiety • Assist patients in identifying appropriate support from rehabilitation services or agencies and appropriate community groups 	3	Case-based discussions Research projects Mini-clinical evaluation exercises Direct observation of procedural skills Examinations

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	<ul style="list-style-type: none"> Communicate effectively with the patient, family, and members of the rehabilitation team. 		
<p>2.10 Occupational injury Describe and demonstrate a detailed knowledge of the assessment, treatment, and management of the disabling consequences of occupational injury</p>	<ul style="list-style-type: none"> Describe and discuss the epidemiology, aetiology, physiology, and pathophysiology of occupational injury including: the types of injury and disability; the incidence and prevalence of injury; morbidity and mortality; and direct and indirect costs of occupational injury to industry and the broader community Demonstrate an understanding and awareness of current technologies for the assessment of work capacity, such as Valpar, West, and Baltimore Therapeutic Equipment Identify and explain relevant aspects of key worker's compensation legislation including the rights and responsibilities of workers and employers and the duties of the rehabilitation physician Define the goals of occupational medicine, the nexus with rehabilitation medicine, and the importance of collaboration in workplace injury management Identify and explain the obstacles to occupational rehabilitation such as adversarial legal proceedings, complex interactions between involved parties, delays in the provision of rehab services, occupational barriers to return to work, and psychosocial factors (e.g. anxiety, depression, financial issues, workplace conflict) Demonstrate an awareness of factors that can influence workplace safety Write medical or medico-legal reports to referring agencies describing: the nature of the accident or injury; 	3	<p>Case-based discussions Research projects Mini-clinical evaluation exercises Examinations</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	<p>current and future rehabilitation management issues and strategies; the prognosis for recovery; and an estimation of the level of permanent impairment</p> <ul style="list-style-type: none"> • Assist patients in identifying appropriate support from rehabilitation services or agencies and appropriate community groups • Communicate effectively with the patient, family, and members of the rehabilitation team, and workplace or employer groups. 		
Domain 3 Management of issues commonly encountered in rehabilitation patients			
Learning objectives			
3.1 Daily living dependence Demonstrate an understanding of the issues and impact of disability, impairment, and limited activity on daily living and patient independence	<ul style="list-style-type: none"> • Describe and discuss how disability and impairment affect a patient's independence including: the ability to work, mobility, and access to services, the potential need for physical modifications to the home, and psychological effects • This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	1	Case-based discussions Research projects Essays and reports Mini-clinical evaluation exercises
3.2 Behavioural disturbance related to cognitive dysfunction Describe and demonstrate knowledge of the assessment, treatment, and management of behavioural disturbance related to cognitive dysfunction in the context of rehabilitation	<ul style="list-style-type: none"> • This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Mini-clinical evaluation exercises Examinations
3.3 Psychological co-morbidities associated with	<ul style="list-style-type: none"> • Describe and demonstrate an understanding of the 	2	Case-based

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
<p><i>disability and rehabilitation</i> Describe and demonstrate an understanding of the assessment, treatment, and management of the psychological co-morbidities associated with disability and rehabilitation</p>	<p>psychological impact of disability, impairment, and activity limitation on patients suffering disease and injury</p> <ul style="list-style-type: none"> • Identify and explain the assessment, treatment, and management of patients presenting with psychological co-morbidities including the use of counselling, motivational interviewing, medication, and referral • Identify and explain the different referral options and agencies available to patients with psychological co-morbidities • Assist patients in identifying appropriate support from rehabilitation services or agencies and appropriate community groups • Communicate effectively with the patient, family, and members of the rehabilitation team. 		<p>discussions Mini-clinical evaluation exercises Examinations</p>
<p>3.4 <i>Bowel dysfunction</i> Demonstrate a detailed knowledge of the causes, treatments, and management of bowel dysfunction along with associated skills and procedures</p>	<ul style="list-style-type: none"> • This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	<p>Case-based discussions Mini-clinical evaluation exercises Direct observation of procedural skills Examinations</p>
<p>3.5 <i>Bladder dysfunction</i> Demonstrate a detailed knowledge of the causes, treatments, and management of bladder dysfunction along with associated skills and procedures</p>	<ul style="list-style-type: none"> • This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	<p>Case-based discussions Mini-clinical evaluation exercises Direct observation of procedural skills Examinations</p>
<p>3.6 <i>Cognitive dysfunction</i> Describe and demonstrate knowledge of the</p>	<ul style="list-style-type: none"> • This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of 	2	<p>Case-based discussions</p>

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
assessment, treatment, and management of cognitive dysfunction in the context of rehabilitation	a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert.		Mini-clinical evaluation exercises Direct observation of procedural skills Examinations
3.7 Dysarthria Demonstrate a detailed knowledge of the causes, treatments, and management of dysarthria	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Mini-clinical evaluation exercises Examinations
3.8 Dysphagia Demonstrate a detailed knowledge of the causes, treatments, and management of dysphagia	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Mini-clinical evaluation exercises Examinations
3.9 Dysphasia Demonstrate a detailed knowledge of the causes, treatments, and management of dysphasia	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Mini-clinical evaluation exercises Examinations
3.10 Mobility: transfers and stairs Demonstrate an understanding of how disability, impairment, and limited activity can impact patient mobility and the responses and interventions available to rehabilitation specialists	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Research projects Essays and reports
3.11 Pain Demonstrate a detailed knowledge of the causes, treatments (including associated skills and procedures), and management of pain	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject 	2	Case-based discussions Mini-clinical evaluation exercises Direct observation of

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
	matter expert.		procedural skills Examinations
3.12 Psychological sequelae of disability Demonstrate an understanding of the issues and impact of disability, impairment, and limited activity on the psychological wellbeing of patients	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Research projects Mini-clinical evaluation exercises Examinations
3.13 Return to work Demonstrate an understanding of the factors associated with assisting patients suffering disability and impairment to return to the workforce	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	1	Case-based discussions Research projects Essays and reports
3.14 Sexuality Demonstrate an understanding of the issues and impact of disability, impairment, and limited activity on sexuality and sexual dysfunction	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Research projects Mini-clinical evaluation exercises Examinations
3.15 Sleep disturbance Demonstrate an understanding of how disability and impairment can impact a patient's sleep, and the treatments and interventions available to rehabilitation medicine specialists	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Research projects Mini-clinical evaluation exercises Examinations
3.16 Spasticity Demonstrate a detailed knowledge of the assessment, treatment, and management of spasticity in patients suffering disability and impairment as a result of disease or injury	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Research projects Mini-clinical evaluation exercises Examinations
3.17 Venous thromboembolism disease Describe and demonstrate a detailed knowledge	<ul style="list-style-type: none"> This learning objective seeks to address the practical, 	2	Case-based discussions

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
of the assessment, treatment, and management of venous thromboembolism disease in patients suffering disability and impairment	day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert.		Mini-clinical evaluation exercises Direct observation of procedural skills Examinations
3.18 Weight management Demonstrate an understanding of, and the ability to provide advice regarding, the role of weight management in the treatment of patients suffering disability and impairment as a result of disease or injury	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Mini-clinical evaluation exercises Examinations
3.19 Wound management Demonstrate a detailed knowledge of the skills and procedures associated with effective wound management, especially in the case of surgical upper and lower limb amputation	<ul style="list-style-type: none"> This learning objective seeks to address the practical, day-to-day assessment, treatment, and management of a specific, single area of rehabilitation medicine and requires content provided by an appropriate subject matter expert. 	2	Case-based discussions Mini-clinical evaluation exercises Direct observation of procedural skills Examinations
Domain 4 Surgical procedures			
Learning objectives			
4.1 Surgical complications Demonstrate a detailed knowledge of the surgical complications that are encountered in patients undergoing rehabilitation	<ul style="list-style-type: none"> Identify, describe, and explain the types of surgical complications that may arise from surgical interventions, particularly from orthopaedic procedures (joint replacements, fracture, soft tissues injuries); neurosurgical procedures; vascular procedures (especially in regard to upper or lower limb amputations); and cardiothoracic procedures Describe and discuss the rehabilitation responses associated with various surgical complications. 	2	Case-based discussions Research projects Mini-clinical evaluation exercises Examinations
Domain 5 Continuing medical education			
Learning objectives			

Rehabilitation Medicine Advanced Training Curriculum learning objectives	Knowledge, skills or competencies required to meet learning objectives (consistent with professional accountabilities)	Level/ weighting	Assessment activities (formative and summative)
5.1 Continuing professional development Demonstrating an understanding of the role and importance of CPD and the methods and resources available to acquire further knowledge and skills	<ul style="list-style-type: none"> Describe the AFRM's requirements for continuing medical education Explain current (legislative) requirements regarding the maintenance of professional standards Demonstrate the ability to complete a personal skills audit and analyse personal learning needs Demonstrate the ability to write and review a personal, professional development plan Identify various sources of professional training, including using information technology. 	1	Case-based discussions Research projects Essays and reports
5.2 Clinical research Demonstrate an understanding of the principles of clinical research (research methodology design), the ability to undertake research projects (data collection and interpretation), and present research findings (preparation and delivery of research reports and research findings)	<ul style="list-style-type: none"> Describe and discuss the principles of research design and conduct including hypothesis development, research design methodology, data collection methods and instruments, data analysis methods, and how to report, present, and deliver research findings Explain and identify key legal and ethical issues associated with clinical research projects Plan and write a clinical research proposal within the context of rehabilitation medicine. 	1	Research projects Essays and report External training module in clinical research Examinations

12. Conclusion – Key Recommendations to Address Identified issues

In response to each of the factors identified in the SWOT analysis, a series of actions was identified with the purpose of reinforcing and capitalising on the positive internal and external factors, and addressing the negative factors both in the short term and in the medium to long term. A summary of these recommendations is presented below.

Recommendations:

1. Develop a vision for rehabilitation medicine in Australasia

So that our specialty can move forward with cohesion, it is critical that a conversation be opened regarding the future role and direction of our specialty. The Horizons document will be extremely valuable in directing this conversation, along with clarification of the current workforce patterns of our specialty.

In response to this open conversation, we must develop a clear vision of the future of rehabilitation medicine in Australasia through facilitated internal discussion and debate. This will direct and inform future decision-making regarding the educational requirements of our training program.

One of two broad directions is likely:

1. Status quo will be maintained within our specialty with a key focus on the management of disability, deferring management of acute medical/surgical issues to those more suitably qualified.
2. Our specialty will evolve to additionally managing acute and medical issues within our patients.

Which of these two broad approaches is decided upon will determine whether some of the other recommendations are adopted.

2. Update scope of practice for adult rehabilitation medicine in Australasia

In response to a clear vision for the specialty of rehabilitation medicine, a clearly defined scope of practice for our specialty will be a natural consequence.

The scope of practice will inform required personal qualities, skills and knowledge required for the Rehabilitation Physician of the future. This scope of practice will also implicate the purpose and content of the future training program. If the trend for more acute medical management is accepted, then substantial change will be expected in the existing scope of practice and the training of specialists in rehabilitation medicine.

3. Perform a gap analysis between current training program and the requirements for the Rehabilitation Physician of the future

Based on the vision for rehabilitation medicine in Australasia and the scope of practice and requirements for training, the existing training program should be evaluated with regards to its fitness for purpose.

Depending on the vision for the future of rehabilitation medicine, this will open serious discussion regarding the very structure of the rehabilitation training program with the possibility of transitioning to the FRACP option.

Independent of the decision regarding the overall structure of training, there are a number of recommendations stemming from the analysis of the training program which underpins this report which must be considered

4. Review entry to training criteria

Independent of the potential need to modify the structure of the training program, a serious consideration of the entry to training requirement for rehabilitation medicine is required. Many of the concerns identified regarding the training program will be mitigated by addressing the entry to training criteria for the rehabilitation medicine training program

Fundamentally, greater clarity is needed to define the characteristics of a trainee suitable for a career in rehabilitation medicine, including personal qualities, commitment to the specialty and baseline knowledge and skills as detailed in the previous chapters.

This will also incorporate examination of the purpose, timing, content and structure of Modules 1 and 2 (assessments completed during the first two years of training).

Depending on the global direction of the specialty as defined by the membership, review of entry to training options will also include the option of changing the training program's structure to the FRACP option. Consideration of this option must include a review of whether such a change would provide trainees with those characteristics making them suitable for a career in rehabilitation medicine and whether the future rehabilitation workforce would be guaranteed.

5. Curriculum review and update

Independent from the potential move to the FRACP option, there is certainly be a need to review the existing curriculum; to include additional content; to review the structure and weighting of content, and to consider moving some content from core to non-core.

If the move to the FRACP option is accepted by the membership, the increased foundational knowledge and skills in internal medicine would be outsourced to the basic training. Approximately one quarter of the content of the current clinical curriculum is duplicated in the BTC and could be removed from the existing Rehabilitation Medicine Advanced Training Curriculum. In this case, the existing curriculum would still require updating.

6. Review teaching and learning components of Advanced Training in rehabilitation medicine

A review of the curriculum would naturally be coupled with a strategic review of the existing teaching and learning program to ensure that trainees have consistent and equitable opportunities to address the curriculum. This includes allocating adequate resources for a bi-national approach to teaching and learning, including appraisal and enhancement of existing teaching programs and the development of innovative approaches to new teaching and learning.

7. Improve the breadth and oversight of clinical experience in the rehabilitation medicine training program

Mechanisms are currently inadequate to ensure that trainees develop the breadth of clinical experience necessary to address key curriculum areas. Approaches such as reviewing term allocation process, introduction of logbooks/portfolios and developing innovative approaches to allow for a greater variety of clinical exposure would provide a more rounded training experience.

8. Review issues identified with some specific training program elements

Specific comments are made regarding the utility of some aspects of training program elements to ensure that they continue to provide meaningful value to the trainees in achieving the stated goals. This includes a review of the density of training program contents within an increasingly crowded curriculum. Many of these recommendations are relatively minor and easy to implement.

9. Review rehabilitation medicine workforce requirements

A clear snapshot of the current rehabilitation medicine workforce across Australasia with the actual settings and mix of practice for the existing specialist workforce is an essential element in informing the strategic planning of the future Australasian rehabilitation medicine workforce.

While rehabilitation medicine trainee numbers are generally approaching adequacy, strategies to enhance awareness of rehabilitation medicine as a career will further strengthen competition for training places and will raise the calibre of trainees, particularly if the entry to training criteria are tightened. Strengthening future specialist numbers is especially critical in rural and regional areas.

If the FRACP option is pursued, the impact on trainee numbers and other workforce implications must be modelled. This is of particular importance for certain geographical areas where adequacy of the rehabilitation medicine workforce is already concerning.

10. Consider the option of changing structure of rehabilitation medicine training program

As detailed in the previous chapters, there are two broad options for reviewing the overall structure of the rehabilitation medicine training program:

1. **Joint training:** this program is currently available and is the model undertaken by trainees in paediatric rehabilitation medicine. Trainees undertake Basic Training, followed by two Advanced Training programs: rehabilitation medicine and another. The overall duration of Advanced Training is less than the total of the two Advanced Training programs combined as there is reciprocal recognition of time from both advanced training specialties. Moving to this model would align adult and paediatric rehabilitation medicine training programs. This would not require any change to the existing training program. Trainees would be exempted from doing Modules 1 and 2 (see Appendix).
2. **The FRACP option:** this option would require substantive and fundamental change to the existing training program and is highly controversial. Trainees would undertake Basic Training followed by Advanced Training in rehabilitation medicine. Details of these options are given in the previous chapters.