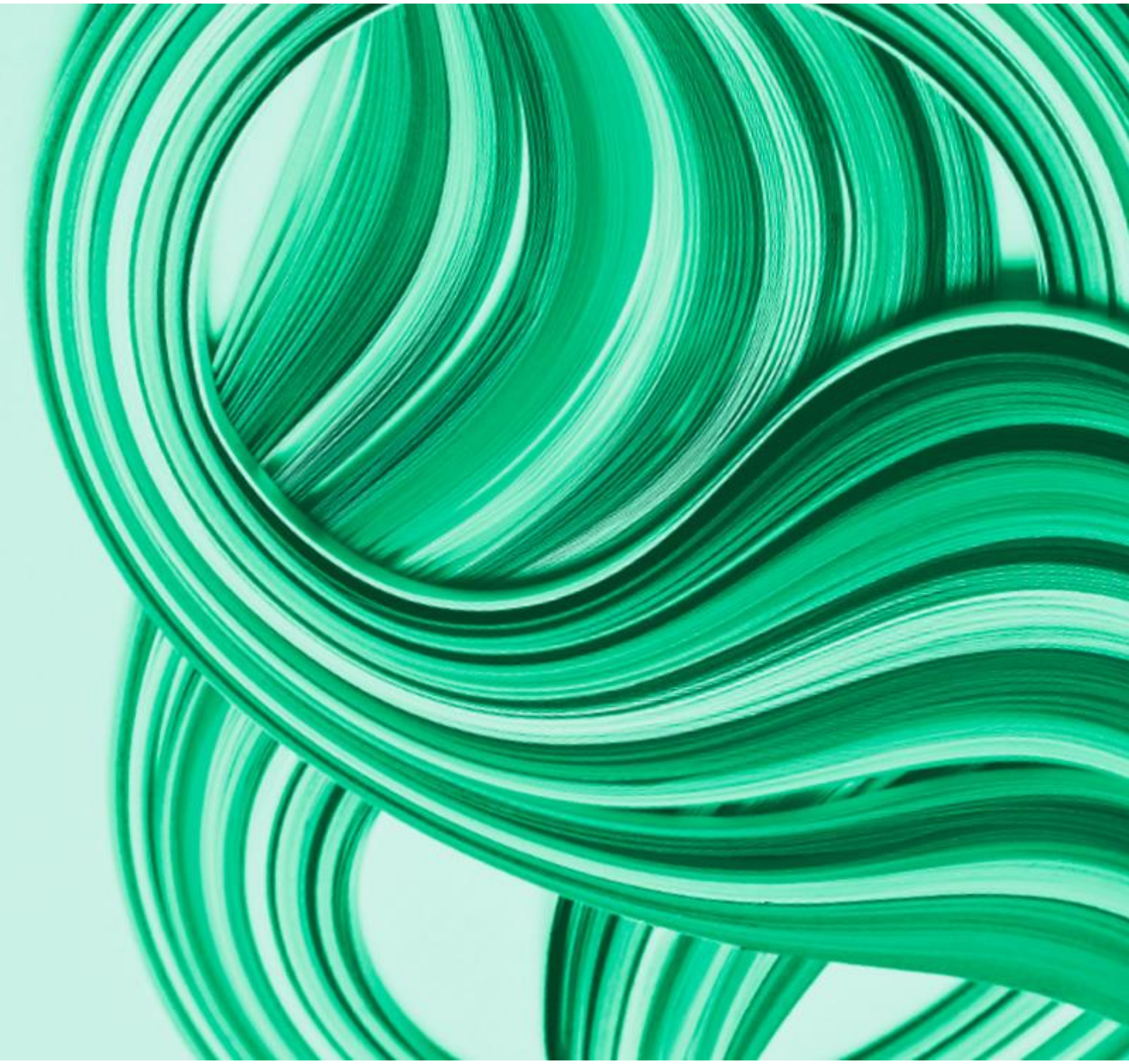
RACGP
Royal Australian College *of* General Practitioners

Practice Experience Program (PEP)

Assessor guide

Version 2022.1



racgp.org.au

Healthy Profession.
Healthy Australia

Practice Experience Program (PEP): Assessor guide. Version 2022.1

Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates.

Accordingly, The Royal Australian College of General Practitioners Ltd (RACGP) and its employees and agents shall have no liability (including without limitation liability by reason of negligence) to any users of the information contained in this publication for any loss or damage (consequential or otherwise), cost or expense incurred or arising by reason of any person using or relying on the information contained in this publication and whether caused by reason of any error, negligent act, omission or misrepresentation in the information.

Recommended citation
The Royal Australian College of General Practitioners. Practice Experience Program (PEP): Version 2022.1. Assessor guide. East Melbourne, Vic: RACGP, 2022.

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade
East Melbourne, Victoria 3002

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au

ABN: 34 000 223 807

ISBN: 978-0-86906-513-6

Published November 2018; updated March 2019, March 2020, October 2020, March 2021, January 2022

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

ID-2445

Contents

Introduction to the Practice Experience Program

The Royal Australian College of General Practitioners' (RACGP's) Practice Experience Program (PEP) is a self-directed education program designed to support non–vocationally registered (non-VR) doctors on their journey to Fellowship of the RACGP (FRACGP). The non-VR Fellowship Support Program (FSP) is funded under the Australian Government's (Department of Health) Stronger Rural Health Strategy for doctors based in Modified Monash Model (MMM) areas 2–7. The PEP aims to provide targeted educational support for non-VR doctors to support their learning and provide feedback on their progress towards achieving FRACGP.

The PEP consists of two streams. The PEP Standard Stream (PEP ST) provides educational support for non-VR doctors to help them prepare for FRACGP. Overseas-trained doctors who hold a specialist qualification that is deemed to be not comparable can attain Fellowship through the PEP ST. The PEP Specialist Stream (PEP SP) provides educational support for overseas-trained doctors with a specialist qualification transitioning to Australian general practice and working towards FRACGP.

The PEP is a self-directed education program. Participants work in general practice while undertaking the PEP and have varying levels of clinical supervision, and in some instances no clinical supervision. While on the PEP, participants are provided access to online learning resources and learning units. There is a clearly outlined program of workplace-based assessment (WBA) that is a requirement for all participants, although there are some key differences in each PEP stream. There is an emphasis on assessment for learning and actionable feedback. Each assessment provides data about the participant's progress and multiple data points can be used to make decisions. The assessment point and decision point are uncoupled, so no assessor individually determines progression.

The PEP is delivered in partnership with training organisations.

The role of the assessor

The role of the PEP assessor is to undertake any of the assessments that are integral to the program. The assessments are grounded in the general practice workplace and are focused on essential skills that enable the general practitioner (GP) to deal competently with problems in the domain of general practice. The competent GP has the potential to use a host of skills for any problem, but selects skills specific to the needs of the problem at hand. This means that there are various skills sets that need to be developed for the various tasks, from direct observation in a practice through to rating a written reflective task. Additionally, since the aim of the assessments is to provide clear, actionable feedback, the assessor needs to be skilled in engaging in a dialogue with participants about what was observed, or providing clear and meaningful written feedback.

The WBA competencies, criteria and performance lists

The curriculum provides a competency framework based on what are considered to be the essential qualities of an Australian GP. The WBA competencies have been developed to enable assessment in the workplace. Criteria describe the outcome expected with performance lists developed across a progression towards the standard expected at FRACGP. Competencies are behavioural descriptors and need a strong link to clinical practice to allow a medical educator (ME) to observe and use them in assessing a trainee's performance and providing feedback. The WBA criteria and performance lists can serve as this link. Within the PEP, the WBA provides feedback to inform the participant's education program, as opposed to formative assessment per se.

The RACGP curriculum describes five domains of general practice within which there are 13 high-level core skills. This is further subdivided into numerous competency outcomes. Each core skill is a statement of the end point that indicates the achievement of competence in a key area of general practice. The core skills describe the 'what' of being a GP.

For assessment purposes, the WBA competencies have been described and mapped to the core skills. This arrangement allows for a synthesis of competency outcomes across the domains. The WBA competencies span the five domains of general practice, with some incorporating a number of competency outcomes and others focused on a more discrete area. Each competency has a specific focus describing not only the clinical consultation but also areas of professionalism, general practice systems and other areas not commonly assessed. There is also a focus on clinical reasoning and specific WBA competencies described to facilitate assessment and

feedback on this important skill.

Within each WBA competency there are a number of criteria, describing the performance expected at the level of early Fellowship. That level is the point at which the doctor is ready to demonstrate competence for unsupervised practice in Australia and is calibrated against the 'Competency profile of the Australian GP at the point of Fellowship'. The performance lists provide a description of the performance that is expected as a trainee progresses through training, and frame the competencies in the context of clinical practice. The performance lists are not linked to a stage of training, which is aligned with the concept that competencies develop at different rates.

There are many ways in which a participant could demonstrate that they have achieved the outcomes, and performance lists are provided to guide assessors and provide narrative anchors for rating performance and providing feedback.

The criteria and performance lists are used to develop the rubrics for the clinical assessments, with each assessment tool focusing on different areas in different ways.

The standard expected is set at the point of Fellowship for all assessments. The decision to be made in any assessment is binary – at the standard or not. Being at the standard expected would mean that the doctor is ready for unsupervised general practice in Australia.

The description for each of WBA competencies is as follows.

Communication and consultation skills

CS1.1 GPs communicate effectively and appropriately to provide quality care.

CS1.2 Through effective health education, GPs promote health and wellbeing to empower patients.

CS2.1 GPs provide the primary contact for holistic and patient-centred care.

This competency focuses on communication with patients, and the use of appropriate general practice consultation techniques. Communication skills enable the consultation to proceed, and the demonstration of specific communication skills, especially in difficult consultations, is a requirement. Communication and the consultation are patient-centred and the doctor engages the patient to understand their ideas, concerns and expectations. The development of respectful therapeutic relationships involves empathy and sensitivity, with the doctor trying to see things from the perspective of the patient. Explanations provided to the patient about the diagnosis or management are appropriate to the patient, their health literacy and their health beliefs. The doctor checks for understanding and agreement at various times during the consultation.

Criteria

Communication

- Uses communication appropriate to the person and the sociocultural context
- Engages the patient to gather information about their symptoms, ideas, concerns and expectations of healthcare and the full impact of their illness experience on their lives
- Matches modality of communication to patient needs, health literacy and context
- Communicates effectively in routine and difficult situations
- Demonstrates active listening skills
- Uses a variety of communication techniques and materials (eg written or electronic) to adapt explanations to the needs of the patient
- Uses appropriate strategies to motivate and assist patients in maintaining health behaviours

Consultation skills

- Adapts the consultation to facilitate optimal patient care
- Consults effectively in a focused manner within the timeframe of a normal consultation
- Prioritises problems, attending to both the patient's and the doctor's agenda

Clinical information gathering and interpretation

CS2.2 GPs diagnose and manage the full range of health conditions in a diverse range of patients, across the lifespan through a therapeutic relationship.

CS2.3 GPs are informed and innovative.

This competency is about the gathering, interpretation and use of data information for clinical judgement. This includes information gathered from the history, clinical records, physical examination and investigations. History-taking includes gathering information from other sources such as family members and carers, where appropriate. Information gathering should be hypothesis-driven and used to confirm or exclude likely diagnoses as well as red flags. The physical examination, and the selection of appropriate and evidence-based investigations, are incorporated into this assessment area. This should be appropriate to the patient and presentation and be evidence-based.

Criteria

History

- Takes a comprehensive biopsychosocial history from the patient
- Considers all available sources of information when taking a history

Physical examination

- Undertakes an appropriate and respectful physical examination, targeted at the patient's presentation and likely differential diagnoses
- Detects physical examination findings accurately and interprets them correctly
- Elicits specific positive and negative findings

Investigations

- Chooses rational options for investigations using an evidence-based approach
- Interprets investigations in the context of the patient's presentation

Making a diagnosis, decision making and reasoning

C2.2 GPs diagnose and manage the full range of health conditions in a diverse range of patients, across the lifespan through a therapeutic relationship.

This is about a conscious, structured approach to making diagnoses and decision making. The focus is on the content and includes all the steps leading up to formulating a diagnosis or problem list. This also includes diagnostic accuracy that does not necessarily require the correct diagnosis, but that the direction of reasoning was appropriate and accurate. The doctor's ability to think about and reflect on their reasoning is another aspect of this assessment domain. This WBA competency is closely aligned with information gathering but can be assessed in different ways.

Criteria

- Integrates and synthesises knowledge to make decisions in complex clinical situations
- Modifies differential diagnoses based on clinical course and other data as appropriate
- Demonstrates diagnostic accuracy: this does not require the correct diagnosis, but that the direction of reasoning was appropriate and accurate
- Collects/reports clinical information in a hypothesis driven manner
- Articulates an appropriate problem definition
- Formulates a rational list of differential diagnoses including most likely, less likely, unlikely and can't miss diagnoses
- Directs evaluation and treatment towards high priority diagnoses
- Demonstrates metacognition (thinking about own thinking)

Clinical management and therapeutic reasoning

CS 2.1 GPs provide the primary contact for holistic and patient-centred care.

CS2.2 GPs diagnose and manage the full range of health conditions in a diverse range of patients across the lifespan through a therapeutic relationship.

CS2.3 GPs are informed and innovative.

CS2.4 GPs collaborate and coordinate care.

CS1.2 Through effective health education, GPs promote health and wellbeing to empower patients.

This competency concerns the management of common, serious, urgent and chronic medical conditions encountered in general practice. Aspects of care beyond managing simple consultations, including management of comorbidity and uncertainty, are incorporated. The management plan is patient-centred at all times. Therapeutic reasoning includes the steps taken based on the problem list or likely diagnosis that has been developed and is a part of the clinical reasoning process.

Criteria

- Demonstrates knowledge of common therapeutic agents, uses, dosages, adverse effects and potential drug interactions and ability to prescribe safely
- Undertakes rational prescribing
- Monitors for medication side effects and risks of polypharmacy
- Outlines and justifies the therapeutic options selected, basing this on the patient's needs and the problem list identified
- Safely prescribes restricted medications using appropriate permits
- Offers and discusses non-pharmacological therapies
- Develops a patient-centred and comprehensive management plan
- Provides effective explanations, education and choices to the patient

Partnering with the patient, family and community to improve health through disease prevention and health promotion

CS 3.1 GPs make rational decisions based on the current and future healthcare needs of the community and the Australian healthcare system.

CS3.2 GPs effectively lead to address the unique health needs of the community.

CS1.2 GPs use effective health education to promote health and wellbeing to empower patients.

This competency is about the provision of general practice care and service that supports an economically rational and effective use of the healthcare system. Issues related to public health are identified and managed. The determinants of health and disease are identified both on the individual and community level. Disease prevention and health promotion activities are included here.

Criteria

- Implements screening and prevention strategies to improve outcomes for individuals at risk of common causes of morbidity and mortality
- Uses planned and opportunistic approaches to provide screening, preventive care and health promotion activities
- Coordinates a team-based approach
- Demonstrates understanding of available services in the local community
- Appropriately manages current and emerging public health risks
- Educates patients and families in disease management and health promotion skills
- Identifies opportunities to effect positive change through health education and promotion

- Uses appropriate strategies to motivate and assist patients in maintaining health behaviours

Professionalism

C.S 4.1 GPs are ethical and professional.

CS4.2 GPs are self-aware.

Professional knowledge, behaviour and attitudes

This requires knowledge of ethical principles, as well as duty of care and maintaining appropriate therapeutic boundaries. The ability to appropriately review potential and actual critical incidents to manage consequences and reduce future risk is an important consideration in this domain. The response to scrutiny of own professional behaviour, and being open to feedback and demonstrating a willingness to change is included.

Criteria

- Encourages scrutiny of professional behaviour, is open to feedback and demonstrates a willingness to change
- Exhibits high standards of moral and ethical behaviour towards patients, families and colleagues, including an awareness of appropriate doctor/patient boundaries
- Appropriately manages ethical dilemmas that arise
- Identifies and manages clinical situations where there are obstacles to provision of duty of care
- Implements strategies to review potential and actual critical incidents to manage consequences and reduce future risk

Learning and professional development

Being able to respond appropriately to feedback as an educational dialogue and demonstrating the ability to reflect on performance and identifying personal learning needs are important components of this competency. Using critical appraisal skills, actively participating in clinical audits and demonstrating a commitment to ongoing professional development all form part of this domain of assessment.

Criteria

- Judges the weight of evidence, using critical appraisal skills and an understanding of basic statistical terms, to inform decision making
- Shows a commitment to professional development through reflection on performance and the identification of personal learning needs
- Attends and participates in all learning and assessment activities of an educational program
- Actively engages in feedback as a dialogue, discussing performance and setting own goals for professional development
- Participates in audits and quality improvement activities and uses these to evaluate and suggest improvements in personal and practice performance.

General practice systems and regulatory requirements

CS5.1 GPs use quality and effective practice management processes and systems to optimise safety.

CS3.2 GPs effectively lead to address the unique health needs of the community.

CS 5.2 GPs work within statutory and regulatory requirements and guidelines.

This competency is about understanding general practice systems, including appropriate use of administration and IT systems, the importance of effective record keeping, clinical handover and recall systems. It also requires an understanding of how primary care is organised in Australia, and the statutory and regulatory requirements and guidelines that are in place. Written communication skills can be assessed in this domain when referral letters and clinical notes are reviewed. Patient consent and maintaining confidentiality are also incorporated into this domain.

Criteria

- Appropriately uses the computer/IT systems to improve patient care in the consultation
- Maintains comprehensive and accurate clinical notes
- Written communication is clear, unambiguous and appropriate to the task
- Demonstrates efficient use of recall systems to optimise health outcomes
- Accurately completes legal documentation appropriate to the situation
- Implements best practice guidelines for infection control measures
- Manages patient confidentiality appropriately
- Explains and obtains informed consent

Procedural skills

CS2.2.5 Appropriate procedures are undertaken after receiving informed consent.

Appropriate procedures are those which are likely to be most beneficial to the individual's health and wellbeing from a diagnostic and/or management perspective. Assessment of the appropriate nature of procedures is inherently related to the practice setting, individual sociocultural context and consequent availability of access to more specialised services. Recommendations for procedures should consider the potential benefits, considering the evidence basis and the possible risks and costs in the context of any relevant sociocultural beliefs of the individual. The individual doctor should be able to demonstrate a range of procedures appropriate for general practice. Consideration is given to the skills that need to be developed, with specific consideration of the local community or practice population needs.

Criteria

- Demonstrates a wide range of procedural skills to a high standard and as appropriate to the community requirements
- Refers appropriately when a procedure is outside their level of competence

Managing uncertainty

CS2.2.10 The uncertainty of ongoing undifferentiated conditions is managed.

Ongoing undifferentiated conditions can cause considerable anxiety for patients, their families and the GP. There is a need for a structured, evidence-based approach to minimise risk from health and economic perspectives. Undifferentiated conditions are often associated with uncertainty and ambiguity, and present management challenges for the clinician. Clinical decision making around choices of investigations need to be rational and balance the potential risks of both over- and under-investigating and management, against the benefits in the context of the individual.

Criteria

- Manages the uncertainty of ongoing undifferentiated conditions
- Uses time as a diagnostic tool
- Addresses problems that present early and/or in an undifferentiated way by integrating all the available information to help general differential diagnoses
- Recognises when to act and when to defer doing so and uses time as a diagnostic tool
- Has confidence in and takes ownership of own decisions while being aware of own limitations

Mapping the assessment

The PEP WBA competencies are mapped to the curriculum core skills to ensure that most of these can be assessed. An additional map of the nine WBA outcomes and the various assessment options (Appendix A) has been developed to ensure that:

- every outcome is addressed
- outcomes are combined where possible
- every outcome is assessed in more than one way
- a variety of assessment tasks are used.

Refer to Appendix A. Map of assessment tasks and other types of evidence.

Developing the rubrics

Every assessment task has a different focus, and rubrics for each clinical assessment have been developed. These scoring guides are used to evaluate the participant's performance and serve to ensure standardisation across assessors. The criteria and performance list are outlined in a rubric for each of the assessments and these are available for MEs and participants online. It is expected that the assessor regularly refer to the rubric when rating an assessment and also when providing feedback. Written feedback can be easily linked to the criteria and performance lists, with the narrative anchors within these readily available to describe why a specific rating has been selected.

An overview of the assessments

In the PEP, evidence of a participant's competence can be gathered in a range of ways, including through clinical assessments, logbooks, multisource feedback (MSF) and supervisor reports. Clinical audits are valuable for providing evidence of reflective practice and quality improvement, as are critical incident reviews, but these are not currently included in the WBA program.

Table 1 provides a summary.

Table 1. Summary of the PEP assessments

What	Aims and evidence requirements	Brief description	Stream requirements
Clinical case analysis (CCA) Use patient cases either randomly selected or in the form of case studies from a written template. The CCA can be undertaken during a practice visit, via videoconference or during small group activities.	**Aim** To assess the participant's clinical decision making, management and therapeutic reasoning. Interpersonal communication, and elements of practice organisation and systems can also be assessed. **Evidence requirements** Provide evidence of competence in the following WBA competencies: • clinical information gathering and interpretation • making a diagnosis, decision making and reasoning	**Case-based discussion (CBD)*** Undertaken as part of a clinical assessment, via telephone or during small group learning session. Cases are submitted to the assessor prior to the assessment. The assessor selects the cases for discussion. The participant can be guided to provide cases on specific topics (eg ranging from chronic care to different phases of life). They should also be guided on providing cases that best demonstrate self-reflection and not those that highlight diagnoses of rare conditions.	**PEP ST** CBD or RCA as decided by the training organisation. Analysis and discussion of a minimum of two cases per six-month term.* **PEP SP** The participant is required to satisfactorily complete at least three clinical case analyses during the six-month term.

	• clinical management and therapeutic reasoning • partnering with the patient • general practice systems and regulatory requirements.	**Random case analysis (RCA)*** Undertaken as part of a clinical assessment visit, this can only take place within the general practice setting. The assessor selects random cases from the most recent consultations.	These can be either RCAs, CBDs, or a combination of both. Analysis and discussion of a minimum of three cases per six-month term.
Direct observation of consultations Each participant requires at least one direct observation of consultations in their workplace. Video-streaming of consultations or simulated patients could be suitable if practice visits are not feasible. Video-recorded consultations are also acceptable, provided that this is compliant with relevant state or territory legislation. If none of these options are feasible, consideration can be given to role-play/simulated consultations.	**Aim** To assess performance criteria best evaluated by direct observation. **Evidence requirements** Provide evidence of competence in the following WBA competencies: • communication and consultation skills • clinical information gathering and interpretation • making a diagnosis, decision making and reasoning • clinical management and therapeutic reasoning • partnering with the patient • general practice systems and regulatory requirements.	**Mini-Clinical Evaluation Exercise (Mini-CEX)†** The Mini-CEX is a WBA modality that assesses the participant's clinical skills and performance through direct observation in the clinical setting. Feedback on performance is provided immediately and also in written format on the rating form.	**Both** Direct observation of a minimum of four patients per six-month term.*

Important note for the PEP SP (substantially comparable) participants: A global assessment of competence will be rated once the additional requirement of four Mini-CEX and four submitted and two assessed CBDs or three RCAs undertaken as a clinical assessment visit have been fulfilled.

*Commencing January 2021, PEP ST participants will require an additional six work-based assessments in lieu of the removal of mandatory assessment of learning units. These additional assessments can be comprised of any combination of Mini-CEX and/or CBD, as agreed upon by the participant and training organisation (eg an additional four Mini-CEX and two CBDs).

What	Aims and evidence requirements	Brief description	Stream requirements
Multisource feedback (MSF) This requires submission of: • completed MSF report covering the colleague and patient components • completed reflective exercise • evidence of discussion with assessor medical educator (ME).	**Colleague assessment** **Aim** Evaluation of performance by recent or current colleagues in areas of communication, interpersonal skills, professional attributes and clinical competence. This evaluation requires assessment by several sources with an appropriate sample size and should include the participant's self-assessment and subsequent reflection on the variances between scores. **Evidence requirements** Evidence is required of colleagues' evaluations of professional behaviour, interpersonal communication skills and clinical performance, as well as of the participant's self-reflection. Although colleagues should have worked with or observed the trainee at work, direct observation is not necessary. Provide evidence of WBA competencies: • communication and consultation skill • professionalism.	**Colleague Feedback Evaluation Tool (CFET)†** Undertaken for 360-degree feedback from 15 colleagues nominated by the participant. Covers a broad spectrum of medical, clinical and administrative staff.	**Both streams** Completed MSF report covering the colleague and patient components. Completed reflective exercise. Evidence of discussion with an ME. Completed once only.
	Patient assessment **Aim** To provide patients' judgement of the participant's communication skills, including active listening, patient-centred approach and empathy. **Evidence requirements** Provide evidence of competence in the following WBA competencies: • communication and consultation skill • professionalism.	**Doctors' Interpersonal Skills Questionnaire (DISQ)†** Each questionnaire (to be filled out by patients) has 12 questions. Forty questionnaires per participant must be completed.	Completed once only.

Clinical examination and procedural skills logbook General practice procedures: • require knowledge and psychomotor skills • may or may not require the use of equipment • are invasive or non-invasive • are performed within the general practice setting. Complex surgical procedures that require a general anaesthetic are **not** included.	**Aim** To encourage the development of general practice procedural skills through maintaining a logbook. A component of this logbook is reflecting on self-identified learning needs. The range of procedural skills that are logged, and any proposed professional development in this area, should take into consideration the community requirements. **Evidence requirements** Provide evidence of competence in the assessment domain of procedural skills.	**Clinical examination and procedural skills logbook** Regularly updated, including a reflection on procedural skills updates required based on community needs.	**PEP ST** Ongoing throughout program participation. Advised but not compulsory.
Learning planning Learning planning and evidence of action on feedback, self-reflection.	**Aim** To encourage the development of self-reflection skills, and actively seek and incorporate feedback. **Evidence requirements** Provide evidence of competence in the assessment domain of professionalism.	Evidence of learning unit completion and learning planning.	**PEP ST** Ongoing throughout program participation. Advised but not compulsory.
Supervisor report‡	**Aim** To triangulate assessments and provide supportive data regarding the participant's clinical competence.	Work performance report for international medical graduates or other supervisor report required by the Australian Health Practitioner Regulation Agency (AHPRA).	**PEP SP** Required. **PEP ST** Optional.
Learning unit assessment tasks	**Aim** To make the link between the acquisition of knowledge from online learning to application in the individual's context and to encourage the development of self-reflection to guide learning.	PEP ST participants have access to all learning units. All learning units are accredited for CPD. A reflective activity for PEP SP.	**PEP ST** Engagement in self-directed education for PEP ST will be evidenced by attaining at least 40 CPD points (or equivalent) per year. Optional process. **PEP SP** Once only, submitted after completion of the learning units.

*Templates and forms are provided by the RACGP (accessible via the PEP online portal).

†The MSF can be provided through the Colleague Feedback Evaluation Tool (CFET) or DISQ survey, or by using a training organisation tool currently in use and tested within Australian General Practice Training.

‡PEP ST supervisor reports are optional and only if available – provided by the participant and uploaded to their records. PEP SP supervisor reports are required.

Learning units

In PEP SP, there are several core units that are completed by all participants. In general, these map to the core skills of the RACGP curriculum. In PEP ST, a suite of learning units is available to all participants that map to the contextual units of the curriculum. Within each unit, there are online and in-practice activities to complete, followed by reflections about learning. The aim is to make the link between the acquisition of knowledge from online learning to application in the individual's context and to encourage the development of self-reflection to guide learning. Self-directed learning is evidenced by attainment of continuing professional development (CPD) points. In PEP SP, an overall reflective essay is assessed. PEP SP participants should be strongly encouraged to complete the core units, especially if they are unfamiliar with working in general practice in Australia.

Learning units may be suggested to address knowledge and clinical practice gaps for participants.

Learning unit assessment for PEP SP

The learning unit assessment for PEP SP consists of a single reflective essay. Participants are asked to reflect on their learning and in-practice experience with specific reference to:

- a comparison between previous experience in general practice and the Australian context
- the challenges in their current practice and how to manage them
- key points from the learning units and areas for future learning.

The assessment is made of the completion and quality of the reflection and the ability to provide a meaningful reflection about present and future learning (WBA competency 6 – Professionalism). The feedback comments can refer to:

- the quality of the writing and the comprehensiveness of the responses
- the level of detail, quality of the comparison and ability to reflect on how past general practice experience can be applied to current practice.
- the ability to reflect about current practice and identify supports – the assessor may suggest supports or future learning activities
- the quality of the reflection about learning and whether it demonstrates the ability to translate what has been learned into practice
- an ability to reflect on strengths and weaknesses and whether future learning needs target them appropriately
- any further resources or learning activities that the assessor can suggest that might assist with any future learning activities identified.

Written feedback and report writing

When writing a report, consider the purpose of the report, who will see the report and how it will be used. The assessment task reports in PEP all include a judgement of performance given as a grade and written comments. A rubric is used to decide on the grade, and the written comments provide information about the reason for a specific grading and suggestions on how this might be improved (or maintained). This information is important for participants as well as others reading the report such as MEs or those making decisions about a participant's progress.

The principles of good verbal feedback also apply to writing. In some cases, the written comments may have been discussed with the participant (eg during a clinical visit) but for the learning unit assessments this is not the case and there may be no opportunity to have a conversation about the feedback. Therefore, as well as thinking about the content of the report, it is also important to consider the tone and how the report is written.

A repeat of the criteria in the marking rubric is not as helpful as specific comments; reasons for assessment decisions are best justified with concrete examples. Balance the content by including things done well and those that need improvement and advice, or further suggestions.

The 'tone' relates to how the report will be interpreted by the reader. Personalise the report by addressing the participant directly; this is more supportive than writing in the third person. Writing should be professional, especially if it includes some assessment of the written skills of the participant.

The clinical assessments – Mini-CEX and clinical case analysis

Direct observation of performance: The Mini-CEX

The Mini-CEX is a WBA modality that assesses the participant's clinical skills and performance through direct observation. The participant's skills in communication, consultation, information gathering, management and overall clinical care can all be assessed. In contrast to CCA, the Mini-CEX involves direct observation of participants in the clinical setting. The Mini-CEX provides an authentic measure of actual clinical performance and assesses at the highest level of Miller's pyramid of competence.

The Mini-CEX is also a powerful learning tool because it offers participants an opportunity to reflect on their practice and receive feedback from the assessor immediately after a clinical encounter.

Each Mini-CEX should be considered as a formative assessment as it provides the opportunity for observation, feedback and learning. Information derived from all Mini-CEX can be used to gauge progression towards the standard expected for unsupervised general practice.

Ideally, the Mini-CEX should be undertaken face to face in the participant's clinical practice or in other suitable clinical contexts. Where appropriate or necessary, some Mini-CEX may be conducted using technology such as video, Skype or recorded consultations. Simulated patients could be used in some instances.

It is suggested that, at a minimum, four consultations are observed and assessed each six-month term. The clinical consultations observed should ideally cover presentations of a range of clinical problems, age groups and gender, and where possible be assessed by a number of different assessors to improve reliability. The objective of each evaluation exercise can be varied depending on the participant's self-identified areas of focus and feedback from previous assessments.

Rating and assessment

The Mini-CEX is best used to measure performance in the following WBA competencies:

- communication and consultation skills
- clinical information gathering and interpretation
- clinical management and therapeutic reasoning
- partnering with the patient, family and community to improve health through disease prevention and health promotion
- general practice systems and regulatory requirements.

The Mini-CEX rating form can be found on the PEP online portal.

Information for assessors

The time required for the Mini-CEX will depend on the complexity of the case, but generally it should take up to 20 minutes to observe the interaction between the participant and patient and a further 10 minutes to discuss various aspects of the case and provide feedback. Patient consent should be obtained before the consultation starts. The assessor observes the consultation without interruption or prompting. At the end of each Mini-CEX, the assessor scores the consultation using the RACGP Mini-CEX form. The Mini-CEX rubric is used to guide and standardise the rating, and the narrative from the performance lists can be used to provide written feedback.

Each Mini-CEX focuses on specific aspects of the clinical encounter. The area of focus should, ideally, be discussed and agreed upon with the participant. Consideration should be given to any previous assessments and identified areas of focus of the learning plan. Assessors rate communication, history taking, management and overall clinical competence for all encounters. Any of these or the remaining WBA competencies can be the agreed focus of the consultation. The assessor can ask to review any written material related to the case, such as reviewing a referral or prescriptions. They can ask probing questions about anything deemed relevant to the clinical encounter.

The emphasis in the assessment is not on giving a grade but on making an observation of the candidate's performance.

Steps

1. Agree with the participant on the focus of the evaluation exercise.
2. Make sure that the patient has consented using 'Patient consent form – Observation of consultation by a medical educator'.
3. Observe a consultation without interruption.
4. Use the rating form to guide the observation. Fill out the form during the consultation.
5. Consider how the participant has performed in each of the areas and how they are progressing towards the expected standard.
6. Encourage the participant to reflect on their own performance before discussing observations.
7. Provide feedback on the performance and agree on any action items.
8. The participant updates their learning plan based on agreed learning outcomes.
9. Complete and submit the rating form on the PEP portal.

CCA – Using random case analysis (RCA) and case-based discussion (CBD)

CCA is a form of chart-stimulated recall, using a documented clinical encounter as a stimulus for questioning. It is a hybrid assessment format that combines clinical note or case report review with oral questioning. Using the participant's own patients situates the assessment within a realistic context, adding to the authenticity and value of the exercise. Probing questions are used to assess clinical decision making and the ability to reflect on and explain the rationale for decisions. CCA can be conducted in the participant's workplace using recent patient notes as a stimulus or it can be done remotely using submitted cases. The participant provides the case material either as submitted cases or as patient notes selected at random by the assessor from the appointment book.

It may be helpful to focus on certain aspects of the consultation. If prior assessments have highlighted areas where competency was not adequately demonstrated, it would be appropriate to spend more time assessing these areas. Alternatively, the case analysis may be guided by the participant's experience and learning plan.

Rating and assessment

CCA is best used to judge across the following WBA competencies:

- clinical information gathering and interpretation
- making a diagnosis, decision making and reasoning
- clinical management and therapeutic reasoning
- partnering with the patient
- professionalism
- general practice systems and regulatory requirements.

The CCA rating form can be found on the PEP online portal. Assessors are encouraged to use the notes for CCA as a guide for exploring the cases.

For the PEP, there are two options for CCA: RCA and CBD. For the PEP ST stream, the training organisation or the assessor selects the most appropriate method based on the local context, feasibility and assessment focus. For the PEP SP stream, participants can choose to complete three RCAs, CBDs, or a combination of both. A minimum of two (for PEP ST), and three (for PEP SP) clinical case assessments should be undertaken in any six-month term, with each assessment lasting up to 30 minutes.

Both CBD and RCA rely on the use of authentic clinical cases, reflective practice and effective feedback. Both are useful WBA tools for exploring and assessing the participant's clinical reasoning and decision-making skills.

CBD

CBD is conducted in the format of a structured discussion between a participant and skilled assessor about recent clinical cases that the participant has managed. The discussion can take place within the context of a practice visit, or via video or telephone. It may be undertaken either one-on-one or as part of a small group learning session or in any other context that can support or enable the assessment.

Cases are submitted to the assessor a week before the assessment using a standardised template. The assessor can request that a participant revise and improve a case if not at an acceptable standard. To improve content validity, the cases must cover a wide range of problems across the curriculum areas and contextual units. Cases selected should be sufficiently complex to allow robust discussion and include both acute and chronic care. Cases where clinical reasoning may be complicated by uncertainty, and/or where decision making requires consideration of multiple issues, would be considered appropriate choices for CBD.

Participants can be required to focus their case selection on specific areas such as chronic care, specific populations, gender or stages of life. The aim of the exercise is to demonstrate clinical reasoning and the ability to reflect on the case, so participants should be guided to select cases that best highlight these characteristics.

Information for assessors

A CBD involves a review of data recorded by a participant on a real patient they have recently managed. The clinical record serves as a trigger for discussion between the participant and the assessor, with a view to exploring the participant's clinical reasoning and decision-making skills in relation to that patient's clinical presentation in the setting of Australian general practice.

The assessor selects the appropriate case for discussion from the ones submitted by the participant. The case and the participant's reflection on their performance should be reviewed by the assessor, and appropriate questions for the participant prepared before the discussion. Using the prepared questions, the assessor should be able to explore the participant's clinical reasoning ability. Attention should be paid to situations where uncertainty or difficulty in decision making has arisen. It is recommended that the assessor document information elicited during the discussion, as this could be useful in making a judgement on the participant's level of performance against each competency area. The notes section of the case-based discussion form can be used for this purpose.

At the end of each case, the assessor needs to complete the RACGP CCA rating form. The observations and content should reflect the discussion, and assessors are discouraged from including significant critique in the rating form that has not already been discussed with the candidate. The assessor must complete sections for feedback and recommendations for further development. The CCA rubric is used to guide and standardise the rating.

After the session, the participant is encouraged to submit learning outcomes for each case in their learning plan.

The suggested time frame for each case of the CDB is 20 minutes for discussion, and 10 minutes for feedback and completion of the assessment form.

Steps

1. The participant submits three to four cases at least one week before the assessment using the case submission template.
2. The assessor selects two cases for discussion and develops discussion notes to guide the assessment.
3. The case is presented to the assessor.
4. The assessor asks questions to probe for understanding and clinical reasoning, using the discussion notes as a guide.
5. 'What if' questions are used to assess what the participant would do in more challenging or different circumstances. These can also be used if there is concern about authenticity of the case.
6. Comments are recorded in the notes and provide a guide for feedback and reflection.
7. The assessor provides feedback, and assessor and participant agree on opportunities for further development.
8. Complete and submit the CCA rating form.
9. The participant updates their learning plan based on agreed learning outcomes.

RCA

RCA is a specific form of case-based discussion where the case is selected at random by the assessor. The random nature of case selection in RCA means that this method may identify gaps in knowledge and skills that were perhaps avoided or not identified by the participant when self-selecting cases for CBD. The analysis is not just of the record but of the case, as it includes the participant's recall of the consultation. There is an exploration of the case to understand the participant's decisions and rate their performance.

RCA provides the opportunity to probe more complex, hypothetical situations generated from the original case through 'What if' questions (refer to 'Guide to framing questions for clinical case analysis, using the 'notes'').

The resultant unpredictable nature of the problems and questions generated aim to highlight areas for development in knowledge and skills that may have been previously unrecognised by the participant and the assessor. Proposing hypothetical scenarios is a core component of the RCA method, which can help uncover learning needs.

RCA can be impacted by poor-quality medical records. If records being reviewed are not of recent consultations, it may be difficult for the participant to recall the detail of the consultation and the clinical reasoning behind decisions made. Poor record quality can be rated in the 'Written communication' section of the RCA. A narrow scope of clinical practice will also impact on this assessment. The assessor should comment in the report on the limited scope of practice, with suggestions on ways in which to address the issue.

Information for assessors

Patient encounters are selected randomly for the RCA. Recent cases (patients seen by the participant over the past week) are preferred to ensure better recall of the case by the participant. Ideally, each session is conducted by a different assessor to ensure assessment is fair and reliable. At the end of each RCA, the assessor needs to complete the RACGP CCA rating form.

The suggested time frame per case for the RCA is 20 minutes for discussion, and 10 minutes for feedback and completion of the assessment form.

The aim of the RCA is to elicit and record sufficient information during the case analysis to make a judgement about the level of performance of the participant.

Steps

1. Ask the participant to open their practice appointment book to a session within the previous week.
2. The assessor randomly selects cases and reads the records.
3. If a record is relatively straightforward and does not appear to contain new learning opportunities, the assessor can progress to another record.
4. The assessor asks the participant about the case to uncover what the participant knew of the patient before the consultation and their recollection of the case selected.
5. The assessor allows the participant to summarise the case without interruptions. The participant may provide additional information that is not documented in the medical record.
6. The assessor elicits further background information about the case if required.
7. A number of questions appropriate to the case are explored, using the 'notes' as a generic guide.
8. The assessor employs 'What if' questions to pose alternative scenarios and explore the participant's strengths and uncertainties. They get the participant to formulate clinical management plans to solve future and hypothetical scenarios, as well as introduce other professional and legal considerations.
9. The assessor records brief details about each RCA into the rating form and provides comments.
10. Feedback is discussed with the participant.
11. Both assessor and participant plan future learning to address identified areas for development, document agreed actions and a time frame for follow-up.
12. The assessor completes and submits the CCA rating form.
13. The participant updates their learning plan based on agreed learning outcomes.

Guide to framing questions for CCA, using the 'notes'

Using the CCA notes before and during the assessment will help guide the analysis. The CCA form, with notes, serves as a guide for assessors to develop their own questions within each assessment area. The assessor refers to the notes while undertaking the assessment and records comments during the process. This provides the basis for feedback and reporting. The notes are used for both CBD and RCA, although in the RCA there is no opportunity to review the case before the assessment.

When reviewing cases and preparing notes, consider the following.

- Design questions that will explore the participant's professional judgement to see why they made the decisions they did.
- Questions should be open ended, unbiased and in simple language.
- Questions should relate to the patient being discussed.
- Questions should be aimed at eliciting evidence of competence, and the discussion should not shift into a test of knowledge.

The following are examples of structured questions that could be used to help explore different competencies.

- How did you arrive at the diagnosis?
- What specific features led you to the diagnosis of …?
- What aspects of the history did you consider important in making the diagnosis?
- What were the other conditions you considered? How did you rule them out?
- What other information would have been useful?
- What are the important issues raised in this case?
- What were the key features you looked for on examination?
- What were your reasons for ordering that investigation?
- Were there other investigations that you considered?
- How would the investigation change your management?
- What did you take into consideration when deciding treatment?
- What were the advantages and disadvantages of each treatment option available to you?
- What factors influenced your decision to prescribe this drug?
- What patient factors did you take into consideration in your decision making?

A key element of CCA is to pose a range of alternative scenarios using 'What if' questions, such as the following examples.

In regard to the doctor:

- What if you were running late?
- What if you were working in a rural setting?

In regard to the patient:

- What if the patient was older?
- What if the patient was unable to get the X-ray done because of difficulties getting to the radiology practice?
- What if the patient was pregnant?

In regard to the presentation:

- What if the backache was waking the patient up at night?
- What if the patient had a family history of prostate cancer?
- What if the patient had a fever?

In regard to the system:

- What if the abnormal result was missed?
- What if the employer requested details regarding the patient's illness?

WBA for PEP SP (substantially comparable) participants

PEP SP (substantially comparable) participants are not required to sit the three barrier RACGP exams. The aim of the WBA for this cohort is to substantiate the comparability finding by providing evidence that the specialist international medical graduate can be awarded FRACGP.

There are some differences in the WBA for this specific cohort. They are required to provide a reflective essay based on the compulsory learning units undertaken. This reflective piece is rated by an ME and forms part of the WBA. The Mini-CEX and CCA are focused on demonstrating competence at the point of Fellowship, and although feedback for self-reflection and continuous improvement is important, it has less emphasis for this cohort. To some extent the clinical assessment becomes more 'high stakes' and the assessor needs to be aware of this pressure point for both participant and assessor. That needs to be offset by the knowledge that the assessor does not make any final determination about awarding Fellowship, but rather provides their expert opinion based on the performance that they have observed.

The combination of at least four Mini-CEX and two CCAs or three RCAs forms the basis of the clinical assessment visit. At the completion of the visit a global assessment of competence is made. This represents an overall impression across all direct observation of patient consultations and clinical case analyses performed. Competent overall performance includes patient-centred communication and management; sound clinical and therapeutic reasoning; demonstrated ability to conduct an effective, integrated consultation; and an awareness of own limitations. Based on these assessments it reflects the doctor's readiness for competent, unsupervised general practice in Australia.

The global assessment is not used to make a final decision regarding the awarding of Fellowship but forms part of the evidence considered by the RACGP panel.

Rating performance and providing feedback

Expert judgement is indispensable in the assessment of performance in a clinical setting. Several factors can affect a rating, including cognitive biases, cognitive load and subject matter expertise.

A bias in this context is a systematic influence of a variable on a judgement that can lead to differences in judgements between people and account for rater variability. Biases are almost impossible to train away, but focusing on recognising, naming and managing biases can prevent them from unduly influencing the assessor's judgement.

Cognitive load refers to the volume and number of items being assessed. Narrowing the focus of an assessment onto key areas lessens the load.

It is acknowledged that assessors can be subjective when making assessments of performance, but that does not necessarily make the assessment poor. Using narratives as anchors to guide the rating and providing global, holistic judgement across the entire domain of competence all add value. Narrative comments from assessors can provide a reliable measurement of performance and are a far better signal regarding the participant than any numerical rating. This is partly because of the difficulty clinical assessors can have with converting an observation into a number.

Assessors are advised to use the narrative anchors provided in the rubrics to minimise subjectivity and assist them to clearly articulate their findings. Being explicit in terms of findings provides a solid foundation for providing feedback.

Feedback should not be a passive process, such as where an assessor tells a participant what they did well and what they can build on. People often make reference to 'giving feedback', which implies that the behaviours are owned by the observer rather than the performer, and this can interfere with the process of identifying problems and plans for their resolution. Feedback is most effective when a discussion takes place around performance, resulting in plans and actions to change behaviour generated by the participant. Providing only a positive or negative critique to the participant does not ensure it is understood, processed and will effect a change in practice.

As a guide, participants should be talking more than the assessor during feedback time. To be ready for unsupervised general practice in Australia, participants should have developed skills in critical self-reflection and practice modification based on this self-reflection. The assessor can therefore be considered a touchstone or

alternative lens for the participant to observe their own behaviour, to facilitate reinforcement or change to practice behaviours.

For guidance on making the best use of feedback for participant learning, and on helping the participant reflect on their performance, assessors are advised to review the following article:

Sandars J. The use of reflection in medical education: AMEE Guide No.44. Med Teach 2009;31(8):685–96. Available at https://pdfs.semanticscholar.org/d3fb/a60f30b83024c2c8d4ab97a00d0ea47b775b.pdf [Accessed 1 November 2018].

Completing the rating forms

Assessors will have access to all assessment tools via the PEP online portal. Once they log in with their RACGP ID and password, they can access their dashboard and, from there, use each interactive assessment tool as required.

The portal will store the information against each participant, so assessors must ensure they enter the correct details for each doctor.

If needed, the assessor can save the information entered in one assessment and complete it later with more notes or feedback. Please note this information will be made available to the participant.

The Mini-CEX and CCA each have a separate rating form, with one form completed for each assessment activity. The global rating that is required for the PEP SP (substantially comparable) is also available as a separate form. The templates for each form are available in the PEP online portal.

Visiting a practice

Before the assessment – Practice preparation

Practice administrative staff should be educated about the purpose, structure and privacy provisions of the assessment. A date and time are arranged for the assessment to take place. The practice principal and manager should be encouraged to ensure that appropriate and sufficient time is allocated for the assessment, including time for feedback and reflection (Table 2).

The assessor should ensure that they are familiar with the practice location, including logistic issues such as parking facilities. They should also ensure that they download hard copies of the assessment rating forms in case internet access is limited or unavailable. If forms are required to be completed in hard copy, the assessor will still be responsible for entering the data into the online forms (hard copies cannot be submitted). They should also ensure that they have copies of any submitted cases and CCA notes that they have prepared.

Commencing January 2021, PEP ST participants will require an additional six WBA in lieu of the removal of mandatory assessment of learning units. These additional assessments can be comprised of any combination of Mini-CEX and/or CCA, as agreed upon by the participant and training organisation (eg an additional four Mini-CEX and two CCA). If intending to complete more Mini-CEX or CCA, this can be done by lengthening a practice visit, or on a separate occasion. Please ensure you are clear with the participant and the practice regarding the time required to complete the activities.

Table 2. Suggested schedule for direct observation (four Mini-CEX) and CCA

30 minutes	Brief meeting with the participant (introductions; discuss purpose of visit and if there are any particular things the participant would like the assessor to focus on; how critical incidents will be managed, should they arise)
30 minutes	Consultation patient one and feedback
30 minutes	Consultation patient two and feedback
30 minutes	Consultation patient three and feedback
30 minutes	Consultation patient four and feedback
At the end of the consultation, the participant can write any further consultation notes while the assessor considers their questions and feedback	

60 minutes	Random selection of cases, review of cases, discussion of two cases and feedback
or	
60 minutes	Case-based discussion of two selected cases and feedback

Consent from patients

All patients being observed must provide consent. Ideally, this occurs three times:

1. verbally, when the patient rings to make the appointment
2. in writing, on arriving for the appointment
3. verbally, when the participant calls the patient into the room.

Consent for review of medical records as part of RCA is covered under relevant state-based health records legislation. The PEP patient consent form is available for use to guide and record consent, including for consultations viewed remotely.

Practices are advised to include in their privacy policy on managing health information that a third party may review records as part of professional development and education. Some practices may also choose to include this information on their patient registration forms.

Further information on managing health information is available in the RACGP publication *Privacy and managing health information in general practice*.

When calling the patient into the room, the participant should double-check that the patient is aware another doctor is present before the patient enters the room.

Setting up the room for direct observation

The assessor should be able to see both the patient and the participant. To reduce the impact of the assessor on the consultation, the assessor should be seated as far away as the room allows.

The assessor's role

The assessor should clarify with the participant that the assessor is present in an observer capacity only.

Assessors should only intervene in consultations when there are concerns for patient safety. Even then, unless the concern is significant, it may be better to raise concerns after the patient has left. The participant can then contact the patient after the assessor's concerns have been considered. This avoids undermining the relationship between the participant and the patient.

Participants are likely to be anxious about the assessment, especially if this is the first time a peer is going to observe their consultations. Briefly explaining the purpose of the assessment and the role of the assessor may be useful if this is the case. Providing guidance on how to introduce the presence of a third party in the room to patients is also usually well received. Brief statements such as 'This is Dr X who is here to support me in my professional development' can be used.

Documentation in medical notes

The assessor should remind the participant to make a brief mention in each medical record that the assessor was present for the consultation – for example, by adding 'Dr John Verano present for assessment visit' into the patient's notes.

What to do when things go wrong

Incidents during patient consultations

Assessors are most useful to the participant when they do not interfere with the clinical consultation while it is taking place, and for this reason assessors are generally advised not to intervene in the consultation. However, an assessor may observe a clinical encounter where there is serious concern as to the participant's competence or the outcome for the patient. In this case:

- consider the level of risk apparent in the situation
- intervene as appropriate if there is immediate risk of significant harm.

The following information is provided as a general guide to approaching critical and non-critical incidents during patient consultations.

Minor or non-critical incident

Assessors are advised as follows:

- Allow the consultation to proceed and conclude without interruption, and provide immediate feedback to the participant regarding the incident once the patient has left the consulting room (Table 3). In some instances, where some form of immediate action might be required, advise the participant to inform the patient to wait in the waiting room.
- Where an alternative management plan is required, discuss with the participant how this plan for rectification can be implemented.
- Review the medical documentation made by the participant in relation to the consultation to ensure there is adequate and accurate detail recorded.
- Follow training organisation procedures for incident notification.
- Notify the supervisor (if applicable).

Table 3. Minor or non-critical incident – Example scenarios and plans for rectification

Example scenarios	Example of plans for rectification
Minimal or incorrect physical examination that does not impact on management	Debrief with participant after the consultation is completed, and plan to complete the examination at their next consultation
Prescription of a medication that is not optimal	Advise the participant to organise a different prescription, and to call the patient advising of a reconsideration of treatment and to collect
Concern regarding communication style or skill	Discuss the doctor–patient interaction following the consultation, and develop approaches to trial in further consultations

Critical incident with immediate risk of harm to the patient

Assessors are advised as follows:

- Intervene on behalf of the patient and ask to see the participant outside the room, in a way that is respectful to both the participant and the patient (Table 4). This gives the assessor an opportunity to explain their action and impart the seriousness of the mismanagement. This should be done in a non-judgemental way that is respectful to both the participant and the patient.
- Suggest an alternative or more appropriate strategy/management to minimise harm to the patient. The revised management plan or action must then be agreed upon by the assessor and participant before re-entering the room.
- Use reasonable efforts to ensure that the participant remedies their action with the patient and provides the revised management plan or action.
- The assessor must discuss with the participant whether they are comfortable to continue with the clinical assessment or whether it will be suspended.

- Review the medical documentation made by the participant in relation to the consultation to ensure there is adequate and accurate detail recorded.
- Notify the relevant training organisation of the incident and follow training organisation procedures for incident notification.
- Notify the participant's supervisor (if applicable).
- Discuss their involvement and steps taken with the intervention with their medical defence organisation.
- Consider making detailed notes of the incident and also record the advice given by your medical indemnity provider. These should be stored in the assessor's personal medico-legal file.
- Consider if mandatory AHPRA notification is warranted – refer to the Medical Board of Australia policies for further information. The Assessor must consider the circumstances of the observation and whether it meets the threshold for mandatory reporting to the AHPRA in the state/territory jurisdiction. Independent of a notification, consider if your training organisation and Medical Defence Organisation should be informed of the circumstance.

Table 4. Critical incident – Example scenarios and plans for rectification

Example scenarios	Example of plans for rectification
Prescription of medication that is potentially life threatening due to a drug allergy	Suggest an 'alternative treatment' to the participant in a helpful way, and then debrief appropriately following the consultation
Omission of critical assessment points such as suicidal assessment in a depressed patient	Advise the participant to consider any 'safety questions', and if not understood may intervene in consultation to ensure safety
Failure to consider a critical or life-threatening condition, such as myocardial infarct or meningococcal disease	Advise the participant to consider the life-threatening condition, and if not acted upon intervene in consultation to ensure appropriate patient assessment
Unsafe procedures, such as needles probing near critical structures	Advise the participant to stop the procedure, discuss, complete the consultation, then debrief regarding the safety concern

Training organisation adverse event and critical incident reporting guideline.

Incidents during review of patient records

In the event of unsafe practice evident in the review of patient records, the participant should be counselled in the first instance, followed by an appropriate management plan (such as outlined earlier), and appropriate incident notification to the training organisation if required (depending on the severity of the incident).

When practice visits are not feasible

Direct observation in the workplace is the ideal but may not always be possible in the PEP. Alternative options, such as participants attending the training organisation and undertaking assessments with simulated patients or role-plays, are encouraged. A CCA can be undertaken via videoconference or telephone. Direct observation in the workplace could also be undertaken remotely via streaming, which is increasingly an option with increased availability of the required technology.

Videotaping is another way to observe consultations, but it is important to be aware of legislation related to the collection and storage, as this varies in different states and territories of Australia. Video recordings may be considered health information. Practice staff would be aware from their clinical practice records that there are specific requirements around health information storage, access and destruction. The consent obtained from the patient for videotaping should reflect the anticipated use and other relevant information.

Patient consent would still be needed but it would appear health records legislation would not apply if the consultation is viewed by live streaming, as in this case no record is made.

Practical information for assessors

Conflicts of interest

A conflict of interest occurs when an assessor knows information about a participant that could influence their assessment. Remember to advise your training organisation if you have a potential or real conflict of interest with a participant, or discuss the issue with the training organisation if you are unsure. Despite the assessment being for learning, and there being no pass/fail or marks, it is better to avoid any situations where a conflict of interest could arise. This includes potential conflicts or those in which the participant may consider a conflict exists.

Confidentiality

Assessors are reminded the material they work with in PEP is confidential. This relates to:

- assessments – the outcomes of the assessment and any information pertaining to the assessment are to be treated as confidential
- clinical material viewed during an assessment – this includes observed consultations, patient information and patient notes or case studies
- any material used in assessor training.

Assessors sign a confidentiality agreement as part of their employment.

Medical indemnity

Assessors need to ensure that they have adequate medical indemnity before conducting in-practice assessments. In general, indemnity should cover observation and any potential intervention in a consultation. If an assessor does not have current indemnity coverage under a standard practising GP category, this must be discussed with the relevant training organisation.

Subject matter experts

A clinical assessor undertaking the RACGP PEP WBA should be in active general practice, or recently have been in active general practice (within the last three years). The assessor should also be actively engaged in professional development and be a Fellow of the RACGP.

Assessment expertise

Clinical assessors should have expertise in assessment and be trained to undertake the PEP WBA. Skills gained from direct observation as a supervisor or external clinical visitor can be very valuable in this role. In addition to making an assessment of performance, assessors should be skilled in encouraging reflection and feedback in both verbal and written format.

Acronyms and initialisms

AHPRA	Australian Health Practitioner Regulation Agency
CBD	case-based discussion
CPD	continuing professional development
CCA	clinical case analysis
DISQ	Doctors' Interpersonal Skills Questionnaire
FRACGP	Fellowship of the Royal Australian College of General Practitioners
GP	general practitioner
Mini-CEX	Mini-Clinical Evaluation Exercise
MSF	multisource feedback
non-VR	non–vocationally registered
PEP	Practice Experience Program
PEP SP	PEP Specialist Stream
PEP ST	PEP Standard Stream
RACGP	Royal Australian College of General Practitioners
RCA	random case analysis
WBA	workplace-based assessment

Appendix A. Map of assessment tasks and other types of evidence

All WBA criteria are addressed; all are assessed in more than one way; there is a variety of assessment tasks.

WBA criteria	Direct obs.	CCA	Role-play	Log-book	Case report	Peer assess.	Patient assess.	Clin. audit	Other evidence
Uses communication appropriate to the person and the sociocultural context	✓	maybe	✓		✓	✓	✓		
Engages the patient to gather information about their symptoms, ideas, concerns, expectations of healthcare and the full impact of their illness experience on their lives	✓	maybe	✓		✓		✓		
Prioritises problems, attending to both the patient's and the doctor's agenda	✓		✓		✓		✓		
Adapts the consultation to facilitate optimal patient care	✓		✓		maybe		✓		
Communicates effectively in routine and difficult situations	✓	maybe	✓		✓	✓	✓		
Demonstrates active listening skills	✓		✓				✓		
Matches modality of communication to patient needs, health literacy and context	✓		✓		maybe		✓		
Uses a variety of communication techniques and materials (eg written or electronic) to adapt explanations to the needs of the patient	✓		✓		✓		✓		
Written communication is clear, unambiguous and appropriate to the task		maybe			✓				Patient notes, referral letters
Uses appropriate strategies to motivate and assist patients in maintaining health behaviours	✓	✓	✓		✓ maybe		✓		

WBA criteria	Direct obs.	CCA	Role-play	Log-book	Case report	Peer assess.	Patient assess.	Clin. audit	Other evidence
Consults effectively in a focused manner within the time frame of a normal consultation	✓					✓	✓		
Has appropriate knowledge base of diagnostic investigations, including the use of relevant guidelines	✓	✓	✓	✓	✓				Also assessed in KFP, AKT, OSCE
Takes a comprehensive biopsychosocial history from the patient	✓	✓	✓	✓	✓				
Appropriately considers all available sources of information when taking a history	✓	✓	✓	✓	✓				
Undertakes an appropriate and respectful physical examination, targeted at the patient's presentation and likely differential diagnoses	✓	maybe		✓	✓ maybe				
Detects physical examination findings accurately and interprets them correctly	✓		✓						
Elicits specific positive and negative findings	✓	maybe	✓		maybe				
Chooses rational options for diagnostic investigations using an evidence-based approach	✓	✓	✓		✓			✓	Audit of investigation requests (Medicare data)
Interprets diagnostic investigations in the context of the patient's presentation	✓	✓	✓		✓				
Integrates and synthesises knowledge to make decisions in complex clinical situations	✓	✓	✓		✓				
Considers costs when requesting investigations		✓			✓				
Considers issues of access when requesting investigations		✓			✓				
Accurately interprets investigations	✓	✓			✓				
A significantly ill patient is identified	✓	✓			✓ maybe				Evidence of CPR and ALS

WBA criteria	Direct obs.	CCA	Role-play	Log-book	Case report	Peer assess.	Patient assess.	Clin. audit	Other evidence
Demonstrates effective reasoning, considering the most likely diagnoses, excluding red flags and commonly missed conditions	maybe	✓			✓				
Modifies differential diagnoses based on clinical course and other data as appropriate	maybe	✓	✓		maybe				
Uses time as a diagnostic tool	maybe	✓			✓				
Demonstrates knowledge of common therapeutic agents, uses, dosages, adverse effects and potential drug interactions and ability to prescribe safely	✓	✓			✓				Assessed in AKT, KFP, OSCE
A significantly ill patient is appropriately managed	✓	✓	✓	✓	✓				Evidence of CPR, ALS or equivalent
Undertakes rational prescribing	✓	✓	✓	✓	✓			✓	Audit of PBS prescribing, NPS MedicineWise reports
Monitors for medication side effects and risks of polypharmacy		✓			✓			✓	
Safely prescribes restricted medications using appropriate permits		✓	✓					✓	Specific questions to assess knowledge of this area in prescribing audit
Non-pharmacological therapies are offered and discussed	✓	✓	✓		✓				
A patient-centred management plan is developed	✓	✓	✓		✓		✓		
Provides effective explanations, education and choices to the patient	✓	✓	✓		✓ maybe		✓		
Manages the uncertainty of ongoing undifferentiated conditions	✓	✓	✓	✓					Specific questions about approach to managing fatigue, dizziness etc

WBA criteria	Direct obs.	CCA	Role-play	Log-book	Case report	Peer assess.	Patient assess.	Clin. audit	Other evidence
Implements screening and prevention strategies to improve outcomes for individuals at risk of common causes of morbidity and mortality	✓	✓	✓	✓	✓			✓	Audit of screening strategies in the practice
Uses planned and opportunistic approaches to provide screening, preventive care and health promotion activities	✓				✓	✓		✓	
Demonstrates understanding of available services in the local community	✓	✓			✓	✓			Specific questions about services in the local community, community visit or contact
Coordinates a team-based approach	✓	✓			✓	✓			
Current and emerging public health risks are managed appropriately	✓	✓	✓	✓	✓				Practice audit or review
Educates patients and families in disease management and health promotion skills	✓	✓	✓	✓	✓	maybe			Copies of handouts used in practice
Identifies opportunities to effect positive change through health education and promotion					maybe				
Encourages scrutiny of professional behaviour, is open to feedback and demonstrates a willingness to change						✓			Self-reflection and planning learning, assessor and medical educator report on response to feedback, response to feedback from learning units, engagement in the tasks in terms of completion and adequacy of the responses
Exhibits high standards of moral and ethical behaviour towards patients, families and colleagues,						✓	✓		Literature review

WBA criteria	Direct obs.	CCA	Role-play	Log-book	Case report	Peer assess.	Patient assess.	Clin. audit	Other evidence
including an awareness of appropriate doctor–patient boundaries									
Identifies and manages clinical situations where there are obstacles to provision of duty of care		✓			✓				
Implements strategies to review potential and actual critical incidents to manage consequences and reduce future risk		✓	✓						Critical case analysis, critical case report to training organisation/ RACGP
Judges the weight of evidence, using critical appraisal skills and an understanding of basic statistical terms, to inform decision making			✓		✓				Critical appraisal exercise, practice audit or review of policies
Shows a commitment to professional development through reflection on performance and identification of personal learning needs				✓					Evidence of learning planning based on self-reflection and feedback, reflection activity at end of learning units
Attends and participates in all learning and assessment activities of an educational program									Training organisation reports, completion of learning unit activities
Actively engages in feedback as a dialogue, discussing performance and setting own goals for professional development									Mentor report, training organisation report, completion of learning unit, reflection
Personally participates in audits and quality improvement activities and uses these to evaluate and suggest improvements in personal and practice performance								✓	Completion of learning unit activities
Appropriately uses the computer/IT systems to improve patient care in the consultation	✓						✓		Practice audit
Maintains comprehensive and accurate clinical notes	maybe					✓			Review of clinical notes

WBA criteria	Direct obs.	CCA	Role-play	Log-book	Case report	Peer assess.	Patient assess.	Clin. audit	Other evidence
Demonstrates efficient use of recall systems to optimise health outcomes	maybe	✓							Review of recall systems
Accurately completes legal documentation appropriate to the situation	✓								Audit of workers compensation certificate, illness certificate etc
Demonstrates knowledge of infection control principles and safe practice in relation to blood-borne infections in patient care	✓								Questions about infection control principles
Patient confidentiality is managed appropriately	✓		✓		✓	✓	✓		Literature review
Informed consent is explained and obtained	✓		✓			✓	✓		Literature review

✓: Can be assessed

Maybe: Possible to assess, may be inferred or examples given during discussion

AKT, Applied Knowledge Test; ALS, Advanced Life Support; assess., assessment; CCA, clinical case analysis; CPR, cardiopulmonary resuscitation; clin., clinical; OSCE, Objective Structured Clinical Exam; obs., observation; PBS, Pharmaceutical Benefits Scheme; RACGP, Royal Australian College of General Practitioners

RACGP

Royal Australian College *of* General Practitioners

Healthy Profession.
Healthy Australia.