

RACGP Rural Generalist Fellowship (FRACGP-RG) Assessment Handbook

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Introduction

The RACGP Rural Generalist Fellowship (FRACGP-RG) is a qualification awarded by The Royal Australian College of General Practitioners (RACGP) in addition to core general practice training, the RACGP Fellowship.

The FRACGP-RG aims to develop additional emergency and specialist skills, and broaden general practice skills to ensure safe, accessible, and comprehensive care for Australia's remote, regional, and rural communities.

This assessment handbook is for registrars, supervisors, medical educators, and assessors that are involved in assessments for the core emergency medicine training component of the Rural Generalist (RG) program, or the Additional Rural Skills Training (ARST).

The purpose of the handbook is to:

- outline the types of assessments used in the RG training program
- provide background on the RG assessment program design with reference to the RG-specific curricula and the RACGP Assessment Framework which declares the principles for all RACGP assessments
- articulate the graduate outcomes for the FRACGP-RG.

This handbook does not include information on assessments only used in the FRACGP program.

The [RACGP Assessment Framework](#) outlines the principles that direct the development and delivery of all RACGP assessments and assessment programs. This aligns assessments with the defined program outcomes, as well as ensuring they are fair, reliable, valid, ethical, impactful, and inclusive. A safe environment both protects all participants and allows the candidate to perform at their best. Assessments need to be rational, acceptable, feasible, and backed by evidence of quality.

The principles underlying progressive assessment are outlined in the [Progressive assessment and workplace-based assessment program handbook](#).

These principles ensure a consistent approach to assessment delivered by all RACGP teams.

Components of the Rural Generalist training

The RACGP Fellowship (FRACGP) training via the Australian General Practice Training Program (AGPT) and Remote Vocational Training Scheme (RVTS) pathway requires completion of:

- 12 months of hospital training
- 18 months of community general practice
- six months of extended skills training (in general practice or another relevant area).

Achievement of the Rural Generalist Fellowship (FRACGP-RG) requires completion of:

- 12 months of Additional Rural Skills Training (ARST)
- six months of core emergency medicine training (core EMT), generally completed as the extended skills term (in AGPT)
- A minimum 12 months of the 18 months community general practice training in a rural MMM3–7 location.

The FRACGP can be completed in three years and the FRACGP and FRACGP-RG in four years.

Core emergency medicine training

Core EMT is required by all doctors completing the FRACGP-RG to provide the knowledge, skills and confidence to manage emergency situations in rural and remote environments, beyond what is expected from all general practitioners. It facilitates the Rural Generalist (RG) effectively caring for patients with a range of emergency presentations in rural and remote environments.

Additional Rural Skills Training

A core requirement of the FRACGP-RG is completion of at least 12 months of ARST, which can be undertaken in a broad range of disciplines that address the needs of rural and remote communities. ARST can be completed as part of the training program or, alternatively, via Recognition of Prior Learning and Experience (RPLE) where evidence can be submitted that demonstrates equivalence in competency gained and assessed through other suitable programs previously completed (refer to [RPLE currency requirements](#)).

The FRACGP-RG supports a number of ARST disciplines for trainees (subject to availability and eligibility). These are broadly categorised as procedural and non-procedural.

Table 1. ARST disciplines

Procedural	Non-procedural
Anaesthesia	Aboriginal and Torres Strait Islander health
Emergency medicine	Academic medicine
Obstetrics	Adult internal medicine
Surgery	Child health
	Mental health
	Palliative care
	Small town rural general practice

Graduate outcomes

The RACGP has graduate outcomes in place for the FRACGP training programs; these are written as capabilities in [The RACGP progressive capability profile of the general practitioner](#) (see 'Statement of fellowship outcomes'). There are 20 high-level capabilities that apply to all graduates of the RACGP Fellowship training programs. In addition to these are graduate outcomes specific to the FRACGP-RG.

The specialist RG is able to:

- integrate in-depth knowledge of the remote or rural community when providing comprehensive general practice care
- provide emergency care
- utilise specialised procedural and/or non-procedural skills
- manage available resources in the remote or rural context to optimise health care
- provide advocacy leadership for a remote or rural community in achieving equitable access to resources
- navigate the tensions of living and working as a GP within the one community
- understand and use relevant population and environmental data to build a healthy remote or rural community.

Contextual competencies of the curricula

Each ARST and the core EMT have a set of contextual competencies that are specific to the curricula for that area.

The outcomes have been divided into the two areas for which evidence must be provided, either through an assessment or through the submission of evidence:

1. Competencies relevant to the ARST, and which meet community needs
2. Experience demonstrating competency for the types of patients, presentations, and experiences specified in the curriculum (12 months for ARST and six months for core EMT)

For each ARST the competencies form the program outcomes for that ARST.

Recognition of Prior Learning and Experience / Recognition of Prior Assessment

Recognition of Prior Learning and Experience (RPLE) and Recognition of Prior Assessment (RPA) is available for any trainee who can demonstrate that they have been assessed and deemed competent at the equivalent level to the ARST. Evidence of independent clinical experience in a rural or remote setting will also be required.

Equivalent assessment and experience must be current and will be assessed against the specific curriculum RPLE requirements.

Workplace-based assessment

Workplace-based assessment (WBA) is the primary assessment method used in the Rural Generalist Fellowship Program (FRACGP-RG) as this assesses the ability to perform in the workplace. Workplace-based assessments also provide the opportunity to assess professional attributes as well as knowledge and skills.

The RACGP WBA program describes all the elements of a program of assessment which can be adapted for each Additional Rural Skills Training (ARST) discipline.

Each ARST discipline has a specific curriculum outlining the competencies that describe the abilities of a Rural Generalist (RG) in a specific context. Competencies include behavioural descriptors with a strong link to clinical practice that allow an assessor or medical educator to observe as part of assessing a registrar's performance and progression.

Assessment tools and ways of providing evidence

No single assessment can adequately assess the multiple components of being an RG. Multiple assessments using multiple methods are required to credibly assess the range of knowledge, skills, and attitudes required. Tools that can be used in workplace-based assessment include self-reflective pieces, clinical audits, clinical assessments, logbooks, multisource feedback, and third-party reports. Multiple forms of assessment provide a holistic overview of ability and progression, facilitating different learning styles and ARST contexts.

Assessors

Any clinical assessor needs to have both subject matter expertise as well as assessment expertise. Training and support for assessors to ensure the quality of delivery of the assessment program and minimising variability across assessors is a key consideration.

Training and tools for the delivery of meaningful feedback will also be employed, providing a platform for trainee understanding and development. Feedback helps to reinforce quality performance and address underperformance.

Assessments across the program and within each modality will be conducted by a number of different assessors to ensure that multiple expert opinions and observations contribute to the final determination of competency, thus increasing reliability of the decision-making process.

An overview of assessment tools and ways of providing evidence

In ARST placements, there are a range of ways that evidence of a trainee's competence can be gathered; self-reflective pieces, clinical audit, clinical assessments, logbooks, multisource feedback, and third-party reports. The choice of assessment tools and ways of providing evidence of competence will vary depending on the ARST, and be aimed at providing assessment as a driver of learning.

Competencies will be viewed in multiple contexts and multiple times across each assessment modality to demonstrate repeatability. Multiple assessors will be utilised throughout the ARST supporting the theory that the collective view of a range of experts will deliver a more accurate and reliable final determination of competency about an individual trainee.

Following is a brief outline of the most commonly used assessment tools:

Random case analysis (RCA) and case-based discussion (CBD)

Using patient notes, either randomly selected or in the form of case studies written up in a templated format, RCA and CBD are aimed at assessing clinical decision-making, management and therapeutic reasoning. In addition, inter-personal communication, and elements of practice organisation and systems can be assessed.

Direct observation of consultations – the mini-CEX

The mini-CEX is a workplace-based assessment modality that assesses a trainee's clinical skills and performance through direct observation in the clinical setting. The format is well-recognised as a valid and reliable tool when used multiple times and can be adapted for each clinical setting.

Peer / colleague assessment – multisource feedback (MSF)

This evaluation requires assessment by several sources with an appropriate sample size and should include the trainee's self-assessment and subsequent reflection on the variances between scores. Evidence is gathered of colleagues' evaluation of professional behaviour, interpersonal communication skills and clinical performance, as well as trainee's self-reflection is required.

Direct observation of procedural skills (DOPS)

DOPS is an evidence-based assessment that involves the observation of the trainee performing a procedure. Feedback is provided in a structured manner, breaking the procedure into skill-related areas.

Procedural skills logbook

A component of the 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.

Medical educator / supervisor reports

These reports should provide a global assessment on performance against the outcomes. Progression, or lack thereof, should be documented.

Table 2. Elements of Assessment and how they map to each assessment modality

Elements of assessment	Self assessment	Mini-cex or dops	CBD	Case note analysis	Logbook	Supervisor reports
Direct Observation		✓		✓		✓
Deep exploration of skills including hypothetical and risk management			✓	✓		
Assesses 'does'		✓	✓	✓	✓	✓
Flexible timing	✓	✓	✓	✓	✓	
Context appropriate	✓	✓	✓	✓	✓	✓
Multiple assessors		✓	✓	✓		
Promotes reflection	✓	✓	✓	✓	✓	✓
Record of skills development and competency achievement	✓	✓	✓	✓	✓	✓
Demonstrates independent practices skills	✓	✓	✓	✓	✓	✓
Provides feedback		✓	✓	✓		✓
Promotes learning	✓	✓	✓	✓	✓	✓

Assessment program design

Curriculum competencies

An overarching workplace-based assessment framework has been developed that describes all the elements of a program of assessment, these can be adapted for each Additional Rural Skills Training (ARST) and the core emergency medicine training (core EMT).

Each ARST and the core EMT has a specific curriculum which provides an outline of the competencies that describe the abilities of a Rural Generalist (RG) in a specific context. Competencies include behavioural descriptors that allow an assessor or medical educator to observe and use in assessing a trainees' performance.

The curricula competencies allow training program participants to:

- identify the competencies to be assessed
- identify and describe the outcomes which indicate the achievement of competencies (a way of linking the competencies to clinical practice to enable the assessment process)
- address each and every outcome in multiple contexts
- combine outcomes where possible (integrated or holistic assessment)
- assess every outcome in more than one way to meet the sufficiency rule
- use a variety of assessment tasks for which rubrics have been developed.

This is visually represented in Table 3.

Competencies	Direct observation	Case discussion	Case reports	Role play	Clinical audit	Supervisor reports	MSF
Outcome 1	x		x				
Outcome 2		x				x	
Outcome 3	x			x			
Outcome 4			x		x		x
Outcome 5		x			x		
Outcome 6	x			x		x	

Candidates will complete a suite of assessments relevant to their core EMT and their chosen ARST. Assessments combine self-reflective tools, supervisor reports, and clinical assessments to inform learning and provide evidence of competency. Each assessment will be followed by a feedback session and self-reflection exercise.

ARST assessments

Specific assessment requirements, including competencies for each individual ARST, are described in the relevant curriculum. The minimum requirements for each clinical ARST are:

- a self-assessment and learning/training plan
- a logbook
- three random case notes analysis sessions reviewing a minimum of three cases per session:
 - two completed by supervisor
 - one completed by an alternative assessor
- two supervisor reports
 - one completed at six months
 - one at completion of 12 months of training
- two mini-CEX sessions (three cases per session) or direct observation of procedural skills (DOPS) sessions (three cases per session)
 - one assessed by the supervisor
 - one assessed by an alternative assessor
- two CBD sessions (submit four cases, assessed on two each session) (independently assessed).

Assessments can be conducted via a variety of formats using available communications technology that allows the assessment to meet its purpose.

Each assessment will be followed by the provision of individual feedback for the candidate in both written and verbal format. Candidates will be expected to reflect on their learning needs and update their learning plans following receipt of each assessment feedback.

Assessment timing

A programmatic approach to assessment has been recommended whereby assessment activities are completed from the start of training through to the completion of the ARST. This methodology supports longitudinal development and enables realignment of the individual's learning/training plan, encouraging experiential learning and providing the time to build on skills and knowledge.

The assessments outlined below are designed to provide a snapshot in time of the trainee's development towards competency. Whilst there are a number of activities recommended, the overall time taken to complete most of these assessments is relatively short.

Table 4. Assessments and how they map to each modality

Timing (Guide only)	Assessment activity	Time to complete	Assessor
Start of training	• Logbook – may start prior to training term and is ongoing	Ongoing	Reviewed at each ME meeting and regularly by the supervisor
	• Self-assessment and learning/training plan	30 minutes – 1 hour	
Month 2–4	• Random case analysis/clinical notes audit	1.5 hours	Supervisor
	• Mini-CEX or DOPS and reflection	2 hours	Supervisor

Month 4–6	• CBD	1 hour	Independently assessed
	• Random case analysis/clinical notes audit	1.5 hours	Alternative assessor
	• Supervisor report		Supervisor
Month 7–8	• Mini-CEX or DOPS and reflection	2–3 hours	Alternative assessor
	• Random case analysis/clinical notes audit	1.5 hours	Supervisor
Month 9–11	• CBD	1 hour	Independently assessed
Month 12	• Supervisor report		Supervisor

Progression

Evaluation of competency and progression should be a continuous process throughout workplace-based assessment and is the responsibility of both the supervisor and the medical educator. Typical evidence to inform supervisor or medical educator evaluations include assessment evidence collected to date, including logbook data, personal reflection, supervisor feedback, and medical educator observations.

All information collected, as well as all parties involved in the assessment process, will be maintained in the strictest confidence via restricted access on a need-to-know basis.

Completion of the ARST to the standard described for that ARST is to be determined by a panel whose participants and size is to be determined by the RACGP Censor in Chief. Currently this occurs as part of the progress review committee (PRC) in each region.

- The RACGP Rural Censor (or designated representative) is invited to any PRC involving an RG registrar
- The Rural Censor is sent the PRC information relevant to RG registrars prior to the PRC for their input

The final competency decision will be based on numerous data points collected across the workplace-based assessment program plus any other relevant information available to that panel. It is important therefore that meaningful qualitative data (eg active personal reflection information) is recorded at each point to provide sufficient evidence for assessment.

A description of both the standard for competency and the methodology for aggregation of the data to formulate a decision must be provided to each stakeholder. This will be determined specifically for each ARST.

Where a candidate's performance is determined to be below that of the standard expected for competency, the censor will decide on any additional learning and assessment that is required prior to another panel review.

Where a candidate decides that they are not yet ready for the panel review, they can request an extension of training prior to scheduling of the review.

Detailed descriptions of assessment types

Self-assessment

The self-assessment is a checklist that describes the relevant competencies for each Additional Rural Skills Training (ARST) discipline. The registrar is asked to rate their confidence in each of the areas and use this information to support the development of the ARST learning/training plan. This can be reviewed by the medical educator to identify areas that require additional support.

Clinical case analysis – case-based discussion (CBD)

CBD is a structured discussion between an assessor and a candidate that allows the candidate to demonstrate the application of their clinical and professional skills and knowledge in real cases. This assessment is therefore suited to most workplace-based assessment situations. Assessors have the ability to explore the candidate's management and clinical reasoning alongside their medical knowledge related to the care of real patients.

Discussions are based on written records that include clinical notes and relevant investigations for a patient for whom the candidate has been the primary or managing doctor. This assessment is particularly effective when the discussion of management develops through evidence of a continuum of care. Where care is based on a one-off consultation or patient interaction, the complexity of the case must be great enough to demonstrate management at the level designated in that ARST.

The candidate presents four sets of relevant** case notes for each CBD assessment session, two of which are assessed at the session. Assessors select two cases from the four presented that represent differing presentations. Cases are discussed and sessions may be recorded for quality assurance. Each case is discussed for 20–30 minutes each, resulting in a maximum one hour of assessment.

**NB: Detailed assessment criteria including the range of presentations/conditions to be assessed are outlined in the specifications for each assessment as relevant to that ARST curriculum.

Marking sheets will detail candidate performance in all areas of competency assessed, providing feedback on management and areas for improvement and skills development.

Direct observation of consultations – the mini-CEX

Mini-CEX is an authentic assessment of practice that is based on the direct observation of multiple real-time patient consultations. It is designed to assess a multitude of competencies in the candidate's own context. Mini-CEX provides the assessor the opportunity to observe patient communication, application of clinical judgement, management, professionalism, and efficiency.

Mini-CEX is conducted in a 2–3 hour session with each session consisting of three patient interactions and with discussion time following, which allows the assessor to provide feedback to the candidate. Each patient interaction should represent a different clinical presentation, enabling the assessor to sample the candidate's performance.

Mini-CEX should be conducted over two sessions and in different settings/contexts as relevant to the ARST. These may include but are not limited to, in clinic or outpatients' departments, in the ward, post treatment, during procedures, during team interactions or meetings.

Direct observation of procedural skills (DOPS)

For procedural ARSTs, DOPS will be utilised to assess and provide feedback on procedural skills essential to the development of competency in the relevant ARST. The direct observation of procedural skills is an evidence-based assessment that involves the observation of the candidate performing a procedure on real patients.

Skills and behaviours observed in DOPS include patient and colleague communication, demonstration of clinical knowledge and the ability to perform appropriate techniques as well as professional behaviours and safe practices.

DOPS is conducted so that each session covers three patient procedures followed by discussion time for the assessor to provide feedback to the candidate. Each procedure should represent a different clinical presentation, enabling the assessor to sample the candidate's performance.

Feedback is provided in a structured manner, breaking the procedure into skill-related areas. Each DOPS session should comprise a range of different practical procedures.

Procedural skills logbook

Each ARST will have a logbook requirement for the candidate to complete throughout their training. 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's needs.

Supervisor reports

These reports should provide a global assessment of performance against the outcomes outlined in the specific ARST curriculum. Progression, or lack thereof, should be documented and discussed with the trainee, with the intent of formulating a plan to remediate any gaps identified either through additional learning, or experiences, or a combination of both.

Random case analysis (RCA)

RCA is similar to CBD, however, in the case of RCA, the supervisor reviews a set of randomly selected cases that the trainee has managed. The RCA provides the opportunity for the supervisor to review the quality of case notes as well as exploring the management of each of the selected cases.

The ability for the supervisor or medical educator to select random cases ensures that a reasonable sampling of the trainee's performance can be viewed and discussed, informing improvements to practice and acknowledgement of competency achievement.

Each RCA is approximately 20 minutes with 10 minutes for feedback and completion of the assessment form. Assessors discuss a minimum of three randomly selected cases in each session.

Details of specific curricula and assessments

The core emergency medicine training and the ARST [curricula and assessment templates](#) are available on the RACGP website.

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