Assessor handbook

Workplace-based assessment program

RACGP

Assessor handbook: Workplace-based assessment program

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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.

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Contents

Workplace-based assessment in general practice training

What is workplace-based assessment?

Workplace-based assessments are used across all RACGP training pathways. This handbook is relevant to the Australian General Practice Training (AGPT) program, the Fellowship Support Program (FSP) and any doctor training towards the Rural Generalist Fellowship. It describes each assessment, providing guidance for assessors on the preparation for and conduct of each assessment modality.

Workplace-based assessment (WBA) refers to a group of activities designed to assess a registrar in their own workplace. The value of completing assessments in the workplace is that it is possible to implement assessments at the highest level of Miller's pyramid – to assess what a registrar actually does (Figure 1). Miller's pyramid represents the development of clinical competence according to a hierarchy, beginning with knowledge and progressing to clinical performance, and highlights that the ability to perform competently requires multiple capabilities, including knowledge and understanding. In assessing what a registrar does in the workplace, it is possible to concurrently assess their underlying knowledge and understanding.

Other benefits of WBA include the ability to assess the safety of the registrar's patient care, as well as complex practitioner competencies, such as professionalism and the ability to tolerate and manage diagnostic uncertainty and to consider the ethical and legal aspects of clinical practice.

The RACGP's assessment framework, through WBA and the Fellowship exams, ensures that a registrar's competence is assessed at each level of Miller's pyramid.

Data from WBA activities can be used for educational purposes – to evaluate a registrar's clinical performance and to support decisions about a registrar's progress. It is also used to provide feedback and plan teaching and learning that is tailored to the individual registra.

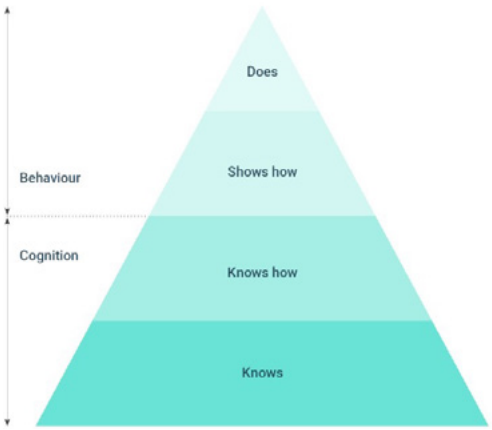


Figure 1. The hierarchical development of clinical competence as illustrated by Miller's pyramid[1]

[1] Based on Miller GE. The assessment of clinical skills/competence/performance. Acad Med 1990;65(9):S63–7.

The RACGP WBA program

The RACGP WBA program is a major element of the progressive assessment framework, which aligns with the Australian Medical Council (AMC) Standards for assessment and accreditation of specialist medical programs and professional development programs and the RACGP Standards for general practice training. For more information about the RACGP progressive assessment framework, refer to Progressive assessment and workplace-based assessment program.

The WBA program commences with the early assessment for safety and learning (EASL), undertaken within the first two to four weeks of a registrar's first general practice term (GPT1). The EASL provides valuable information to guide the development of the clinical supervision plan by the supervisor.

The WBA activities used in the training programs are outlined in Table 1. Activities used for specialty training in the additional rural skills training (ARST) component of the Rural Generalist Fellowship are listed in Table 2.

Table 1. WBAs and selected educational activities in RACGP training programs

WBA	AGPT	FSP	Rural Generalist Fellowship	
			Additional rural skills training (ARST)	Core emergency medicine training (core EMT)
Early assessment for safety and learning (EASL)	x (within first 4 weeks)	x (within first 2 weeks)	-	-
Mini-clinical evaluation exercise (mini–CEX)	x	x	x	x
Case based discussion (CBD)	x	x	x	-
Random case analysis (RCA)	x	x	x	x
Multi-source feedback (MSF)	x	x	-	-
Medical educator progress reports	-	x	-	-
Supervisor assessments/ reports	x	x	x	x
Clinical audit*	x	x	-	-
Direct observation of procedural skills (DOPS)	-	x Optional	x	x
Event analysis*	-	x	-	-
Evidence-based medicine activity*		x	-	-

Logbook	-	-	x	x
Reflective exercise*	x	-	-	-

* These are not strictly workplace-based assessments but are included in the WBA activities.

Table 2. WBAs in additional rural skills training by specialty

WBA requirement	Aboriginal and Torres Strait Islander health	Adult internal medicine	Child health	Mental health	Palliative care	Surgery
Mini–CEX	x	-	x	x	x	-
CBD	x	x	x	x	x	x
RCA	x	x	x	x	x	x
DOPS	-	x	-	-	-	x
Logbook	x	x	x	x	x	x
Supervisor reports	x	x	x	x	x	x

WBA assessors

The role of assessors

Multiple assessors are involved in delivering WBA and each assessor may play more than one role in a registrar's training. For example, you might be a supervisor to one or more registrars at your practice and, from time to time, might visit a different practice in your role as an external clinical teaching visitor (ECT visitor). You might be a medical educator (ME) with responsibility for the education of a group of registrars and also a clinical supervisor to another registrar, as well as performing the role of ECT visitor from time to time.

All assessors who deliver WBA activities are required to be in active general practice, engaged in ongoing professional development and Fellows of the RACGP. You must also complete the RACGP's program specific assessor training.

You should be skilled in encouraging reflection and engaging in a feedback discussion with the registrar.

It's the registrar's responsibility to engage in assessments, to openly discuss feedback with the assessor, and proactively manage their learning.

The role of the supervisor

As a supervisor, you play a pivotal role in monitoring a registrar's performance in the workplace, providing feedback, mentoring, teaching and encouraging them to plan their learning.

You make expert judgements about a registrar's competency, based on the outcomes of the WBA activities, your regular interactions with the registrar, and by gathering evidence at the practice and from other sources. By assessing a registrar's competency, you're able to make decisions about the safety of the registrar and their patients, the appropriate level of supervision required, and the registrar's progress and educational needs.

Your primary responsibility is to ensure the safety of the registrar and their patients. The first assessment you'll conduct is the early assessment for safety and learning (EASL) – an important suite of activities undertaken to support patient safety when you have a new registrar in their first general practice term (GPT1). The EASL will also help you develop the clinical supervision plan and the teaching plan. The EASL must be completed *within* the first two to four weeks of GPT1.

Assessment activities you're responsible for:

- The EASL:
    - review the registrar's multiple-choice question (MCQ) test results
    - observe and assess the registrar in at least four consultations
    - discuss a selection of consultations each day.
- Mini-clinical evaluation exercises (mini–CEXs).
- Random case analyses and/or case-based discussions).
- Mid- and end-term assessments/reports.

You may also be involved in other WBA activities, such as reviewing and discussing with a registrar their

multi-source feedback (MSF) report and the outcome of their clinical audit.

There will be some variation between WBA activities across training programs. Refer to the section 'WBA requirements'.

As part of each assessment, you should meet with the registrar to discuss your observations. Consider the registrar's self-assessment and engage in a clear, meaningful and supportive feedback discussion, and make recommendations to help them attain competency in areas identified as gaps.

Tip! You should also be aware of any issues or changes that might indicate that your registrar needs additional educational support or pastoral care and seek assistance from the local ME if appropriate.

The role of the medical educator

As an ME, you provide a link between the registrar's training program and the assessment program. You provide each registrar with educational and pastoral support and ensure they have a tailored training plan and feel comfortable to seek your advice and mentoring throughout the training program. You work closely with the registrar's supervisor to ensure that the training environment is appropriate and supportive.

As an assessor, you make expert judgements about a registrar's competency, support their progression through training where appropriate, and flag any concerns if you consider a registrar is underperforming to enable early educational intervention and additional support.

Assessment activities you're responsible for:

- Assisting registrars to reflect on their EASL multiple-choice question (MCQ) test results if required.
- Conducting case-based discussions.
- Reviewing and discussing the multi-source feedback (MSF) with the registrar.
- Conducting the reflective exercise.
- Reviewing and discussing results of the clinical audit with the registrar.
- Reviewing submitted WBAs as appropriate. For example, when a flag has been raised or when there are concerns about registrar performance or progress.
- Referral to the progression review committee (PRC).

The role of the external clinical teaching visitor

External clinical teaching visitors (ECT visitors) provide an independent assessment of a registrar's competency. As an ECT visitor, you'll sit in on a registrar's consulting session in their practice and undertake multiple WBA activities to assess their performance, discussing feedback with the registrar and engaging with the practice and supervisor.

Assessment activities you're responsible for:

- Random case analysis (RCA).
- Case based discussion (CBD).
- Mini-clinical evaluation exercises (mini–CEXs).

External clinical teaching visits (ECTVs) are conducted in the AGPT program only. An AGPT registrar has five visits throughout their core vocational training (GPT1–3).

More detail can be found in the AGPT Practice and Supervisor Handbook.

What is being assessed?

WBA competencies

The RACGP curriculum and syllabus for Australian general practice describes five domains of general practice and provides a competency framework based on the essential qualities of an Australian GP. The WBA competencies (Figure 1) have been developed to facilitate assessment in the workplace.

Communication skills	Consultation skills	Clinical information gathering and interpretation	Making a diagnosis, decision making and reasoning
Clinical management and therapeutic reasoning	Preventive and population health	Professionalism	General practice systems and regulatory requirements
	Managing uncertainty	Identifying and managing the seriously ill patient	

Figure 1. The WBA competencies

The WBA competencies need to be clearly linked to clinical practice to allow a supervisor, ME or ECT visitor to use them to assess a registrar's performance and discuss feedback. The WBA competency rubric outlines criteria and performance lists that serve as this link by providing descriptions of performance or observable behaviours to guide assessors in rating performance and providing feedback.

Each competency is described by several criteria, and each criterion is further described by the performance (observable behaviours or word pictures) expected at three stages of competency. The final level is Fellowship standard – the point at which the registrar is ready to demonstrate competence for unsupervised practice in Australia. This level is calibrated to the Statement of Fellowship outcomes in the Progressive capability profile of the general practitioner.

The three stages described in the performance lists are:
1. Well below Fellowship standard

2. Progressing towards Fellowship standard

3. At Fellowship standard.

You should use the performance lists to measure the registrar's performance in each criterion. They are a guide to selecting the most appropriate rating and shouldn't be used as a checklist because there are many ways a registrar might demonstrate they have achieved a competency.

You are asked to choose a rating that best matches your assessment of the performance you have observed. Your focus should be on providing feedback on observable behaviours.

The competency areas, with their corresponding criteria and performance lists, as well as a rating grid, can be found in the Appendices. In AGPT, the EASL competency rubric is specifically for use with the EASL activities, and the WBA competency rubric covers the remaining assessments. In FSP, the WBA competency rubric is used for all assessments including the EASL.

Workplace-based assessments

Early assessment for safety and learning

Standard 1.1 of the RACGP Standards for general practice training requires that: 'Supervision is matched to the individual registrar's level of competence and learning needs in the context of their training post'. The EASL suite of activities has been designed to provide information about a registrar's current clinical competence as they begin their first general practice placement (GPT1). The EASL activities help identify areas where closer supervision and guidance may be needed, and whether the registrar has the clinical knowledge, skills and attitudes to assess common general practice presentations and is able to recognise their limitations and seek help appropriately when required.

The EASL has three components:

- a multiple-choice question test with an integrated confidence rating completed by the registrar
- direct observation of consultations by the supervisor (minimum of four)
- daily case discussions and debriefing conducted by the supervisor (only a selection of each day's cases needs to be discussed).

Review of the 'call for help' list completed by the registrar will also provide useful information.

For FSP registrars, the EASL also includes two random case analysis or case based discussion.

The EASL provides useful information to assist the supervisor in developing the clinical supervision plan.

EASL multiple-choice question test

The EASL MCQ test is delivered online through the RACGP gplearning platform, before the start of GPT1. Registrars are provided a one-time access to a set of 70 questions that assess applied knowledge with a focus on acute and serious illness and common presentations in general practice. A self-assessed confidence rating grid is embedded into the test, providing insight into the registrar's self-awareness, which may unmask unconscious incompetence.

Once the test has been completed, an EASL MCQ report is generated for use by the registrar, supervisor and ME. The registrar is encouraged to discuss the report with their ME and supervisor.

The report displays performance against curriculum areas and self-confidence ratings and allows the registrar, supervisor and ME to identify learning needs early in training, especially in areas that are critical to patient safety. It also provides information that may help the supervisor identify areas for in-practice teaching and where the registrar may require closer supervision.

The 'call for help list' is a document which was created by registrars, supervisors, and medical educators and contains a list of 'uncertainty flags' and circumstances where it was identified that a registrar should call for help. Some because they are 'high risk' situations and others because they are common pitfalls for new registrars. Review of your registrar's completed 'call for help' list confidence rating grid will also provide useful information.

Supervisors should review the EASL MCQ report with their registrar and discuss:

- areas in which the registrar lacks confidence, is over-confident or would like extra support

- any potential gaps in knowledge
- their perceived supervision and learning needs.

The ME may also discuss the EASL MCQ results with their registrar to help them to plan their learning.

EASL direct observation of consultations by the supervisor

As a supervisor, you should observe a minimum of four consultations undertaken by the registrar within the first two to four weeks of GPT1. Although the observations may be completed in one session, it is recommended that they are completed across multiple sessions during normal teaching time to enable the registrar to make changes based on your feedback.

Rating and assessment

The focus of this activity is on the basic knowledge and skills needed to consult independently including appropriate consultation and communications skills, record-keeping and the ability to make safe prescribing and management decisions with a patient.

The EASL direct observation assesses competency in four areas:

- communication skills
- consultation skills
- clinical management and therapeutic reasoning
- general practice systems and regulatory requirements.

During the consultation, record any observations about your registrar's performance in each of the four competency areas to help guide your feedback discussion. After the observation, first explore the registrar's self-assessment before discussing the comments you've recorded; include in your discussion their strengths and weaknesses and any concerns you have. Your discussion can be used to inform the development of the clinical supervision plan, and you should encourage the registrar to use the feedback to plan their learning.

Following the observations, complete the direct observation assessment form.

Steps in conducting a direct observation

1. Agree on a time for the observation session(s).
2. Ensure that enough time is scheduled for the observation(s), including time for feedback discussion.
3. Ask the receptionist to advise the registrar's patients that you will be observing the consultation. This should be done both at the time of booking the appointment and when the patient attends. Have the registrar greet the patient, reconfirm the patient's consent to the process, and explain that you, as their supervisor, will observe only and not be otherwise involved in the consultation.
4. After the patient leaves the room, allow time for the registrar to complete their notes.
5. Review the consultation with the registrar, explore the registrar's self-assessment first and then discuss feedback.
6. Use the direct observation of consultation rating form to record your feedback conversation and any comments that may be helpful for registrar learning.

EASL daily case discussion

When a registrar begins GPT1, each day you should discuss the care of a selection of the registrar's patients with them. This should include cases that your registrar wishes to discuss as well as cases selected at random and consultations where your registrar did not call you for help. This may be done either throughout the day or at the end of each day; alternatively, it can be done before commencing consultations the following day, provided that patient safety is not impacted.

Case discussions provide useful information about the registrar's level of competence and learning needs. You should allow the registrar to debrief before engaging in a feedback discussion with them and providing guidance as appropriate. Encourage the registrar to take notes during the discussion to guide their learning and for later reference.

Case discussions should continue routinely until you have enough evidence to be confident that daily case discussions are no longer needed for the EASL activity.

While the information gained from these discussions informs the clinical supervision plan, details of the cases discussed don't need to be formally documented unless there are concerns about a registrar's performance or if you consider it necessary.

Performance summary

Once all the EASL activities have been completed, you should indicate the overall outcome of the registrar's performance and flag any concerns for review by the ME in the performance summary section.

Clinical supervision plan

Once all EASL activities have been completed, you should develop the clinical supervision plan. The results of the EASL MCQ test, the EASL direct observations, daily case reviews/discussions and the 'call for help' list, will inform the development of the clinical supervision plan.

The mini–CEX

The mini-clinical evaluation exercise (mini–CEX) is an assessment of the registrar's clinical skills and performance by a supervisor, ME or ECT visitor directly observing a clinical consultation. Immediately after the assessment, allow the registrar to reflect on their performance before providing your feedback. Discuss your assessment of their performance including strengths, areas for improvement and any concerns you may have.

The mini–CEX can be used to assess any one or a combination of 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
- preventive and population health
- professionalism
- general practice systems and regulatory requirements
- managing uncertainty
- identifying and managing the seriously ill patient.

The assessor may choose to conduct a focused or non-focused assessment, based on the above competencies and/or the registrar's learning needs. In a focused mini–CEX, you will focus on specific aspects of the clinical encounter. The area(s) of focus should ideally be discussed and agreed with the registrar. Consider any previous assessments and previously identified areas of focus.

The mini–CEX is usually done face to face in the registrar's clinical practice. Where appropriate or necessary, some may be conducted via streaming technology with the assessor situated remotely.

For supervisors with registrars in the AGPT program, mini-CEXs will be conducted in core GP terms. A minimum number of mini-CEXs will need to be completed during each core GP term. We recommend that the first mini–CEX be undertaken early in the term, and further observations should occur after the registrar has had sufficient time to reflect on their performance and respond to feedback.

A mini-CEX will also be conducted by an external clinical teaching (ECT) visitor as part of an external clinical teaching visit (ECTV) in core GP terms.

We recommend that the required number of consultations be observed and assessed in each of the core six month GP terms and ideally should cover presentations that include a range of clinical problems, age groups and gender.

Information for assessors

The time required to conduct a mini–CEX will depend on the complexity of the consultation, but generally it will include the time taken to observe the consultation, review the case and engage in a feedback discussion with the registrar.

The registrar is responsible for ensuring the patient consents to the consultation being observed. This can be done by verbal consent at the time of the consultation which is noted in the patient records or other means as required by the practice.

You should observe the clinical consultation without interrupting or prompting unless there is a concern about patient safety. After the patient has left, review any written material related to the case, such as a referral or prescriptions. Then review the consultation with the registrar asking probing questions relevant to the clinical encounter, explore the registrar's self-assessment and discuss feedback.

Use the mini–CEX assessment form to rate the registrar's performance and record the feedback discussion . Use the WBA rubric to guide and standardise your rating, and use the narrative from the performance lists in the rubric as a guide to giving feedback.

The emphasis in the assessment is on observing the registrar's performance and discussing the findings with the registrar. The registrar is required to create actionable learning goals based on their performance and the feedback discussion.

Steps in conducting a focused mini–CEX

1. Agree on the focus of the evaluation exercise with the registrar.
2. Check that the patient has given consent for the consultation to be observed.
3. Observe the consultation without interrupting or prompting.
4. Consider and record how the registrar has performed in each area of focus and how they are progressing towards the expected standard.
5. Encourage the registrar to reflect on their own performance before discussing your observations.
6. Review the consultation, explore the registrar's self-assessment and discuss feedback based on their performance.
7. Guide the registrar in developing actionable learning goals and agree on a time frame for when these will be followed up.
8. Encourage the registrar to plan their learning based on the agreed learning outcomes.
9. Complete and submit the mini-CEX rating form in the appropriate online portal.

Direct observation of procedural skills

If you're an assessor of FSP and/or rural generalist registrars, you may complete a direct observation of procedural skills (DOPS) during your assessment visit. Steps to follow should mirror the mini–CEX set-up, and you should use the DOPS rating form to complete the assessment details.

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

Random Case Analysis (RCA) and Case-based discussion (CBD) are WBA tools that explore your registrar's application of clinical reasoning and decision-making skills. Both RCA and CBD are assessment activities which involve the review of the registrar's clinical notes or case reports followed by a structured discussion to explore issues relating to the case. RCA and CBD can be conducted by the supervisor, ME or ECT visitor. You should ask probing questions to assess the registrar's clinical decision-making skills and ability to reflect on and explain their rationale for decisions.

RCA and CBD can be used to assess the following WBA competencies:

- clinical information gathering and interpretation
- making a diagnosis, decision making and reasoning
- clinical management and therapeutic reasoning
- preventive and population health
- professionalism
- general practice systems and regulatory requirements.

The discussion may focus on certain aspects of the consultation; for example, if prior assessments have highlighted areas where competency was not adequately demonstrated, it would be appropriate for you to explore these areas.

Alternatively, the focus may be guided by the registrar's experience and learning needs.

Random case analysis

In an RCA, you'll randomly select one of the registrar's recent clinical consultations to discuss. The random nature of case selection means that this method may identify gaps in the registrar's knowledge and skills that they may have been avoiding or not identified. You may ask the registrar to think about the case from different perspectives and discuss these through the lens of the curriculum and syllabus, in particular the five domains of general practice.

The RCA discussion explores the case and includes the registrar's recall of the consultation and self-assessment of their performance, in an effort to understand the decisions they made. RCA also provides the opportunity to elaborate on the original case and consider more complex, hypothetical situations through 'What if' questions. The process of RCA allows registrars to develop their clinical reasoning by demonstrating how changing one of four contextual influences – the doctor, the patient, the problem and the system – changes the case.

RCA is helpful to ensure registrars explore scenarios that they may not usually encounter in their day-to-day practice.

Case selection for RCA

Randomly select a recent patient encounter. Cases seen over the past week are preferred, to ensure better recall of the case by the registrar. Cases should be of an appropriate complexity and offer an adequate learning opportunity.

Presentations that wouldn't meet this standard include upper respiratory tract infection, immunisation or request for prescription.

Information for assessors

For registrars in the AGPT program, RCAs will be conducted in core GP terms by supervisors.

A minimum number of RCAs will need to be completed as part of WBA during each core GP term. We recommend that the first RCA be undertaken early in the term, and further RCAs should occur after the registrar has had sufficient time to reflect on their performance and respond to feedback.

For registrars in the AGPT program, RCAs can also be conducted in core GP terms as part of an ECTV

For registrars in FSP, RCAs will be conducted in core GP terms by medical educators.

The time required to conduct a RCA will depend on the complexity of the case and your registrar's learning needs, but generally it will include the time taken to review the case, explore your registrar's rationale for clinical decisions and engage in a feedback discussion with them.

The aim of the RCA is for you to elicit and record sufficient information to make a judgement about the registrar's level of competency.

At the end of each RCA, have a feedback conversation with the registrar and complete the RCA assessment form using your notes from the discussion to rate the registrar's performance; we recommend you don't include feedback beyond what you discussed with the registrar. Use the WBA competency rubric to guide and standardise your rating.

The registrar is required to create actionable learning goals based on their performance and the feedback discussion.

Steps in conducting a random case analysis

1. Ask the registrar to open their practice appointment book to a session in the past week.
2. Randomly select a case for discussion from the appointment book and read the record.
3. Choose another record if the first chosen is relatively straightforward and doesn't appear to contain new learning opportunities.
4. Ask the registrar about the case to uncover what they knew of the patient before the consultation and their recollection of the case.
5. Allow the registrar to summarise the case without interrupting, as the registrar may provide additional information that is not documented in the medical record.
6. Ask for further information about the case if required.
7. Explore the case using the patient notes as a guide.
8. Ask 'What if' questions to pose alternative scenarios and explore the registrar's strengths and uncertainties. Ask the registrar to formulate clinical management plans to solve future and hypothetical scenarios, and to consider other professional and legal considerations.
9. Record brief details about the RCA. Consider the registrar's performance in the RCA and provide comments.
10. Encourage the registrar to reflect on their own performance before discussing your observations.
11. Discuss the consultation, explore the registrar's self-assessment and provide feedback on their performance.
12. Guide the registrar in developing actionable learning goals and agree on a time frame for when these will be followed up.
13. Encourage the registrar to plan their learning based on the agreed learning outcomes.
14. Complete and submit the RCA rating form in the appropriate online portal.

Case-based discussion

A CBD is a structured discussion between a registrar and an assessor about a recent clinical case that the registrar has managed or a simulated clinical scenario.

The clinical case serves as a stimulus to discuss and explore the registrar's clinical reasoning and decision-making skills. As you work through the case with the registrar, you may pose questions from varying perspectives to explore clinical reasoning further.

The CBD can take place in person as part of a practice visit or ECTVor via video or telephone. It should be done one-on-one to enable an individualised feedback conversation with the registrar immediately after the session.

Case selection for CBD

Cases used for CBD can be either acute or chronic; they should be complex enough to stimulate a robust discussion and enable the registrar to demonstrate their clinical reasoning and decision making skills and ability to reflect on the case.

The registrar selects clinical cases they have encountered from their own practice, or you may select a simulated clinical scenario for the CBD. Ask the registrar to choose cases that they either found challenging, or that cover specific areas they find challenging.

The cases must cover a range of clinical presentations from the contextual units of the curriculum and syllabus. Cases in which clinical reasoning may be complicated by uncertainty, and/or where decision making requires multiple issues to be considered, are appropriate choices. The registrar uses the case submission template to submit the cases prior to the CBD. You should review the cases prior to the CBD, and if they aren't of an acceptable standard, ask the registrar to submit alternative cases.

Information for assessors

The time required to conduct a CBD will depend on the complexity of the case and your registrar's learning needs, but generally it will include the time taken to review the case, explore your registrar's rationale for clinical decisions and engage in a feedback discussion with them.

Select an appropriate case to discuss from those submitted by the registrar or you may prefer to use a simulated clinical scenario. Review the case and pre-prepare questions to ask the registrar that will explore their clinical reasoning ability.

During the session with the registrar, note instances where they were uncertain or had difficulty in making a decision. We recommend you document your observations about the registrar's performance in each competency area to help you with the feedback conversation.

At the end of each CBD, have a feedback conversation with the registrar and complete the CBD assessment form using your notes from the discussion to rate the registrar's performance; we recommend you don't include feedback beyond what you discussed with the registrar. Use the WBA competency rubric to guide and standardise your rating.

The registrar is required to create actionable learning goals based on their performance and the feedback discussion.

Steps in conducting a case-based discussion

1. The registrar submits cases before the assessment, using the case submission template.
2. Select a case for discussion (either a case submitted by the registrar or a simulated clinical scenario) and develop discussion notes to guide the assessment.
3. Ask questions to probe the registrar's understanding and clinical reasoning, using your discussion notes as a guide.
4. Ask 'What if' questions to assess what the registrar would do in different or more challenging circumstances.
5. Consider and record how the registrar has performed in the CBD.
6. Encourage the registrar to reflect on their own performance before discussing your observations.
7. Discuss the case , explore the registrar's self-assessment and provide feedback on their performance.
8. Guide the registrar in developing actionable learning goals and agree on a time frame for when these will be followed up.
9. Complete and submit the CBD rating form on the appropriate online portal.

Multi-source feedback

Multi-source feedback is a valid and reliable method of assessing interpersonal and professional behaviour and clinical skills.

This assessment is managed by an external provider, Client Focused Evaluation Program (CFEP), and comprises the following components:

- patient assessment tool: the Doctor's Interpersonal Skills Questionnaire (DISQ)
- colleague feedback assessment tool: the Colleague Feedback Evaluation Tool (CFET)
- self-assessment tool.

The registrar receives a report based on the assessment, and they complete a reflective activity based on the report which they then discuss with their ME.

The MSF is an opportunity for the registrar to reflect on feedback about their professional behaviour. There is no pass or fail mark.

Clinical audit

A clinical audit is carried out as part of the education and training program and involves the registrar doing a systematic review of certain aspects of their clinical practice or practice processes. Examples of areas for clinical audit include:

- rational ordering of investigations (radiology/pathology)
  - review of the frequency of tests ordered; for example, thyroid function test in patients on long-term thyroxine replacement
  - imaging in acute knee and ankle injuries; for example, what the indications are and what modalities could be used
- management/prescribing
  - review of prescribing as compared to current best practice
  - how closely were the clinical guidelines followed for the management of low back pain (for example)?
- preventive medicine activities
  - review of patient records for recording of smoking status and smoking cessation advice given
  - review of patient records for recording of current alcohol use and alcohol cessation and reduction advice given.

In GPT1, FSP registrars will be provided with the Registrar Clinical Encounters in Training (ReCEnT) tool to facilitate their clinical audit. On completion, the registrar will be provided with a report to discuss with their ME in GPT2 to assist the registrar to plan their learning.

For AGPT registrars, the clinical audit is usually completed during GPT3 and registrars may seek guidance from either their ME or supervisor. Once an audit is completed, the registrar analyses the results and discusses the findings with their ME.

Reflective exercise

Reflective practice is an important aspect of continuing professional development and effective self-directed lifelong learning. It can help clinicians to review and improve their own practice by identifying their strengths and weaknesses and specific learning needs. The reflective exercise is conducted by the registrar's ME.

The purpose of the reflective exercise is to help the registrar:

- explore and assess their level of competency with regards to professionalism and general practice systems and regulatory requirements
- identify areas of professionalism and general practice systems and regulatory requirements that require further development
- develop their reflective skills.

To prepare for this exercise, AGPT registrars are asked to:

- identify two previous general practice encounters that presented challenges in the competency areas of professionalism or general practice systems and regulatory requirements. An example may be a challenging interaction with a patient or colleague or a difficulty in maintaining the doctor–patient boundary.
- submit the encounters using the reflective exercise submission template prior to the activity.
- reflect on this experience prior to the session.

During the session, the ME will:

- select one of the registrar's submitted encounters or select a simulated scenario as the stimulus for discussion
- use a structured approach to facilitate guided reflection
- explore the registrar's self-assessment and discuss feedback on their performance and areas for improvement
- guide the registrar in developing actionable learning goals and agree on a time frame for when these will be followed up.
- complete the registrar reflective exercise assessment form using notes from your discussion. We recommend you don't include feedback beyond what you discussed with the registrar.

Event Analysis

This involves analysis of any event that may have implications for patient care. Examples of events that could be used for this activity include patient complaints, medication errors, communication failures or delayed or missed diagnoses.

To prepare for this exercise FSP registrars are asked to:

- identify an event where you believe something has gone wrong even when the patient has not come to harm.
- submit a Significant Event Analsysis proforma via the FSP portal
- reflect on the experience prior to a group discussion activity.

Logbook

Registrars are encouraged to develop and maintain an up-to-date general practice procedural skills logbook throughout their training. They should log procedures they perform in the general practice setting and discuss any knowledge gaps with their supervisor. You should encourage the registrar to plan their learning based on these discussions.

The core emergency medicine procedural skills logbook is mandatory for all rural generalist registrars.

Planning learning

Supervisors and MEs should encourage registrars to plan their learning based on the competency areas identified by the workplace-based assessments as needing further development. This will help registrars to develop self-reflection skills and actively seek and incorporate feedback from their assessors.

Feedback

Feedback is an important aspect of WBA and is a complex skill to master. It requires you to develop a supportive relationship with your registrar, and it also requires the active involvement of your registrar in the process. Giving feedback in the context of an assessment can be challenging, especially for GP supervisors.

When undertaking an assessment, it is important to record specific details about your registrar's performance for use in the feedback discussion. The feedback discussion should be learner-centric and start with your registrar's self- assessment and an understanding of the areas they would like feedback on. Discuss what they did well, to reinforce this behaviour, and areas that need further development. Base your suggestions for change on observed behaviour and make them specific.

Always discuss with your registrar your rating of their performance and any comments you are going to make before submitting the assessment.

Progression

Monitoring registrar progression

The progress and performance of all registrars is discussed regularly throughout training by their supervisor, ME, ECT visitors, training coordinator and other local training program team members. These discussions are driven by the results of WBA activities, feedback from assessors, MEs and supervisors, and other available information relating to a registrar's training or circumstances. The discussions are designed to support planning for learning, track progression and competency attainment, and enable early identification of registrars needing additional support.

Flagging

In each WBA activity, assessors are given the opportunity to flag any concerns they have about a registrar. A graded flagging system is used, with green, amber or red flags indicating the level of concern (Figure 2).

Indicate your level of concern with this registrar's performance and/or progress *Please check the appropriate box*	Significant concern ☐	Moderate concern ☐	No concern ☐
If moderate (amber) or significant (red) concern selected			
Details of concern			
Please discuss concerns with your registrar as soon as possible. Consider also contacting your local team.			
Have you reviewed your concerns with the registrar? ☐ Yes ☐ No			

Figure 2. An example of the WBA flagging system

A flag may be raised for a variety of reasons, including but not limited to:

- assessments that indicate performance is consistently well below standard
- feedback that raises concerns
- concerns about professionalism
- a critical incident.*

Most registrars will progress through training with green flags on their assessments. For those registrars who receive amber or red flags, the assessor needs to discuss feedback with the registrar at the time of the assessment and document descriptive comments about the performance that elicited the flag. Sometimes, the underlying problem may be a practice incident or a personal issue.

If a red or amber flag is raised during an in-practice assessment by an external assessor, it's important that the assessor notify the supervisor so that appropriate and immediate action can be taken in the practice to address the issue.

Additionally, a formal diagnostic process should be initiated by the registrar's ME to identify the areas of concern. This may involve a discussion with the registrar and their supervisor, a review of data from previous WBA activities and a review of previous flags. In the case of a red flag, this process needs to be undertaken immediately, whereas for an amber flag this process can be undertaken within a fortnight.

If a red or significant amber flag is raised, the registrar needs to be referred to the progression review committee* (PRC) by the ME. The referral should detail the areas of concern identified via the formal diagnostic process, actions already undertaken and any further plans for addressing those concerns. Before submitting a referral, an ME should read the PRC referral process for further details. The training coordinator will be able to advise of the next PRC meeting date.

The progression review committee

The PRC oversees the progress of all registrars in training and endorses educational support plans made by local training teams about educational interventions, remediation and supervision requirements. The PRC also conducts ongoing reviews of registrars who have been flagged through WBAs or supervisor or ME feedback. The committee's role extends to determining eligibility to sit Fellowship exams and application for Fellowship.

The PRC meets every two months or as appropriate to the needs of each region and/or program.

Any recommendations on changes in training progression made by the PRC are communicated to the registrar by their ME. The outcome of the PRC review is also communicated to the supervisor if they are involved in providing educational support.

*If a critical incident has been identified a critical incident form should be completed. Further information about managing adverse events and critical incidents can be found in Critical incident and adverse event management and reporting guidance document

WBA requirements

WBA in the AGPT program

Figure 3 provides an overview of the assessments conducted in the AGPT program. Refer to tables 1 and 2 for further information on the numbers and timing of each assessment.

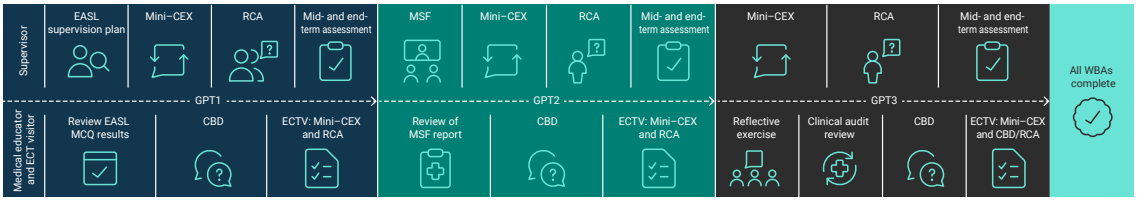


Figure 3. Workplace-based assessments in the AGPT program

Table 3. WBAs and selected educational activities to be completed by the supervisor during core GP training terms (GPT1–3)

WBA requirement	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur	GPT1 Week 1–4	GPT1	GPT2	GPT3
EASL direct observation^	Min. 4	Up to 2 hours	As soon as practicable, but *within* first 4 weeks	x	-	-	-
EASL Case discussion	Selection of cases be discussed each day	Part of supervision requirement	Until appropriate level of supervision has been determined	x	-	-	-
EASL MCQ report review	1	30 minutes	Before end Week 4	x	-	-	-
Mini–CEX	Min 2	1 hour	Throughout term (recommend one be completed early during term)	-	x	x	x

RCA	2	1-2 hours	Throughout term (recommend one be completed before mid-term assessment)	-	x	x	x
Mid-term assessment	1	Up to 1 hour	Middle of each term	-	x	x	x
End-term assessment	1	Up to 1 hour	End of each term	-	x	x	x

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting, and following up (unless listed as a separate requirement). Time requirement is part of normal teaching hours.

^The outcome of the EASL is a decision by the supervisor as to the appropriate level of supervision required by the registrar. The number of observations required for the supervisor to reach a decision will vary depending on the competence level of the registrar.

Table 4. WBAs and selected educational activities to be completed by the ME during core GP training terms (GPT1–3)

WBA requirement	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur	GPT1 Week 1–4	GPT1	GPT2	GPT3
EASL MCQ review and discussion with registrar	As needed	30 minutes	Before end Week 4	x	-	-	-
CBD	1	1 hour	Week 9–12 of each term (approx.)	-	x	x	x
Clinical audit review and discussion with registrar^	1	1 hour	During GPT3	-	-	-	x
MSF review and discussion with registrar	1	1 hour	During GPT2	-	-	x	-
Reflective exercise^	1	1 hour	Prior to clinical competency exam (CCE)	-	-	-	x
Review WBAs submitted for registrar including mid- and end-term assessments✧	As appropriate	1-2 hours	Throughout term	-	x	x	x

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^These are not strictly workplace-based assessments but are included in the WBA activities.

✧ Review of WBAs for registrars where there are concerns regarding progression or, previous flags

WBA in the FSP

Figure 3 provides an overview of the assessments conducted in the FSP. Refer to tables 3, 4 and 5 for further information on the numbers and timing of each assessment.

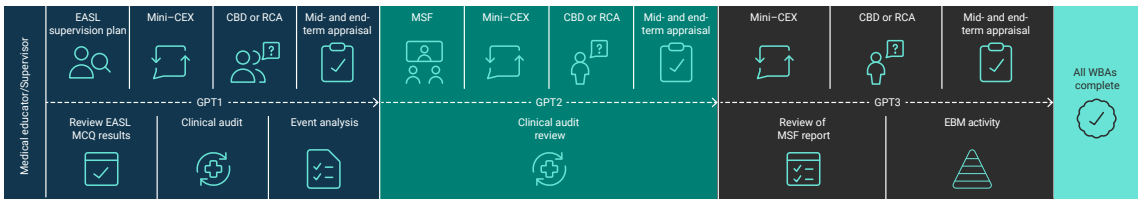


Figure 3. Workplace-based assessments in the FSP

Table 5. WBAs to be completed by the supervisor during GPT1

WBA requirement	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur
EASL direct observation (mini–CEX)^	Min. 4	Up to 2 hours	As soon as practicable, but within first 2 weeks
Daily case review	Daily	Part of supervision requirement	Until appropriate level of supervision has been determined
EASL MCQ report review	Optional	30 minutes	Before end Week 2
RCA or CBD	2	1 hour	Within first two weeks

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting, and following up (unless listed as a separate requirement).

^The outcome of the EASL is a decision by the supervisor as to the appropriate level of supervision required by the registrar. The number of observations required for the supervisor to reach a decision will vary depending on the competence level of the registrar.

Table 6. WBAs and selected educational activities to be completed by the ME during GPT1

WBA requirement	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur
EASL MCQ review and discussion with registrar^	1	30 minutes	Before end Week 2
Mini–CEX	4	2 hours	Throughout term
RCA or CBD	2	1 hour	Throughout term
Event analysis^	1	1 hour	During term
Induction report	1	1 hour	Before end Week 4
End-term report	1	1 hour	End of term

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^These are not strictly workplace-based assessments but are included in the WBA activities.

Table 7. WBAs and selected educational activities to be completed by the ME per term (GPT2–3)

WBA requirement	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur	GPT2	GPT3
Mini–CEX	8	4 hours	Throughout term	x	x
RCA or CBD	4	2 hours	Throughout term	x	x
MSF review and discussion with registrar	1	2 hours	MSF conducted during GPT2 and discussed in GPT3	x	x
Clinical audit review and discussion with registrar^	1	1 hour	Registrar completes clinical audit in GPT1 and discussed during GPT2	x	-
Evidence-based medicine activity^	1	1 hour	Discussed during GPT3	-	x
End-term reports	1	1 hour	End of each term	x	x

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^These are not strictly work-place based assessments but are included in the WBA activities.

WBA for additional rural skills training

Aboriginal and Torres Strait Islander health

Table 8. WBAs to be completed for Aboriginal and Torres Strait Islander health

WBA requirement	Assessor	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur^
Mini–CEX	Supervisor	1 session with 3 observations	2–3 hours	Completed during months 2–4
	Independent assessor	1 session with 3 observations	2–3 hours	Completed during months 7–8
CBD	Independent assessor	2 sessions, each with 2 case discussions	1.5 hours per session	Completed during months 4–6 and 9–11
RCA	Supervisor	2 sessions, each with 3 case discussions	2 hours per session	Completed during months 2–4 and 7–8
	Independent assessor	1 session with 3 case discussions	2 hours	Completed during months 4–6
Logbook/ cultural journal	Regular review by the supervisor and/ or cultural mentor, and by the ME at each ME meeting	Refer to the ARST curriculum	-	Throughout training
Supervisor reports	Supervisor	1	1 hour	Middle of training (eg at 6 months)
		1	1 hour	End of training (eg at 12 months)

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^Timing of when the assessments occur is based on 12 months of FTE training.

Adult internal medicine

Table 9. WBAs to be completed for adult internal medicine

WBA requirement	Assessor	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur^
CBD	Independent assessor	2 sessions, each with 2 case discussions	1.5 hours per session	Completed during months 4–6 and 9–11
	Supervisor	2 sessions, each with 3 case discussions	2 hours per session	Completed during months 2–4 and 7–8
RCA	Independent assessor	1 session with 3 case discussions	2 hours	Completed during months 4–6
DOPS	Supervisor	1 session with 3 observations	2–3 hours	Completed during months 2–4
	Independent assessor	1 session with 3 observations	2–3 hours	Completed during months 7–8
Logbook	Regular review by the supervisor and by the ME at each ME meeting	Refer to the ARST curriculum	-	Throughout training
Supervisor reports	Supervisor	1	1 hour	Middle of training (eg at 6 months)
		1	1 hour	End of training (eg at 12 months)

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^Timing of when the assessments occur is based on 12 months of FTE training.

Child health

Table 10. WBAs to be completed for child health

WBA requirement	Assessor	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur^
Mini–CEX	Supervisor	1 session with 3 observations	2–3 hours	Completed during months 2–4
	Independent assessor	1 session with 3 observations	2–3 hours	Completed during months 7–8
CBD	Independent assessor	2 sessions, each with 2 case discussions	1.5 hours per session	Completed during months 4–6 and 9–11
RCA	Supervisor	2 sessions, each with 3 case discussions	2 hours per session	Completed during months 2–4 and 7–8
	Independent assessor	1 session with 3 case discussions	2 hours	Completed during months 4–6
Logbook	Regular review by the supervisor and by the ME at each ME meeting	Refer to the ARST curriculum	-	Throughout training
Supervisor reports	Supervisor	1	1 hour	Middle of training (eg at 6 months)
		1	1 hour	End of training (eg at 12 months)

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^Timing of when the assessments occur is based on 12 months of FTE training.

Mental health

Table 11. WBAs to be completed for mental health

WBA requirement	Assessor	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur^
Mini–CEX	Supervisor	1 session with 3 observations	2–3 hours	Completed during months 2–4
	Independent assessor	1 session with 3 observations	2–3 hours	Completed during months 7–8
CBD	Independent assessor	2 sessions, each with 2 case discussions	1.5 hours per session	Completed during months 4–6 and 9–11
RCA	Supervisor	2 sessions, each with 3 case discussions	2 hours per session	Completed during months 2–4 and 7–8
	Independent assessor	1 session with 3 case discussions	2 hours	Completed during months 4–6
Logbook	Regular review by the supervisor and by the ME at each ME meeting	Refer to the ARST curriculum	-	Throughout training
Supervisor reports	Supervisor	1	1 hour	Middle of training (eg at 6 months)
		1	1 hour	End of training (eg at 12 months)

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^Timing of when the assessments occur is based on 12 months of FTE training.

Palliative care

Table 12. WBAs to be completed for palliative care

WBA requirement	Assessor	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur^
Mini–CEX	Supervisor	1 session with 3 observations	2–3 hours	Completed during months 2–4
	Independent assessor	1 session with 3 observations	2–3 hours	Completed during months 7–8
CBD	Independent assessor	2 sessions, each with 2 case discussions	1.5 hours per session	Completed during months 4–6 and 9–11
RCA	Supervisor	2 sessions, each with 3 case discussions	2 hours per session	Completed during months 2–4 and 7–8
	Independent assessor	1 session with 3 case discussions	2 hours	Completed during months 4–6
Logbook	Regular review by the supervisor and by the ME at each ME meeting	Refer to the ARST curriculum	-	Throughout training
Supervisor reports	Supervisor	1	1 hour	Middle of training (eg at 6 months)
		1	1 hour	End of training (eg at 12 months)

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^Timing of when the assessments occur is based on 12 months of FTE training.

Surgery

Table 13. WBAs to be completed for surgery

WBA requirement	Assessor	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur^
CBD	Independent assessor	2 sessions, each with 2 case discussions	1.5 hours per session	Completed during months 4–6 and 9–11
	Supervisor	2 sessions, each with 3 case discussions	2 hours per session	Completed during months 2–4 and 7–8
RCA	Independent assessor	1 session with 3 case discussions	2 hours	Completed during months 4–6
DOPS	Supervisor	1 session with 3 observations	2–3 hours	Completed during months 2–4
	Independent assessor	1 session with 3 observations	2–3 hours	Completed during months 7–8
Logbook	Regular review by the supervisor and by the ME at each ME meeting	Refer to the ARST curriculum	-	Throughout training
Supervisor reports	Supervisor	1	1 hour	Middle of training (eg at 6 months)
		1	1 hour	End of training (eg at 12 months)

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^Timing of when the assessments occur is based on 12 months of FTE training.

WBA in core EMT

Table 14. WBAs to be completed for core EMT

WBA requirement	Assessor	Number of assessments/ activities	Time requirement*	When assessment/ activity should occur^
Mini–CEX	Independent	1 session with 3 observations	2–3 hours	Completed during months 4–5
	Supervisor	1 session with 3 case discussions	2 hours	Completed during months 2–3
RCA	ME or independent assessor	1 session with 3 case discussions	2 hours	Completed during months 4–5
DOPS	Supervisor	1 session with 3 case discussions	2–3 hours	Completed during months 2–3
	ME or independent assessor	1 session with 3 case discussions	2–3 hours	Completed during months 4–5
Logbook of core procedural skills	Signoff by supervising senior clinician or educator	Listed in logbook	-	Throughout training
Supervisor reports	Supervisor	1	1 hour	Middle of training (eg at 3 months)
		1	1 hour	End of training (eg at 6 months)

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^Timing of when the assessments occur is based on 6 months of FTE training

Practical considerations

Assessment rating forms and supporting materials

How you access the assessment rating forms and supporting documents will be specific to the program you're working on. The rating forms themselves and the way you conduct the assessments are the same regardless of your role and the program.

AGPT

For the AGPT program, including registrars training towards Rural Generalist Fellowship, all the assessments will be submitted through online forms in the RACGP training management system (TMS). You may prefer to print out the rating forms and complete the assessment manually, however, you won't be able to upload the printed version and will need to fill in the online rating forms to submit your assessment.

Supporting materials, including assessment rubrics, guides and FAQs will be available to all assessors in the TMS document library.

Reports, such as a registrar's EASL MCQ report or MSF report, will be uploaded into the TMS and available for review by assessors.

FSP

All assessment forms and supporting materials, including assessment rubrics, guides and FAQs will be available to assessors in the FSP portal.

Before the assessment

The RACGP will ensure that practice administrative staff are educated about the purpose, structure and privacy provisions of the assessment. Once a date and time have been arranged for the assessment, 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.

Before you attend an assessment:

- know where the practice is located, including logistical issues, such as where to park
- download hard copies of the assessment rating forms or have an editable version on your device in case internet access is limited or unavailable. (If a form has to be completed in hard copy, you are responsible for entering the data into the online forms as well, as hard copies can't be submitted.)
- have copies of any submitted cases and CBD notes that you have prepared
- make sure the registrar and practice understand how much time is required to complete the activities.

Obtaining consent

It is the registrar's responsibility to ensure a patient has given consent for a direct observation. Ideally, this occurs three times:

- verbally, when the patient rings to make the appointment
- verbally and/or in writing, on arriving for the appointment
- verbally, when the registrar calls the patient into the room.

You should remind the registrar to reiterate to the patient before they enter the room that another doctor will be present during the consultation. Patient consent may be documented in the consultation notes.

Consent for review of medical records as part of a random case analysis is covered by relevant state- and territory-based health records legislation.

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

Setting up the room

You should be able to see both the patient and the registrar. To reduce the impact on the consultation of you being in the room, seat yourself as far away from the patient and registrar as possible.

What to do when things go wrong

Incidents during patient consultations

In general, an assessor shouldn't intervene in a consultation. However, if you observe a clinical encounter where you have a serious concern about the registrar's competence or the outcome for the patient, it's important that you:

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

We encourage you to discuss the incident with the registrar either at the end of the clinical consultation or at the end of the direct observation session. We also recommend that you bring your concerns to the attention of the registrar's supervisor to ensure they are informed and can put appropriate actions in place to prevent such incidents from occurring in the future.

Incidents during review of patient records

If you detect unsafe practice while reviewing patient records during either a RCA or CBD, you should counsel the registrar in the first instance, and then put in place an appropriate management plan. If required, make an appropriate incident notification to the RACGP (depending on the severity of the incident).

Further information about managing adverse events and critical incidents can be found in the Critical incident and adverse event management and reporting guidance document.

When practice visits are not feasible

In WBA, direct observation in the workplace is the ideal, but may not always be possible. Direct observation can be done remotely via streaming when necessary. Patient consent to a third party observing a consultation must still be obtained and documented.

CBD can be done via video conference or telephone if direct face-to-face contact with the registrar isn't feasible.

Conflict of interest, confidentiality and insurance

Conflict of interest

A conflict of interest occurs when an assessor knows information about a registrar that could influence their assessment. Despite the assessment being for learning, and there being no pass/fail marks, it is better to avoid any situation where a conflict of interest could arise. If you have a potential or real conflict of interest with a registrar, or if you are unsure if you do, please contact the local RACGP team.

Confidentiality

It's important to remember that the material you work with as an assessor is confidential. This includes:

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

You will need to sign a confidentiality agreement as part of your employment as an assessor.

Medical indemnity

You must have adequate medical indemnity before conducting in-practice assessments. In general, indemnity should cover observation and any potential intervention in a consultation.

Acronyms

AGPT	Australian General Practice Training
AMC	Australian Medical Council
ARST	additional rural skills training
CBD	case-based discussion
CCA	clinical case analysis
CCE	Clinical Competency Exam
CFEP	Client Focussed Evaluation Program
CFET	Colleague Feedback Evaluation Tool
DISQ	Doctors' Interpersonal Skills Questionnaire
DOPS	direct observation of procedural skills
EASL	Early Assessment for Safety and Learning
EBM	evidence-based medicine
ECTV	external clinical teaching visit
EMT	emergency medical training
FAQ	frequently asked question
FSP	Fellowship Support Program
GP	general practitioner
GPT	general practice training
MCQ	multiple-choice questionnaire
ME	medical educator
MSF	multisource feedback
NPS	National Prescribing Service
PRC	progression review committee
RACGP	The Royal Australian College of General Practitioners
RCA	random case analysis
ReCEnT	registrars' clinical encounters in training
TMS	training management system
WBA	workplace-based assessment

Glossary

Term	Definition
Additional rural skills training (ARST)	A training term of 52 calendar weeks (FTE) in an accredited training post that provides the appropriate depth and breadth of experience necessary to meet the requirements of the particular ARST curriculum.
Assessment	The systematic process for making judgements on the participant's progress, level of achievement or competence, against defined criteria and standard.
Clinical Competency Exam (CCE)	A component of the RACGP Fellowship exams designed to assess clinical competence and readiness for independent practice as a specialist GP.
Colleague	A professional who the doctor directly works with in the same practice or indirectly works or collaborates with through the broader healthcare system. Includes other GPs, nursing and administrative staff, allied health professionals and non-GP specialists.
Competency	An observable ability, integrating multiple components, such as knowledge, skills, values and attitudes.
Conflict of interest	A situation in which it is reasonable to conclude that an individual's or group of individuals' personal interests directly conflict with the best interests of the registrar or where individuals' actions may be influenced by their personal interests rather than education and training outcomes. A conflict of interest includes, but is not limited to, when: i. close personal friends or family members are involved ii. an individual or their close friends or family members may make financial gain or gain some other form of advantage iii. an individual is bound by prior agreements or allegiances to other individuals or agencies that require them to act in the interests of that person or agency or to take a particular position on an issue. This definition applies to the RACGP Conflict of Interest Policy in the context of general practice training.
Core vocational training	The mandatory components of the AGPT program: three terms of general practice placements (GPT1,2,3) and an extended skills training term.

Curriculum and syllabus	The *RACGP curriculum and syllabus for Australian general practice* describes the key competencies and learning outcomes of general practice education. It informs the development and delivery of training programs and guides learners by detailing the scope of educational content to be learnt across the domains of general practice, with suggestions for learning modalities and educational resources.
Fellowship	Admittance to either: i. Fellowship of the RACGP (FRACGP), or ii. FRACGP and Rural Generalist Fellowship (FRACGP-RG).
Fellowship exams	The exams run by the RACGP that assess competency for unsupervised general practice anywhere in Australia. They include: i. Applied Knowledge Test (AKT) ii. Key Feature Problem (KFP) test iii. Clinical Competency Exam (CCE).
Framework	A conceptual structure for placing things in relation to each other.
Full-time equivalent (FTE)	The RACGP determines FTE to mean 38 hours per week and includes all practice time, education, and training program activities – the composition of which will vary depending upon the registrar's stage of training.
General practice training terms	In the AGPT and FSP, training terms are referred to as GPT1, GPT2 and GPT3. The extended skills term is sometimes referred to as GPT4.
Local RACGP team	RACGP staff with local knowledge and relationships who support registrars from the time they enter the AGPT program through to Fellowship. The team includes a training coordinator, medical educator, cultural mentor and an administrator.
Medical educator	An experienced and qualified person who delivers education to the registrar; normally a GP, but can also be a suitably qualified and experienced non-GP.
Portfolio	A collection of evidence of learning progress and completion of assessments. Can include data that is quantitative (eg test scores) and qualitative (eg supervisor reports, self-reflections, practice visit reports).
Progress	Demonstrated improvement in competency.
Progressive assessment	The assessment of registrars throughout training for the purpose of directing their education and for determining progress decisions based on the achievement of competency milestones.

Registrar	A medical practitioner enrolled in the Australian General Practice Training (AGPT) program or Fellowship Support Program (FSP).
Remediation	The process by which a registrar receives additional support in order to address performance concerns.
Rural Generalist Fellowship	Admittance to RACGP Rural Generalist Fellowship (FRACGP-RG).
Safety	The condition of being protected from or unlikely to cause danger, risk or injury. Educational safety is defined as a learning environment that values support, respectful communication, bi-directional feedback, reflection and the acquisition of new skills. It meets the learner's current level of competency and learning needs and facilitates growth and learning.
Supervisor	An accredited GP who works in an accredited training practice and takes responsibility for the education and training needs of the registrar while in the practice.
Training program	Either the: i. Australian General Practice Training (AGPT) program, or ii. Fellowship Support Program (FSP).
Workplace-based assessments	Observation and assessment of a registrar's practice to track progression through training.

Appendices

EASL competency rubric

Competency area	**Description of registrar competency at foundation level**
	For registrar to achieve 'at foundation level' the supervisor has observed (over at least four separate registrar– patient consultations) that the registrar: • is safe and competent to practise without direct supervision for all consultations • has good clinical knowledge • has good insight into the limitations of their knowledge and skills • demonstrates appropriate help-seeking behaviour when required • is able to safely practise with more independence with the safety net of a supervisor ensuring that mechanisms are in place to monitor for safe and quality patient care. At this stage of training, the supervisor must be readily available at all times to provide advice and support as needed.
Communication skills	
Criteria	**Performance list**
Communication is appropriate to the person and the sociocultural context	Demonstrates awareness of patient's perspective Able to communicate with consideration of the patient's sociocultural context
Engages with the patient to gather information about their symptoms, concerns and expectations	Asks appropriate questions to elicit relevant information Appropriately uses open and closed questions to gather information Clarifies information if patient's statements unclear
Demonstrates active listening skills	Actively engages with patients; listens attentively to concerns Allows patient to talk without interrupting
Responsive to patient cues	Demonstrates ability to recognise and respond to verbal and non-verbal patient cues
Demonstrates empathy and compassion and uses language and non-verbal behaviour to establish rapport	Explanations are adequate and generally match the patient's understanding
Communicates effectively in routine and difficult situations	Able to recognise the need for sensitivity in difficult situations

Consultation skills

Criteria	Performance list
Adapts the consultation to facilitate optimal patient care	• Able to achieve consultation outcomes, and is flexible in approach
Consults effectively in a structured and focused manner within an appropriate time frame	• Consultation timing managed appropriately in most situations • Timing may be a challenge in complex situations
Obtains sufficient information to include or exclude red flags	• Elicits sufficient information that can be used to identify red flags and the 'masquerades' of general practice
Prioritises problems, attending to both the patient's and the doctor's agenda	• Demonstrates ability to negotiate agenda with the patient • Able to appropriately prioritise problems when patient presents with multiple issues
Appropriate safety netting and follow-up is arranged, especially when diagnosis is uncertain	• Uses safety-netting techniques appropriately and/or provides specific instructions for follow-up

Clinical management and therapeutic reasoning

Criteria	Performance list
Makes safe and rational prescribing decisions	• Makes safe and rational prescribing decisions appropriate for the patient
Checks patient understanding	• Usually checks patient's understanding of the information given and plans made, especially when the diagnosis is unclear
Explains and negotiates the management plan with the patient	• Generally negotiates the management plan with the patient

General practice systems and regulatory requirements

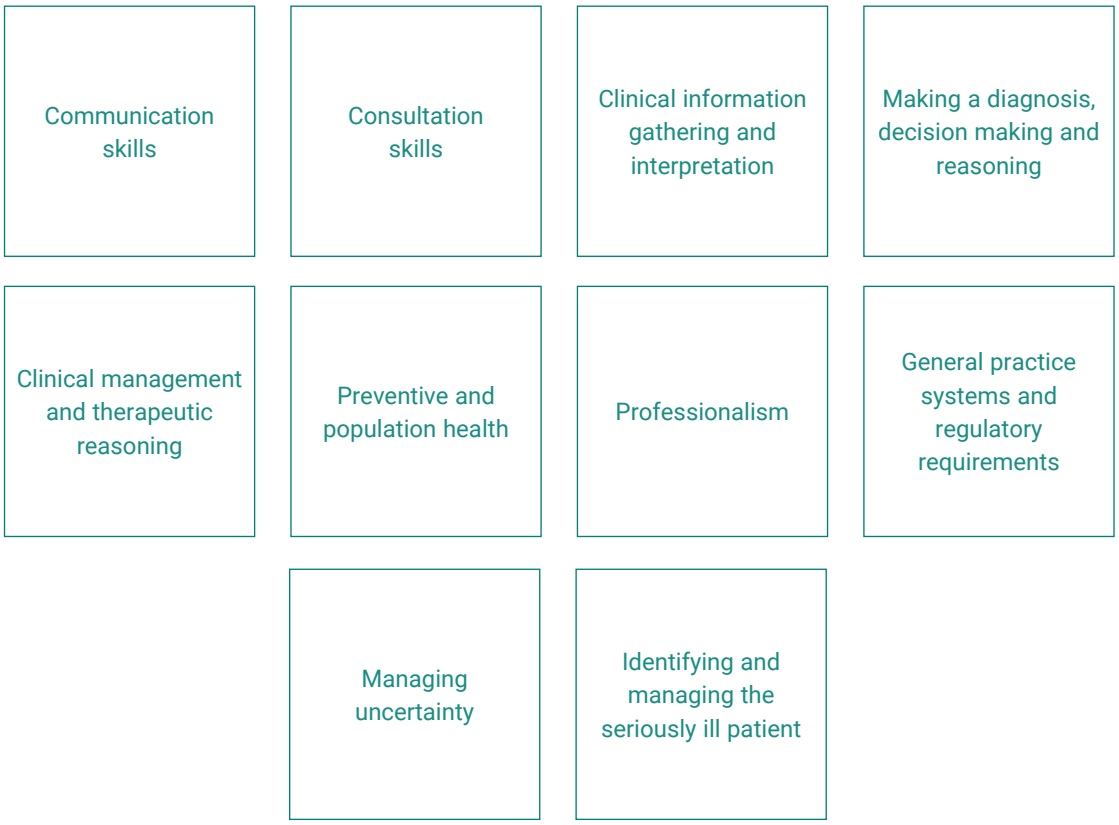
Criteria	Performance list
Appropriately uses IT systems to improve patient care in the consultation	• Uses computer effectively during consultation, in most cases not interfering with patient communication
Maintains comprehensive and accurate clinical notes	• Clinical notes are generally concise and accurate • Clinical notes contain sufficient information about diagnosis and management plans
Informed consent is explained and obtained	• Generally provides clear explanations relating to consent • Demonstrates understanding of informed consent and has ability to obtain consent

WBA competency rubric

The RACGP curriculum and syllabus for Australian general practice describes the key competencies and learning outcomes of general practice education. It consists of seven core units, including the five domains of general practice together with the Aboriginal and Torres Strait Islander health and rural health units. Within the five domains of general practice there are fifteen core competencies that describe what is expected of a competent GP. This is further sub- divided into numerous core competency outcomes. Each core competency is a statement of the end point that indicates the achievement of competence in a key area of general practice.

Specific workplace-based assessment (WBA) competencies have been developed to enable assessment in the workplace and have been mapped to the core competency framework outlined in the curriculum and syllabus. The WBA competencies focus on the clinical consultation, including clinical and therapeutic reasoning as well as areas that are often not adequately assessed by the Fellowship exams, such as professionalism and general practice systems and regulatory requirements.

WBA competency areas



Criteria and performance lists

Within each WBA competency are criteria that describe the performance expected at the level of Fellowship – the point at which the registrar is ready to demonstrate competence for unsupervised practice in Australia. The criteria provide a description of the performance that is expected as a registrar progresses through training and frame the competencies in the context of clinical practice. The performance lists are not linked to a stage of training; this is to align the assessments with the concept that competencies develop at different rates. The criteria and performance lists serve as the link between the competencies and clinical practice.

Each criterion is a description of a measurable action, and further descriptions of performance or observable behaviours are listed against which that action can be measured. This behavioural approach looks at the registrar's knowledge, skills and attitudes and how this is applied in clinical practice. The focus is on providing feedback on observable behaviours.

The performance lists provide 'word pictures' of behaviours indicative of performance at a particular level. The performance list should be used as a guide for rating performance and providing feedback and not as a checklist. Choose the rating that best matches your assessment of the performance(s) you have observed.

The standard expected is set at the point of Fellowship for all workplace-based assessments. This is the level at which the registrar is ready to demonstrate that they are capable of unsupervised general practice in Australia.

Competency grid rating

Each competency area is rated using the scale shown in the table below. If a competency is not observed in a particular assessment or is observed in a limited capacity with insufficient evidence collected to make a judgement, the assessor may select the 'not observed/assessed' option.

☐	☐	☐	☐	☐
Not observed/ assessed	**Well below Fellowship standard**	**Some criteria at Fellowship standard**	**Most criteria at Fellowship standard**	**All criteria at Fellowship standard**

Global assessment of competence

The global assessment represents the assessor's overall impression of the registrar's performance in the assessment. For the mid- and end-term assessments/reports that are completed by the primary supervisor, the global assessment is the overall impression gained from all assessments completed during the period. It should reflect the registrar's progression towards competent, unsupervised general practice in Australia. To be rated at the expected Fellowship standard, the registrar should consistently perform at that level.

Global assessment of competence	☐	☐	☐
	Well below Fellowship standard	**Progressing towards Fellowship standard** *Needs further development to meet performance expectations for indicated competencies*	**At Fellowship standard**

Communication skills

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 core skill in general practice. Communication and consultation are patient- centred, and the registrar engages with the patient to understand their ideas, concerns and expectations. The development of respectful therapeutic relationships involves empathy and sensitivity, with the registrar 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 registrar checks for understanding and agreement at various times during the consultation.

Criteria	**Performance lists**		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Communication is appropriate to the person and the sociocultural context	• Lack of awareness of patient's perspective, doctor-centred approach with a strong focus on the disease/diagnosis rather than the patient • Does not take into consideration the patient's sociocultural or occupational context	• Mostly explores the problem from the patient's perspective • Limited ability to consider the patient's sociocultural or occupational context	• Explores the presenting problem from the patient's perspective • Considers and discusses the patient's sociocultural context as part of the consultation – Considers occupational aspects of the presenting problem – Adapts communication style as appropriate for the patient

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Engages the patient to gather information about their symptoms, ideas, concerns, expectations of healthcare and the full impact of their illness experience on their life	• Does not recognise or respond to patient cues • Misses significant patient cues • Lack of effort to understand the patient's ideas, concerns or expectations • Does not display empathy or curiosity about the patient	• Develops a relationship that works, but may focus on the problem rather than considering the patient's perspective • May provide sympathetic responses ("I am sorry to hear that") • Responds to some cues, but misses key verbal and non-verbal patient cues at times	• Considers and discusses the impact of the presentation on the patient's function • Shows respect throughout • Responds to verbal cues from the patient or their family • Provides empathic responses where appropriate • Responds to non-verbal cues – this can be verbal (commenting that a patient may seem upset), or active (a change in posture, offering the patient a tissue) • Explores presenting problem from the patient's perspective • Shows a genuine curiosity to find out what the patient really thinks

Matches modality of communication to patient needs, health literacy and context	• Does not adapt language to match the patient's needs and level of understanding • Uses medical jargon most of the time	• Uses medical jargon at times without checking for patient understanding	• Adapts language to match the patient's level of understanding • Uses concise, easily understood language, and avoids or explains jargon
	• Does not display effective communication in difficult situations • May fail to recognise when patients are angry and inflame/ escalate situations • Inappropriate delivery of bad news, and may appear insensitive	• Breaks bad news using a pragmatic, doctor-centred approach • May appear uncomfortable in difficult situations or talk excessively • Appropriately matches communication to the situation, but may appear awkward at times • Recognises when patients are distressed, angry or when their expectations haven't been met • Attempts to employ strategies to de-escalate angry patients	• Uses silence effectively • Uses appropriate balance of open and closed questions • Breaks bad news sensitively • Uses framework for delivering bad news, such as the SPIKES model[2] • Effective use of de-escalation strategies to manage situations when a patient is angry or agitated • Sensitively discusses prognosis and end-of-life decisions • Sensitively manages patients affected by trauma

[2] Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES - A six-step protocol for delivering bad news: Application to the patient with cancer. Oncologist 2000;5(4):302 -11. doi: 10.1634/theoncologist.5-4-302" and check on Word doc that this is correct

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Demonstrates active listening skills	• Does not demonstrate active listening • Interrupts patients when they are talking • At the start of the consultation, does not use the '90 second rule' and does not let the patient tell their whole story • May give responses to the patient that demonstrate that they have not heard what is being said • May demonstrate poor eye contact or inappropriate body language • Focus may often be directed at the computer rather than the patient • May miss patient cues	• Uses the '90 second rule' at the start of consultations • May use many closed/ directed questions • May interrupt the patient at inappropriate times • Maintains appropriate eye contact • Uses appropriate body language, faces the patient and appropriately uses mirroring • Active listening may be interrupted by computer use at times	• Listens attentively to the patient's opening statement without interrupting or directing patient's response • Listens attentively, allowing patient to complete statements without interruption, and leaves space for patient to think before answering or to pause before continuing • Uses open and closed questioning technique, appropriately moving between open and closed • Appropriate use of body language and minimal encouragers • Recognises and responds appropriately to patient cues

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Uses a variety of communication techniques and materials (eg written or electronic) to adapt explanations to the needs of the patient	• Poor explanations given to patients that are not appropriate to the patient's needs • Limited variety of communication techniques used • Does not display consideration of the patient's health beliefs or level of health literacy • May not engage use of an interpreter when needed	• Provides adequate explanations • Checks for patient's understanding most of the time • Seeks to understand and consider the patient's health beliefs most of the time • Uses both verbal and written communication techniques • Mostly engages interpreters where appropriate	• The patient's problem is explained in such a way that they can easily understand • The explanation is relevant, understandable and appropriate • Checks patient's understanding of information given, or plans made • Uses a variety of explanation techniques, including images and patient handouts where appropriate • The patient's health beliefs are taken into consideration or referenced during the explanation of the problem • Gives explanation at appropriate times, and avoids giving advice, information or reassurance prematurely • 'Chunks and checks': gives information in manageable amounts, and checks for understanding • Uses patient's response as a guide to how to proceed • Effectively engages interpreters where appropriate

Consultation skills

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Adapts the consultation to facilitate optimal patient care	• Consultation is unfocused, unstructured and doctor may appear stressed or chaotic • Does not appropriately accommodate patient's needs • Does not appropriately include significant others in the consultation	• Uses a formulaic approach to achieve the main tasks of the consultation • Unable to adapt the consultation to new information • Mostly accommodates patient's needs, including having significant others in the consultation for support	• Flexible in approach, with regard to both what is covered in the consultation and timing • Accommodates the patient's needs, including having family or other support in the consultation • Allows the patient adequate time to tell their story
Consults effectively in a focused manner within the timeframe of a normal consultation	• Consultation length inappropriate for the patient's needs or presentation • Mostly uses closed questions when open questions more appropriate • Poor time management	• Consultation may be overly long for the presentation or too brief for a complex presentation • Mostly obtains a comprehensive problem list from the patient and prioritises appropriately • Uses open questions	• Consultation is focused with a clear structure • Prioritises appropriately when the patient presents with multiple issues • Confirms patient's problem list and screens for further problems • Uses open and closed questioning technique, appropriately moving between open and closed • Clarifies any of the patient's statements that are unclear • Periodically summarises to verify own understanding

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Prioritises problems, attending to both the patient's and the doctor's agenda	• The consultation may be too focused on the doctor's agenda or the doctor may give in to inappropriate requests from the patient	• Demonstrates need to negotiate the agenda for the consultation with the patient • Effectively incorporates both patient's and doctor's agenda in the consultation in most instances	• Effectively negotiates the agenda for the consultation with the patient • Takes account of the patient's expectations • Effectively addresses both the patient's agenda and other relevant medical needs
Safety netting and specific follow-up arrangements are made	• Fails to demonstrate safety-netting techniques • Fails to arrange follow-up when appropriate	• May give instructions for follow-up arrangements which are vague or non-specific • May not provide adequate safety-netting advice or guidance on when to seek help	• Gives clear follow-up advice to patients routinely • Educates patients on when to seek guidance for symptom deterioration

Clinical information gathering and interpretation

This competency is about the gathering, interpretation and use of data 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. They should be appropriate to the patient and presentation and be evidence-based.

Criteria	**Performance lists**		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
A comprehensive biopsychosocial history is taken from the patient	• Demonstrates lack of awareness of red and yellow flags and the 'masquerades' of general practice • Asks questions without clear focus on potential diagnoses • History-taking is overly detailed, but not relevant to the presenting symptoms • Minimal or no history-taking • History-taking may be disorganised, inflexible or inefficient	• Takes a history that is organised and relevant to the presenting symptoms/problem, but it may be too detailed or inefficient • May not be able to adapt history-taking to new information that becomes available • May fail to obtain sufficient information to rule out all red flags	• Obtains sufficient information from the history to include or exclude any likely relevant significant conditions (red flags, masquerades) • Organised approach to history-taking so it is relevant and targeted to the presenting symptoms • Responds to patient cues to elicit positive and negative details • Use questions that are relevant and focused • Integrates a mental state assessment, depression screen and risk assessment into history-taking where appropriate
All available sources of information are appropriately considered when taking a history	• Fails to gather information from patients' medical records or other relevant sources	• May not seek information from all relevant sources • Uses existing information in patient records	• Considers information provided by a third party, such as a family member or carer • Reviews any available clinical notes or patient medical records that would provide relevant information

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
An appropriate and respectful physical examination is undertaken, targeted to the patient's presentation and likely differential diagnoses	• Fails to conduct an appropriate and focused physical examination that is relevant to the patient's problem • Examination technique is poor • Demonstrates lack of consideration for patient comfort. Patient may appear upset during the examination. • May fail to obtain consent for physical examination • Provides no or poor explanation of reasons for the examination to the patient • May demonstrate poor hand hygiene	• Conducts an appropriate and focused examination for the presenting problem, but it may be inadequate or incomplete • May not fully consider patient comfort • May provide inadequate explanation of reasons for the examination	• Performs a systematic physical examination that is appropriately focused • Obtains appropriate consent before performing an examination • Enquires if the patient would prefer a chaperone present when undertaking an examination that could be intimate • Identifies potential cultural considerations that may affect the appropriateness of an examination, such as doctor's gender • Appropriate consideration is given to patient comfort, safety and modesty • Provides appropriate explanation of the reasons for the examination and findings to the patient throughout • Washes hands prior to performing a physical examination

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Physical examination findings are detected accurately and interpreted correctly Specific positive and negative physical examination findings are elicited	• Fails to recognise significant physical examination signs • Fails to use examination equipment correctly • Fails to identify normality	• May fail to recognise some physical examination findings • Uses examination equipment correctly, but may fail to identify some relevant abnormal physical signs	• Performs physical examination using appropriate recognised techniques • Appropriately interprets examination findings to confirm or exclude possible diagnoses • Uses appropriate examination equipment correctly to perform physical examination (eg ophthalmoscope) • Examines all relevant areas to assist in confirming or excluding possible diagnoses

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Rational options for investigations are chosen using an evidence-based approach	• Investigation requests are inappropriately ordered, and are outside of recognised guidelines • Demonstrates lack of consideration for patient access to investigations, such as cost and location • May choose inappropriate investigations that could result in patient harm • Fails to select most appropriate and relevant investigations – either very limited list is provided or provides an exhaustive list that includes multiple investigations that are not relevant to the case • Demonstrates poor rationale for investigations requested	• May request investigations outside of recognised guidelines or investigations that are not appropriate for the patient's problem • May fail to request all appropriate investigations • May not be able to adequately justify rationale for all the investigations requested • May not fully consider patient access to investigations, such as cost and location	• Requests appropriate investigations for the patient's presentation and likely diagnosis • Selects relevant investigations in an appropriate sequence • Defers investigations that are directed to less likely or important diagnoses • Considers which diagnostic tests are likely to be the most beneficial to the health of the patient • Considers cost and patient access when requesting investigations • Provides appropriate rationale for investigations requested
Interprets investigations in the context of the patient's presentation	• May incorrectly interpret investigation results outside the context of the patient's presentation • Fails to understand the significance and implications of abnormal results	• May not fully interpret investigation results in the context of the patient's presentation	• Accurately interprets investigations • Interprets investigations taking into consideration the patient's history, current presentation and current medication

Making a diagnosis, decision making and reasoning

This competency 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 registrar's ability to think about and reflect on their reasoning is another aspect of this assessment domain. This competency is closely aligned with information gathering; however, it can also be assessed in different ways.

Criteria	**Performance lists**		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Integrates and synthesises knowledge to make decisions in complex clinical situations	• Demonstrates difficulty managing the full range of patients who present to the practice • Demonstrates poor integration of presenting symptoms and signs when considering diagnosis • Poor or incorrect diagnostic formulation. Decision making is indecisive or illogical • May fail to consider key features of a patient's presentation to synthesise clinical decisions	• May demonstrate difficulty managing some patients who present to the practice with multiple problems or complex needs • May not be able to integrate all features of the patient's presentation to synthesise clinical decisions • Makes decisions by applying recognised guidelines without consideration of epidemiological factors of disease or the patient's local context • May demonstrate inadequate understanding of disease pathophysiology	• Demonstrates ability to treat the full range of patients who present to the practice • Demonstrates sophisticated diagnostic reasoning. Discusses key and differentiating features of symptoms and uses this to sort them into likely diagnoses • Demonstrates awareness of local and population health factors when making a diagnosis. Discusses epidemiology of symptoms (who gets the disease), including demographics and risk factors • Considers the temporal course of illness, including the duration and pattern of the symptoms • Demonstrates clear understanding of the pathophysiology of the disease

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Modifies differential diagnoses based on clinical course and other data as appropriate	• Fails to seek out and consider important clinical information over time in an episode of care • May demonstrate rigid thinking and difficulty in modifying differential diagnoses as appropriate over time	• May fail to conduct ongoing review of relevant clinical information as it comes to hand • May demonstrate lack of flexibility in reconsidering diagnoses and management plans as appropriate for the clinical course	• Reviews history, progress and current status at follow-up • Reviews discharge summaries and specialist reports • Reflects on feedback from the patient or others and incorporates this in decision making
Demonstrates diagnostic accuracy (this does not always require the correct diagnosis, but that the direction of reasoning was appropriate and accurate)	• Demonstrates poor diagnostic accuracy • Demonstrates poor rationale for diagnostic reasoning • May demonstrate 'premature closure' and fail to consider a comprehensive range of differential diagnoses • Fails to consider serious diagnoses or misses relevant diagnoses • Lacks knowledge of most likely diagnosis, important differential diagnoses and serious conditions not to be missed	• May demonstrate minor errors in diagnostic accuracy and reasoning • Mostly considers a wide range of potential differential diagnoses based on the information available and employs a systematic approach to ruling diagnoses in or out	• Demonstrates understanding of patterns of disease presentation and how the pattern recognition enables diagnostic accuracy • Considers full range of differential diagnoses and employs a systematic approach to ruling diagnoses in/out • Gathers information appropriately and targeted to the most likely diagnoses and to rule out serious conditions
Collects/reports clinical information in a hypothesis-driven manner	• Fails to formulate appropriate working hypothesis/likely diagnosis • Demonstrates disorganised approach to reporting clinical information	• May demonstrate lack of structure in collecting or reporting clinical information	• Follows a clear line of enquiry, directing questioning and examination to specific findings likely to increase or decrease the likelihood of a specific diagnosis

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Articulates an appropriate problem definition	• Fails to articulate appropriate problem definition and problem list • Problem list may be inappropriate or incomplete	• Has difficulty in articulating clinical problem, and problem list may be incomplete • May give undue emphasis to certain findings • Develops an appropriate and adequate problem list	• Provides a clear synopsis of the clinical problem • Emphasises important positive and negative findings
Formulates a rational list of differential diagnoses, including most likely, less likely, unlikely and can't miss diagnoses	• May demonstrate unsafe diagnostic strategy • May miss important likely diagnoses • May fail to consider full range of differential diagnoses or serious diagnoses not to be missed	• May demonstrate inaccurate ranking or differential diagnosis • May demonstrate minor errors in diagnostic strategy	• Provides an accurately ranked list of differential diagnoses • Demonstrates the use of a safe diagnostic strategy
Directs evaluation and treatment towards high priority diagnoses	• Fails to appropriately direct evaluation and treatment towards high priority diagnoses	• May not always appropriately defer investigations directed towards low- priority diagnoses • May demonstrate some inefficiencies in diagnostic evaluation and treatment	• Defers investigations that are directed to less likely or important diagnoses • Efficiently directs evaluation and treatment towards more likely diagnoses and diagnoses not to be missed
Demonstrates metacognition (thinking about own thinking)	• Fails to articulate own thinking and decision making	• May not fully articulate all factors influencing own decision making	• Demonstrates conscious awareness of factors which influenced decision making, including any emotional or situational factors

Clinical management and therapeutic reasoning

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	**Performance lists**		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Demonstrates knowledge of common therapeutic agents, including uses, dosages, adverse effects and potential drug interactions, and the ability to prescribe safely	• Does not refer to or use evidence- based or accepted guidelines when prescribing	• Is aware of and appropriately applies prescribing guidelines in most instances	• Chooses medication using an evidence-based approach • Demonstrates extensive knowledge of commonly prescribed medications • Appropriately applies prescribing guidelines
Undertakes rational prescribing	• May demonstrate unsafe prescribing, such as prescribing medication without checking allergies, drug interactions or taking into consideration the patient's age and comorbidities • May be unduly influenced by patient expectations	• Makes safe and rational prescribing decisions • May make minor errors by failing to consider multimorbidity when prescribing	• Makes safe prescribing decisions, routinely checking on drug interactions and side effects • Prescribing is influenced by consideration of patient age, comorbidities and possible drug interactions

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Monitors for medication side effects and risks of polypharmacy	• Demonstrates poor knowledge of risks of polypharmacy • May not monitor for medication side effects • Fails to review medication when appropriate to do so	• Describes how to stop or step down medication where appropriate • Is aware of risks of polypharmacy and seeks assistance where appropriate	• Plans and performs medication reviews • Checks for acute and chronic side effects • Demonstrates confidence in stopping or stepping down medication where appropriate • Addresses and manages issues of polypharmacy appropriately
Outlines and justifies the therapeutic options selected, basing these on the patient's needs and the identified problem list	• Demonstrates lack of knowledge of appropriate therapeutic options • Demonstrates significant errors in justification of therapeutic options	• Outlines common and appropriate therapeutic options • May lack awareness of full range of therapeutic options • May demonstrate minor errors in justification of therapeutic options	• Discusses appropriate therapeutic options • Articulates sound therapeutic reasoning
Safely prescribes restricted medications using appropriate permits	• Demonstrates lack of awareness of legal frameworks when prescribing restricted medication or does not adhere to the requirements • Documentation may be inadequate • Demonstrates poor understanding of pain management and the importance of a pain management plan	• Demonstrates awareness of the legal frameworks for restricted medication prescribing • Maintains adequate records • Can describe the importance of a pain management plan	• Prescribes restricted medication within the appropriate legal frameworks • Keeps clear and accurate records regarding rationale for prescribing • Has pain management plans in place for patients prescribed opioids • Refers appropriately to a pain management specialist

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Non-pharmacological therapies are offered and discussed	• Failure to consider non- pharmacological therapies where these options could reasonably be considered	• Has limited discussion about non- pharmacological options and focuses mainly on pharmacological options	• Where appropriate discusses: • lifestyle modifications (smoking, nutrition, alcohol, physical activity [SNAP]) • physical therapies • psychological approaches • surgical procedures (eg hip replacement surgery) • return-to-work planning
A patient-centred and comprehensive management plan is developed	• May fail to provide appropriate follow up or safety net arrangements • Fails to check for patient understanding or ability to comply with management advice	• May provide general management plans that lack detail or are not • specific to the patient or patient-centred • May not fully ensure that patient agrees with or understands the plan	• Appropriate safety netting is arranged • Consideration is given to patient's health literacy, expectations and social circumstances • Assesses and addresses patient expectations
Provides effective explanations, education and choices to the patient	• Fails to provide effective explanations • Does not check patient understanding	• Performs a cursory check of patient understanding • Has limited discussion about possible outcomes, benefits or risks	• Discusses possible outcomes • Discusses uncertainties of treatment options • Provides balanced communication regarding risks versus benefits • Specifically checks that the patient understands the management plan

Preventive and population health

This competency is about the provision of general practice care and service that supports 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 at both the individual and community level. Disease prevention and health promotion activities are included here.

Criteria	**Performance lists**		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Implements screening and prevention strategies to improve outcomes for individuals at risk of common causes of morbidity and mortality	• Fails to implement recognised guidelines for preventive and screening activities • May recommend inappropriate screening or preventive activities that are not supported by an evidence base	• Conducts screening that is mostly evidence based and appropriately targeted for the patient	• Identifies specific risk factors for priority diseases • Engages in age and risk-appropriate screening • Follows recognised guidelines for preventive and screening activities (RACGP Red Book) • Recall systems are used (eg cervical smears, vaccinations)
Uses planned and opportunistic approaches to provide screening, preventive care and health promotion activities	• Fails to provide opportunistic screening and preventive health activities	• May miss opportunities to provide screening and preventive health activities	• Incorporates disease prevention and health promotion in the ongoing care of patients • Provides opportunistic and appropriate immunisation • Provides targeted immunisation appropriate to the patient and the population

Criteria	Performance lists		
	Well below Fellowship standard	Progressing towards Fellowship standard	At Fellowship standard
Coordinates a team-based approach	• Demonstrates limited knowledge of healthcare teams • Fails to appreciate the value of a team-based approach • Fails to coordinate a team-based approach	• Describes the health practitioners who could be involved in care, but may not always involve other practitioners or refer appropriately	• Appropriate referrals are considered and discussed • Involves other healthcare practitioners in the care of the patient
Demonstrates understanding of available services in the local community	• Demonstrates a lack of awareness of the range of available local resources • Referrals to other services may be inadequate or inappropriate • Approach to patient care may risk fragmenting care of the patient	• Demonstrates limited engagement with local healthcare teams • Has a limited understanding of how to access community services	• Discusses local services with the patient and their family • Assists the patient to negotiate obstacles to the care that they need in the community (eg aged care referrals) • Actively engages with local healthcare teams
Manages current and emerging public health risks appropriately	• Demonstrates poor knowledge or awareness of public health risks or issues	• Is aware of public health issues, but may not always manage appropriately • Demonstrates some awareness of disease trends	• Identifies and manages issues of public health concern • Implements vaccination programs. • Is up to date with disease trends. • Is up to date with guidelines regarding screening and prevention • Makes appropriate notifications to the state or territory department of health • Assists with contract tracing

Criteria	Performance lists		
	Well below Fellowship standard	Progressing towards Fellowship standard	At Fellowship standard
Educates patients and families in disease management and health promotion skills	• Demonstrates poor understanding of the options for modifying risk factors	• Recognises the role of the GP in health promotion • Makes limited use of the consultation to engage with the patient and family about disease management or health promotion skills	• Uses the consultation to provide education to the patient/family • Discusses modifiable risk factors • Provides advice on lifestyle modification • Opportunistically checks immunisation status
Identifies opportunities to effect positive change through health education and promotion	• Does not assist patient with behaviour change	• May not make full use of opportunities to provide health education and promotion	• Provides specific advice on lifestyle modification appropriate to the patient's specific context • Discusses harm minimisation with patients with substance addictions
Uses appropriate strategies to motivate and assist patients in maintaining health behaviours	• Does not modify approach to providing health advice when the patient appears to be resistant • May demonstrate a judgemental, authoritative or paternalistic style or coerce the patient to change • Does not demonstrate use of motivational interviewing techniques	• Describes how to identify the patient's stage of change • Is aware of motivational interviewing techniques, but may not be proficient in applying this technique • Adopts a non-judgemental and supportive approach for each patient	• Identifies the patient's stage of change • Appropriately assesses the patient's level of health literacy • Provides information about risks of not changing behaviours • Acknowledges the patient's perspective

Professionalism

This competency incorporates two aspects of professionalism. 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, demonstrating a willingness to change, is included.

Learning and professional development

Being able to respond appropriately to feedback as an educational dialogue, demonstrating 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	**Performance lists**		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Encourages scrutiny of professional behaviour, is open to feedback and demonstrates a willingness to change	• May avoid feedback discussions • May demonstrate defensive behaviour and a non-willingness to accept feedback or initiate change	• Engages in feedback discussions • Demonstrates willingness to change	• Seeks feedback and engages in dialogue about professional behaviour
Exhibits high standards of moral and ethical behaviour towards patients, families and colleagues (including an awareness of appropriate doctor–patient boundaries)	• May demonstrate poor knowledge of ethical standards and codes of conduct • May lack insight into professional limitations • May fail to seek help appropriately • May not fully take responsibility for own actions • May demonstrate breach in confidentiality or inappropriate doctor– patient relationships	• Demonstrates good knowledge of ethical standards and codes of conduct • Maintains confidentiality • Recognises professional limitations and asks for help appropriately • Takes responsibility for own actions • Recognises challenging situations with respect to doctor–patient relationships	• Upholds high ethical standards and follows codes of conduct for medical practitioners • Respects doctor–patient boundaries • Maintains confidentiality • Recognises professional limitations • Respects the patient's culture and values • Care of the patient is the primary concern • Practises medicine safely at all times • Demonstrates honesty at all times • Takes responsibility for own actions

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Appropriately manages ethical dilemmas that arise	• May fail to recognise ethical dilemmas as they arise • May demonstrate inappropriate regard for the patient's culture or values • Demonstrates poor approach to management of ethical dilemmas that arise	• Demonstrates good understanding and respect for the patient's culture and values • Recognises ethical dilemmas as they arise and seeks help appropriately • Is able to discuss how to appropriately manage ethical dilemmas that arise	• Is aware of own values and belief systems and how these may have an impact on patient care • Recognises and appropriately addresses ethical dilemmas as they arise • Considers multiple perspectives and available options to facilitate a decision
Identifies and manages clinical situations where there are obstacles to meeting duty of care responsibilities	• Poorly describes both how to manage clinical situations where there are obstacles to meeting duty of care responsibilities and how to ensure that care of the patient is the primary concern • Fails to identify obstacles to meeting duty of care responsibilities	• Appropriately identifies barriers to meeting duty of care responsibilities • Can discuss both how to manage clinical situations where there are obstacles to meeting duty of care responsibilities and how to ensure that care of the patient is the primary concern	• Understands issues involved in contact tracing for communicable disease where the patient wishes to remain anonymous • Is able to manage expectations of workplace stakeholders when dealing with workers compensation injuries • Describes how requirements of mandatory reporting can impact the provision of care • Reviews fitness to drive and is aware that this could impact on patient care or the therapeutic relationship

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Implements strategies to review potential and actual critical incidents to manage consequences and reduce future risk	• Fails to recognise potential and actual critical incidents • Fails to report significant incidents • Fails to take appropriate action to maintain patient safety or comply with relevant policies and procedures	• Recognises and appropriately reports potential and actual critical incidents • Takes appropriate action to maintain patient safety • Complies with relevant policies and procedures	• Recognises potential and actual critical incidents • Acts immediately to rectify the problem, if possible, and seeks any necessary help and advice • Explains to the patient, as promptly and fully as possible, what has happened and the anticipated short-term and long-term consequences • Acknowledges any patient distress and provides appropriate support • complies with any relevant policies, procedures and reporting requirements, subject to advice from medical indemnity insurer • Reviews adverse events and implements changes to reduce the risk of recurrence • Reports adverse events to the relevant authority, as necessary

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Personal health issues are identified and managed by accessing professional support as needed	• May fail to identify own physical or psychological impairment • May fail to access appropriate professional support when needed	• Is aware of need to identify own physical or psychological impairment that may impact on ability to manage professional responsibilities	• Identifies own physical or psychological impairment that may impact on wellbeing or ability to manage responsibilities, and ensures that a robust management plan is developed
Judges the weight of evidence, using critical appraisal skills and an understanding of basic statistical terms, to inform decision making	• May fail to apply evidence-based approach to inform decision making • Demonstrates poor critical appraisal skills	• Accesses relevant clinical evidence-based information and uses this to inform decision making	• Uses critical appraisal skills to determine if resources are applicable to a particular patient • Actively seeks out evidence-based knowledge and applies this to patient care
Shows a commitment to professional development through reflection on performance and the identification of personal learning needs	• May fail to demonstrate commitment to professional development • May fail to reflect on own performance • May fail to appropriately identify or act on personal learning needs • Lacks insight into own performance and learning needs • May demonstrate poor reflection on personal behaviour and the impact of that behaviour on patients and colleagues	• Demonstrates commitment to professional development • Demonstrates ability to reflect on own performance • Formulates and acts on appropriate personal learning needs	• Reflects on clinical skills and knowledge in order to engage in a process of continuous learning • Undertakes regular reflection and self-appraisal • Appraises and reviews own response to constructive feedback • Participates regularly in activities that maintain and develop knowledge, skills and performance • Regularly reviews continuing medical education and continuing professional development activities to ensure they are consistent with recommendations from the relevant professional organisation and regulatory authorities

Criteria	Performance lists		
	Well below Fellowship standard	Progressing towards Fellowship standard	At Fellowship standard
Attends and participates in all learning and assessment activities of an education and training program	• Fails to attend all required learning activities • May not fully participate or engage in learning activities or assessments	• Attends most learning activities as required by the training program • Actively participates in learning and assessment activities	• Attends learning activities as required by the training program • Actively participates in learning and assessment activities
Actively engages in feedback as a dialogue, discussing performance and setting own goals for professional development	• May demonstrate avoidant or defensive behaviours when offered feedback on performance	• Is receptive to feedback when provided	• Actively seeks feedback • Contributes to feedback by reflecting on performance • Identifies areas for improvement
Participates in audits and quality improvement activities and uses these to evaluate and suggest improvements in personal and practice performance	• May fail to participate in audits and quality improvement activities	• Actively participates in audits and quality improvement activities	• Undertakes a clinical audit to a high standard

General practice systems and regulatory requirements

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	**Performance lists**		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Appropriately uses the computer/IT systems to improve patient care in the consultation	• Use of the computer during the consultation consistently interferes with patient communication	• Use of the computer may sometimes interfere with patient communication	• Uses the computer effectively during the consultation without it interfering with patient communication • Uses the IT systems available to access recall systems, relevant patient data
Maintains comprehensive and accurate clinical notes	• Medical records may contain insufficient detail or inaccurate information • There may be frequent delays in providing documentation, which may impact on colleagues or patient care	• Clinical records are accurate but may be incomplete or lack appropriate detail • Clinical records may be poorly structured, wordy or difficult for others to follow, providing a barrier to patient care • There may be occasional delays in providing documentation	• Records are accurate and provided in an appropriate time frame • Patient notes are up to date, clear and accurate • Diagnoses are clearly and precisely documented in patient notes • Management and follow-up plans are clearly and precisely documented
Written communication is clear, unambiguous and appropriate to the task	• Written communication may be unclear or inadequate to convey the intended messages	• Written communication is adequate to convey the intended messages	• Referral letters are legible and clearly state the purpose of the referral • Instructions to the patient are legible and in language that the patient can understand

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Demonstrates efficient use of recall systems to optimise health outcomes	• May demonstrate lack of awareness or inadequate use of recall systems • May not ensure appropriate follow-up	• Appropriately uses recall systems • Describes the systems used to identify and notify individuals in need of follow-up	• Uses a recall system to ensure appropriate follow-up of patient results • Uses a follow-up system to ensure appropriate follow-up of agreed management steps
Accurately completes legal documentation appropriate to the situation	• Demonstrates poor knowledge of legal requirements, such as work certificates, workers compensation certificates and reports	• Accurately completes legal documentation • May demonstrate minor errors in knowledge of legal processes and systems	• Accurately completes fitness to drive documentation • Accurately completes work capacity or fitness to work certificates • Accurately completes any other documentation as appropriate to the situation • Describes the legal requirements when undertaking assessment and reporting of fitness to drive • Describes the legal requirements when undertaking work capacity certificates • Describes the considerations of work capacity certificates

Criteria	Performance lists		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Implements best practice guidelines for infection control measures	• Fails to wash hands prior to physical examination or procedures • May not be aware of or may not implement appropriate infection control measures	• Practises appropriate hand hygiene and infection control measures in most instances	• Regularly practises appropriate hand hygiene • Responds appropriately in the event of body fluid spills or needle stick injury • Promotes immunisation of self and staff
Patient confidentiality is managed appropriately	• May inappropriately breach patient confidentiality (ie when there is no evidence of need to break confidentiality to protect public interest)	• Maintains confidentiality appropriately • May demonstrate difficulties in managing situations where there are valid exceptions to the rule of confidentiality. Seeks help appropriately	• Keeps identifiable information private • Manages exceptions to this obligation, such as when there is a legal subpoena or requirements for mandatory reporting
Informed consent is explained and obtained	• May not fully explain and obtain appropriate informed patient consent	• Explains and obtains appropriate patient consent in most instances • Has some understanding of how to determine capacity to give informed consent and how capacity impacts on ability to obtain informed consent	• Provides accurate and comprehensive information tailored to the individual, including the options available and the risks and benefits of these options • Gains consent for physical examination, procedures, management plans and to have a third party present in the room for educational purposes • Appropriately assesses capacity to provide consent

Managing uncertainty

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 both health and economic perspectives. Undifferentiated conditions are often associated with uncertainty and ambiguity, and present management challenges for the clinician.

Clinical decision making regarding choice of investigations needs to be rational and balance the potential risks of both over- and under-investigation and management, against the benefits to the individual.

Criteria	**Performance lists**		
	Well below Fellowship standard	**Progressing towards Fellowship standard**	**At Fellowship standard**
Manages the uncertainty of ongoing undifferentiated conditions	• May fail to appropriately manage undifferentiated conditions • May prescribe unnecessarily • May request inappropriate investigations	• May demonstrate some discomfort with clinical uncertainty and ambiguity • May tend to prescribe or act in situations where there is a lack of clear evidence for doing so • Can articulate uncertainties and approach to managing undifferentiated conditions • Appropriately uses time as a diagnostic tool	• Excludes serious or red flag conditions • Formulates a management plan in the absence of a diagnosis • Refrains from treatment when applicable (watchful waiting) • Appropriately uses time as a diagnostic tool • Makes rational and evidence-based choices about investigations • Arranges appropriate and timely patient review
Addresses problems that present early and/or in an undifferentiated way, by integrating all the available information to help generate differential diagnoses	• May not seek out or consider all available information • May demonstrate difficulty in managing undifferentiated presentations or complex situations • May exhibit 'premature closure' and make premature clinical decisions based on inadequate information	• Appropriately addresses problems that present in an undifferentiated way, in most instances • Demonstrates flexibility in integrating all available information to help generate differential diagnoses	• Discusses key and differentiating features of symptoms and uses this to sort them into likely diagnoses • Gathers information appropriately targeted to the most likely diagnosis • Considers the temporal course of disease, including the duration and pattern of symptoms • Demonstrates the use of a safe diagnostic strategy

Criteria	Performance lists		
	Well below Fellowship standard	Progressing towards Fellowship standard	At Fellowship standard
Recognises when to act and when to defer doing so, and uses time as a diagnostic tool	• May fail to act in serious or time-sensitive situations • Fails to seek help when unsure	• Acts appropriately in serious and time-sensitive situations in most instances • Mostly avoids unnecessary intervention when there is no clinical justification	• Avoids intervention when there is no clinical justification • Acts appropriately in serious and time-sensitive situations • Arranges appropriate review • Applies knowledge of normal course of disease and intervenes when appropriate

Identifying and managing a significantly ill patient

A significantly ill patient is an individual at any life stage who is at risk of actual or acute potentially life-threatening health problems. GPs are required to identify significant illness early and manage this in line with accepted guidelines.

Criteria	Performance lists		
	Well below Fellowship standard	Progressing towards Fellowship standard	At Fellowship standard
A significantly ill patient is identified	• May fail to identify significantly ill patients	• Correctly identifies significantly ill patients in most instances	• Correctly identifies actual or potentially life-threatening health problems
Has confidence in and takes ownership of own decisions while being aware of own limitations	• May fail to take ownership of decisions or provide leadership in care of unwell patients or emergency situations • Demonstrates lack of confidence in identifying and managing serious situations • May demonstrate lack of awareness of own limitations	• Mostly takes ownership of decisions and responsibilities and demonstrates confidence in identifying and managing emergency situations and unwell patients • Demonstrates awareness of own limitations	• Reflects on clinical skills and knowledge in order to engage in a process of continuous learning • Identifies areas for improvement • Recognises professional limitations • Takes responsibility for own actions

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